TITLE V BLOCK GRANT APPLICATION

2025 ANNUAL REPORT AND 2027 APPLICATION

MARCH 31, 2026

NJ DEPARTMENT OF HEALTH
55 N. Willow Street Trenton, NJ 08611

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III.A.1 Program Overview

New Jersey (NJ) prioritizes cross-state collaboration to strengthen services and reduce duplication of efforts to ultimately improve maternal and child health outcomes. The NJ Department of Health (NJDOH), Family Health Services Division (FHS), manages the Title V Program (TVP) across the state, to ensure families receive evidence-based and culturally appropriate services through the following programs:

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

- Healthy Women Healthy Families (HWHF): Through the HWHF initiative, the NJ Title V TVP has taken a targeted approach to reduce infant mortality rates beginning in 2018. As a result, partners from the Departments of Labor and Workforce Development, Education, Transportation, Children and Families, Human Services, and Community Affairs, as well as community partners, regularly collaborate with the NJDOH to strategize on ways to address these high rates. One of the most salient aspects of the HWHF initiative is the implementation of specific infant mortality reduction activities. To better address these disparities, recent TVP efforts include an emphasis on the 4th trimester (i.e., postpartum period) and contemporary ways to focus on and expand breastfeeding support and postpartum doula services.
- New Jersey Doula Learning Collaborative (NJDLC): To ensure the sustainability of community doula services, NJ TVP partnered with the NJ Department of Human Services (DHS) to offer doula services to women through Medicaid Benefits. NJ Medicaid benefits have been expanded to cover doula services. Presently, NJ pregnant and post-partum women whom Medicaid covers can receive services from a Medicaid-enrolled community doula. To date, 400 individuals have been trained to become community doulas, and as of December of 2025, 190 individual doulas and 10 group agencies have enrolled as fee-for-service community doulas.
- Colette Lamothe-Galette Community Health Worker Institute (CLG-CHWI): NJ TVP has also established and expanded NJ’s Community Health Worker (CHW) workforce. Created and hosted by the NJDOH, CLG-CHWI partners with multiple county colleges to deliver a standardized training course. This training equips CHWs with skills to provide equitable care for their clients and communities they serve. Concurrently, TVP is working with key officials to expand Medicaid benefits to cover CHWs' services. As of March of 2026, over 1200 CHWs have been trained and in the fall of 2024, the

first cohort for Spanish-speaking trainees was facilitated, with linguistic specific trainings ongoing through March of 2026.

- ConnectingNJ (CNJ): ConnectingNJ is a county-level, centralized point-of-entry referral system for pregnant women, post-partum women, fathers, and families with young children, to access programs, services, and supports. CNJ provides:
    - Linkages to resources from pregnancy to age five
    - Referrals to community services to promote child and family well-being
    - Case management services, developmental health promotion, and developmental screening
    - Primary referral source to Evidenced Based Home Visitation programs and the NJDOH's HHF Program

- NJ Post-Partum Resource and Support Network (NJPRSN): The primary goal of the PRSN Program is to enhance postpartum resources and service delivery through a statewide approach. This includes administering education and training for community providers to improve Perinatal Mood and Anxiety Disorders (PMAD) screening and ensure appropriate referrals to support services. A secondary goal is for grantees to educate and engage birthing individuals and their families on the signs and symptoms of PMADs, the importance of screening, and connecting to care—ultimately reducing the stigma associated with perinatal mental health conditions and improving maternal health outcomes. NJPRSN grantees support the maternal health population by providing free access to support groups and connecting individuals in need to maternal and child health mental health providers. In Fiscal Year 2025, 1,008 pregnant women participated in support groups, 1,976 support people for birthing individuals were trained and engaged in trainings, and 1,739 professionals completed trainings, equipping a multidisciplinary workforce—including health educators, obstetricians and gynecologists (OB-GYNs) and midwives, therapists, nurses, Community Health Workers (CHWs), doulas, and social workers—to better serve their communities.

- Chronic Disease and Maternal Health: The Chronic Disease and Maternal Health Program is funded by the Preventive Health and Health Services Block Grant and is in collaboration with the Division of Health Promotions. The program purpose is to implement a multi-prong strategy to improve chronic disease outcomes in pregnant people. The interventions will focus on implementing evidence-based activities that improve maternal outcomes for gestational diabetes, cardiovascular, and oral health. The grantee, Family Health Initiatives Prematurity Prevention Initiative, will identify partners that can implement self-management programs and oral health interventions for perinatal people.

- Fetal Alcohol Spectrum Disorders (FASD): The FASD Program is a statewide program focused on the education, screening, and prevention of perinatal alcohol exposure, a key risk factor in developing FASD. This program has two primary goals: 1) to develop regional projects to prevent alcohol and drug use, pre-pregnancy and post-pregnancy, and 2) to increase the number of pregnant individuals screened for risk of substance use or abuse and refer pregnant individuals to appropriate services. These goals are achieved through the FASD program components of education of clinical and non-clinical professionals, prenatal and child screening, and connecting individuals to substance use treatment resources and social services. Program components are fulfilled through the NJ FASD Program grantees, with a recently expanded scope from solely a focus on prenatal alcohol exposure to pre-natal substance use.

Child and Adolescent Health Program

- Title V funds the Child and Adolescent Health Program (CAHP) which currently holds six federal grants to prevent teen pregnancy, promote youth development and address the overall health and well-being of children, youth and young adults. Through the Personal Responsibility Education Program, the Sexual Risk Avoidance Education (SRAE) Project, and the Whole School, Whole Community, Whole Child School Health Program, CAHP staff operate a statewide youth engagement initiative consisting of 10 Youth Advisory Boards and the NJDOH Voice of Youth Planning Committee. This is managed primarily by the NJ School Health, SRAE and Personal Responsibility Education Program Management Officers with support from the CAH Program Manager. Additional grants, Rape Prevention Education; STOP School Violence, which uses the intervention SAFENJ, prevent violence in schools and communities; Garrett Lee Smith Tribal/State Youth Suicide Prevention and Early Intervention and Pediatric Mental Health Care Access addresses mental health and suicide prevention.
- Early Childhood Comprehensive System (ECCS) Health Integration: Prenatal to Three (ECCS P-3) Initiative is an initiative of the NJ Department of Children and Families (DCF), in partnership with NJ TVP. The system maintains integrated developmental health promotion and screening as a service of the statewide Connecting NJ system.

Adolescent Health

- Training on screening and assessment using the Ask Suicide-Screening Questions, Columbia Suicide Severity Rating Scale, SafeSide™ Training for primary care settings, Safety Planning, Adolescent Care and Treatment of Suicide (ACTS Training), and interventions for suicidal teens (e.g., Collaborative Assessment Management of Suicide and Attachment-Based Family Therapy). These trainings help prepare school and community based behavioral health clinicians detect suicidality, stabilize suicidal youth

and manage interpersonal and family dynamics to promote better outcomes for youth with mental health issues.

- The Garrett Lee Smith (GLS) Suicide Prevention Project and MCH Block Grant supports a new learning and resource portal for professionals, parents, caregivers, and youth called Prevent Suicide NJ. This project was launched in September of 2022, and to date has provided trainings to 4,383 primary care practitioners, supported screening initiatives for 6,586 youth for suicidal ideation, provided 1,290 referrals, and confirmed 684 accessed appropriate treatment. Additionally, this project has implemented Lifelines, a comprehensive suicide prevention, intervention and post suicide response program, at 15 school districts throughout NJ to further train school professionals, community partners and students in the 24-month curriculum. In addition to Lifelines Trilogy, these programs include the Teen Outreach Program (TOP®), Love Notes, and Teen Prevention Education Program (Teen PEP).
- All CAH programs support evidence-based models rooted in social and emotional learning and positive youth development, proven frameworks to reduce bullying by increasing empathy and self-awareness.

The Maternal Child Health (MCH) Block Grant specifically supports adolescent mental health, suicide prevention, and school health, implementing evidence-based models that help reduce bullying and stigma and improve school climate. All CAH programs work together to support adolescents and their health needs holistically. Mental health and suicide prevention activities include:

- Professional training in 2025 included Attachment Based Family Therapy level 1 (42) and level 2 (17), Collaborative Assessment and Management of Suicide Care (30), Safety Planning (398) and Question, Persuade, Refer (622)
- Lifelines Trilogy implementation in 16 school districts is ongoing
- In the summer of 2025, the Youth Planning Committee (YPC) on Suicide Prevention launched a for youth-by-youth suicide prevention campaign. The YPC is comprised of youth from across NJ, each summer, youth are recruited and join the YPC. They through a summer educational program to gain a better understanding of suicide and how it impacts their peers. Youth in the YPC often have lived experience, including personal struggles with suicide and suicide loss. The school campaign toolkit is available for all schools in NJ to create their own campaign with their students. https://www.preventsuicidenj.org/toolkit/

<u>Children with Special Health Care Needs (CSHCN)</u>

In NJ, families of CSHCN have access to many services to meet their needs. Within FHS at the NJDOH, CSHCN receive services through the following programs:

- Newborn Screening and Genetics Services (known as NBS) provide timely and appropriate follow-up services for all newborns affected by an out-of-range blood spot screening result. NJ currently screens for 61 disorders. NJ remains among the leading states offering the most blood spot screenings and has recently implemented a long-term follow-up component.
- NJ's newborns are also screened with pulse oximetry through the Critical Congenital Heart Defects (CCHD) screening program. The intention of the program is to identify newborns who might have an undiagnosed condition which is otherwise observed and who after discharge become symptomatic. All babies who fail this screening are registered with the Birth Defects Registry (BDR) and are followed through the diagnosis process.
- Birth Defects Registry ensures that all children 0 through five years old who have a congenital disability are registered. Nurses work with the birthing hospitals to verify the diagnoses. Once registered, all children are referred to the Family Centered Care Services (FCCS) for case management services at the county level. Approximately 10,000 children are registered annually.
- Data Systems and Emerging Threats program works to improve and integrate data systems and works with the CDC to surveil emerging threats to newborns such as syphilis and congenital cytomegalovirus (cCMV).
- Autism Registry ensures that all children 0 through 21 years old who have an Autism Spectrum Disorder (ASD) are registered and referred to FCCS for case management. Approximately 64,000 children have been registered since 2009.
- The NJ Early Hearing Detection and Intervention (EHDI) program abides by the national public health initiative "1-3-6 Guidelines" These guidelines seek to ensure that all babies born in NJ receive a newborn hearing screening before one month of age, complete diagnostic audiologic evaluation prior to three months of age for infants who do not pass their hearing screening, and enroll in Early Intervention by no later than six months of age for children diagnosed with hearing loss. The EHDI program offers technical support to hospitals on their newborn hearing screening and follow-up programs.
- FCCS addresses families' medical and social conditions by providing resources, referrals, and support to families in obtaining accessible services within state departments, divisions, and county and municipal agencies. When working with families, FCCS case managers refer children to local, state and federal resources and programs, assist with transitions to adult services, and work to increase the percentage of children with special health care needs who have a medical home. Annually, over 19,000 families received case management services.
- Approximately four million dollars are awarded to eight Child Evaluation Centers, three Pediatric Tertiary Centers, and five Cleft Lip/Palate Craniofacia

l Centers. The Specialized Pediatric Services Program (SPSP) grants provide access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services to families with CSHCN that are 21 years old or younger. Annually, over 76,000 children are served across all centers within the Specialized Pediatric Services Program.

- The NJ Early Intervention Services (NJEIS) provides services to children from birth to three years of age who are experiencing developmental delays. Approximately 18,000 children receive services at any given time annually, including Occupational Therapy, Speech Therapy, Physical Therapy, and Developmental Intervention.

NJ's Title V CSHCN program collaborates with intergovernmental and community-based partners to ensure that care through these multiple systems is coordinated, family-centered, community-based, and culturally competent. Communication across State agencies and timely training for State staff, community-based organizations, and families with CSHCN remain a priority to ensure that families are adequately supported.

Cross-Cutting/Systems Building

The NJ Title V Program's work within the Cross-Cutting & Systems Building domain includes collaboration across programs within the FHS division, as well as cross population domains. This includes:

- MCH and CSHCN programs plan to collaborate on informing OB/GYN's about emerging threats that impact both parents and the unborn child. Information about cCMV and ways to prevent the infection in pregnant women is part of the CSHCN's grant work with the CDC. While pregnant women may not experience any symptoms if they contract CMV, the virus can have profound effects on the fetus. Newborns with cCMV can have birth defects including microcephaly and hearing loss.
- MCH & Health Promotion Division collaborations for oral health prevention and intervention efforts. The Oral Health Services Unit (OHSU) continues to educate the public about the importance of preventive oral health services and good oral health, with programs predominately targeted to school-aged children and pregnant women. Other preventative services include dental screening, nutrition counseling, and placement of sealants and fluoride varnish for underserved, uninsured, and underinsured children across NJ. In January of 2023, NJ FamilyCare (NJ's Medicaid program) began covering dental insurance for all youth under 19 years old in the state. This comprehensive dental program continues to extend beyond the identified population and to other eligible youth with comprehensive dental and medical benefits. To continue this important work, the OHSU has also expanded its dental sealant program, an evidence-based practice for low-income children and children at-risk of increased tooth decay.

TVP Role

The FHS within the NJDOH works to promote and protect the health of mothers, children, adolescents, and those with unique health care needs such CSHCN and their families. The MCH Block Grant Application and Annual Report that FHS submits annually to the Maternal Child Health Bureau provides an overview of innovative initiatives, state-supported programs, and other state-based responses to the needs of pregnant and parenting women and their families. These initiatives and programs are strategically designed to address NJ's maternal and child health needs.

MCH priorities continue to be a focus for the NJDOH, FHS, and the TVP in NJ. In this work, the TVP has identified, 1) improving access to health services through partnerships and collaboration, 2) reducing gaps in health outcomes across the lifespan, and 3) increasing knowledge of services, as three priority goals for the MCH population. These goals are consistent with the Life Course Perspective, which proposes that an interrelated web of social, economic, environmental, and physiological factors contribute to varying degrees through the course of a person's life and across generations to achieve good health and well-being. Community Health Factors (CHF), the conditions in which people live, learn, work, play, worship, and age, significantly affect health, functioning, and quality of life.

The State Priority Needs (SPNs) selected by the TVP are consistent with the findings of the Five-Year Needs Assessment from last grant cycle and the national performance measures. These SPNs build upon the work of prior MCH Block Grant Applications/Annual Reports and align with the NJDOH's and FHS' goals and objectives to ensure access to enabling services and population-based preventive services. (Peterson & Alexander, 2001).

The 2026-2027 NJ SPNs:

SPN 1- Increase Healthy Births and Bridge Gaps in Birth Outcomes
SPN 2 - Reduce Maternal and Infant Mortality and Expand & Strengthen Evidence-Based Programs Addressing Infant Mortality
SPN 3 - Reduce Differential Outcomes in Maternal Health Care for Specific Populations
SPN 4 - Improve Nutrition, Food Security & Increase Physical Activity
SPN 5 - Improve Exclusive Breastfeeding Rates for the first Six Months after Birth
SPN 6 - Promote Healthy Youth Development from Childhood Through Adolescence & Young Adulthood
SPN 7 - Promote Healthy Youth Development & Reduce Teen Pregnancy & Sexually Transmitted Infections (STIs)
SPN 8 - Improve Access to Quality Care for CSHCN
SPN 9 - Promote Healthy Youth Development over the course of Childhood, Adolescence and Young Adulthood

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

NPM 1 - Postpartum Visit
NPM 3 - Postpartum Mental Health Screening
NPM 5 - Perinatal Care Discrimination
NPM 8 - Breastfeeding
NPM 9 - Safe Sleep
NPM 11 - Medical Home for CSHCN
NPM 13 - Developmental Screening
NPM 14 - Preventive Dental Visit
NPM 19 - Transition to Adult Health Care
NPM 20 - Bullying
NPM 21 - Adult Mentor
NPM 22 - Food Sufficiency

State Performance Measures (SPMs) have been reassessed through the needs assessment process, engaged during the last grant cycle, and include:

The existing SPMs:

SPM - Black Non-Hispanic Preterm Infants in NJ
SPM - 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.
SPM - Referral from Birth Defects and Autism Registry System (BDARS) to Case Management Unit
SPM - Age of Initial Autism Diagnosis
SPM - Teen Outreach Program (TOP®), Get Real, Love Notes, Teen Prevention Education Program, Teen Connection Project and Lifelines completion
SPM - Black, Non-Hispanic Infant Mortality in NJ
SPM - Rate of live births to adolescents (ages 10-19 y/o) per 1,000 families in NJ
SPM - Percent of children, ages 9 through 35 months, who receive a developmental screening using a parent-completed screening tool in the past year
SPM - Food sufficient households
SPM - Preventive dental visit

The 2010 Affordable Care Act transformed the health insurance landscape in the United States, with coverage further extending essential benefits to categorical populations such as women, pregnant women, children, homeless individuals, and CSHCN. However, health differences burden marginal populations the most as pervasive issues lead to worse health outcomes over time. Nationally, the persistence of these hardships proliferates as there remains a focus on the provision of sick care in place of creating and elevating a system that

prioritizes complete wellness to mitigate the potential for disease manifestation. However, in NJ an orientation toward addressing the CHF has prompted greater emphasis on prevention efforts to endorse wellness. This is evidenced by NJ's commitment to expansion of Medicaid benefits for adults without disabled or pregnancy-status, and postpartum coverage for up to 365 days postpartum, beyond the federally mandated two months.

The expansion of Medicaid helps ensure continuous insurance coverage for low-income pregnant women. This type of comprehensive service coverage improves the health of those covered, mainly those impoverished, who tend to have higher rates of smoking, preeclampsia and diabetes, and lower rates of prenatal visits and breastfeeding initiation (Reichman et al., 2015; Sontag et al., 2020). Speaking to the Medical Home NPM, the expansion of Medicaid to populations that existed in the space between "too resourced" to receive Medicaid support and yet "not resourced enough" to connect with medical care at the frequency clinically indicated, leads to morbidities over time that can be avoided with insurance coverage.

Furthermore, charity care monies were able to be diverted into other fountains of care once Medicaid expansion occurred. One clear demonstration of the benefit of this diversion was in the arena of hemophilia grants, which paid for important interventions that moderated future emergency room visits and intensive care episodes. Those enrolled in Medicaid were able to get coverage and stay out of the hospital emergency room for ambulatory sensitive conditions, attending to their primary care appointments and getting treatment early and often.

Hearing from people with lived experience is paramount to achieving person-centered care programming and correlated positive health outcomes for families in NJ. For this reason, the TVP and state agencies that serve pregnant women, caregivers, children and CSHCN work closely with grantees to center the voices of people with lived experience while programming is crafted and implemented. This occurs via focus group engagement, quarterly, biannual and annual feedback opportunities and regular parent meetings, hosted by the State's SPAN Advocacy Network (NJ's Family Voice). People with lived experience are also integrated into the MCH workforce through the community health worker program, providing opportunities for professionals with first-hand experience to offer their perspective on programmatic functionality and efficiency.

Evaluation efforts are being created and solidified for programs throughout the MCH Unit. Broad program evaluation efforts have been instituted and are collaborative in nature as the NJDOH works closely with Rutgers University, The College of NJ, and Johns Hopkins University to evaluate program implementation efforts and outcomes utilizing standardized procedures and evidence-based evaluation metrics to ensure aims are met and modifications are made when necessary. Evaluation and quality improvement efforts are growing to enhance communication and standardize follow-up on quantitative efforts on a monthly and quarterly basis.

One of the ongoing challenges in quality assurance and improvement efforts is the systematizing of efforts across the MCH Unit. Engaging in quality improvement initiatives takes time and person power. These efforts are becoming a more established part of the DOH as a newly created performance management unit has been in development over the past 18 months.

The NJDOH established the Performance and Grant Management Unit in August of 2024 to enhance health outcomes through improved program evaluation, quality improvement, data integration, grant management and acquisition, and strategic alignment. Collaborating with department leaders, this unit is developing mechanisms that fully capture and set performance standards, and align all programs, whether related to public health surveillance, grants, policy implementation, or other services, ensuring that they contribute to the Department's strategic goals and strengthens the NJDOH's impact on public health. Throughout 2025 and into 2026, the Performance and Grant Management has expanded their efforts in this work, transitioning from "pilot" program engagement to cross-department program engagement, leading workshops for staff and offering myriad professional development opportunities for those seeking to build on and enhance their skill sets.

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

Title V Funds are essential in supporting NJ's MCH efforts and complement existing contracts that the NJDOH maintains with public and private partners throughout the state, including local health systems, education and outreach programs. Moreover, Title V bolsters the work of various divisions and helps to align efforts across funding sources. FHS uses Title V MCH funding as the primary source for multiple public health interventions for NJ's pregnant women and women of childbearing age. In the past few years, a greater emphasis has been set on decreasing gaps in health outcomes across the varied populations in the state, and in health care service delivery in NJ. The TVP has worked cross-divisionally, across state agencies and between the public and private sectors to find creative solutions to the issues that NJ residents face. Below are ways in which the Title V funds complement state-supported efforts:

NJ's TVP:

1. Serves as the main funding source to support MCH populations in accordance with Title V and other federal and state guidelines to protect and promote the health and well-being of women, children, CSHCN, and families
2. Supports NJ's state-priority MCH efforts throughout all 21 counties through programs such as HWHF and NJ Post-partum Resource and Support Network
3. Supports the infrastructure needed to sustain Special Child Health Service (SCHS) including but not limited to evaluation and treatment centers
4. Supports specialized pediatric services across the state to ensure access to comprehensive, coordinated pediatric specialty and sub-specialty services

5. Supports the Birth Defects and Autism Registries, NBS activities, and county-based free case management services to children birth through age 21 who have special health care needs
6. Supports home visiting with braided Maternal, Infant and Early Childhood Home Visiting (MIECHV) funding
7. Supports school health programming and works compatibly with CDC funding to reach impoverished and underserved communities
8. Supports the capacity for developing data-informed strategies to prevent maternal mortality and morbidity and address existing gaps
9. Funds grantees to conduct NJ Fetal Infant Mortality Review (FIMR)-related activities (e.g.,chart review, family interview); these activities seek to identify ways to strengthen the systems of care and resources available to families to prevent future deaths
10. Funds grantees working with underserved school districts in NJ to create nurse led school health teams and implement evidence based social-emotional learning programming aligned with the CDC Whole School, Whole Community, Whole Child framework

Title V funds are used to support NJ's state-priority MCH efforts, including increasing healthy births, reducing infant mortality, improving nutrition and physical activity, promoting youth development, improving access to quality care for CSHCN, improving breastfeeding rates and reducing teen pregnancy and sexually transmitted infections, and reducing differences in service delivery. Therefore, Title V funds are necessary to improve the health of pregnant women and their families in NJ.

III.A.3. MCH Success Stories

Special Child Health Services

When Stephanie, a Special Child Health Case Manager, received a referral for a newly relocated family of five to NJ, the family was navigating an unfamiliar system with limited support. Of particular concern was 15-year-old F.M., who had been diagnosed with hydrocephalus and spina bifida. The family was unaware that despite his diagnosis, F.M. was eligible for school enrollment, support services, and community-based resources.

Through collaborative efforts with a Visting Nurse Association nurse, hospital social worker, and SPAN, the Case Manager coordinated a series of home visits to assess the family's immediate and long-term needs. One of the most impactful outcomes was the successful enrollment of F.M. in a local high school, initiating an educational evaluation ensures appropriate placement and the development of a medical plan — including securing a one-to-one nurse for his daily care needs.

To further support F.M.'s quality of life, the Case Manager helped secure a wheelchair, coordinated food assistance, and distributed Visting Nurse Association gift cards to ease the family's financial burden. The involvement of Seasons of Hope, an organization that provides counseling and holiday gifts, provided additional relief and support during this transitional period. Recognizing the many medical appointments F.M. must attend, free transportation services were also arranged to ensure continuity of care.

Thanks to this coordinated, compassionate approach, F.M. is now thriving in his new environment, receiving the education, medical care, and daily support he deserves. Despite the challenges of managing complex medical needs, this family has found stability, empowerment, and hope for a brighter future.

CAHP Success Story: STOP School Violence – Safe NJ Strengthens Early Intervention and Student Safety

Safe NJ is an anonymous reporting app for school districts, funded and implemented through the Department of Justice, Bureau of Justice Administration, Students, Teachers and Officers Preventing (STOP) School Violence. The app operates 24/7 both in and out of school time, with a crisis response center and a data dashboard that allows schools to address threats in real time.

A recent incident in a district demonstrated how Safe NJ,supports fast, coordinated responses to student safety concerns. One evening, district leaders received a high-risk alert after a student submitted a detailed report, including screenshots of concerning online behavior from a peer. Safe NJ immediately escalated the alert and notified local law enforcement, who conducted a prompt safety check.

Once school was back in session, district administrators accessed the report, coordinated communication with building-level staff, and quickly organized a unified response. Using Safe NJ's anonymous messaging feature, staff were able to communicate directly with the reporting student, offer reassurance, and connect them to support—while fully protecting their identity.

As a result of the timely notification and coordinated action, the student of concern was linked to appropriate mental health and community-based services, and the reporting student was offered assistance as well. This incident showed how SafeNJ enables early identification of students in crisis and supports rapid intervention that prioritizes safety, well-being, and access to care.

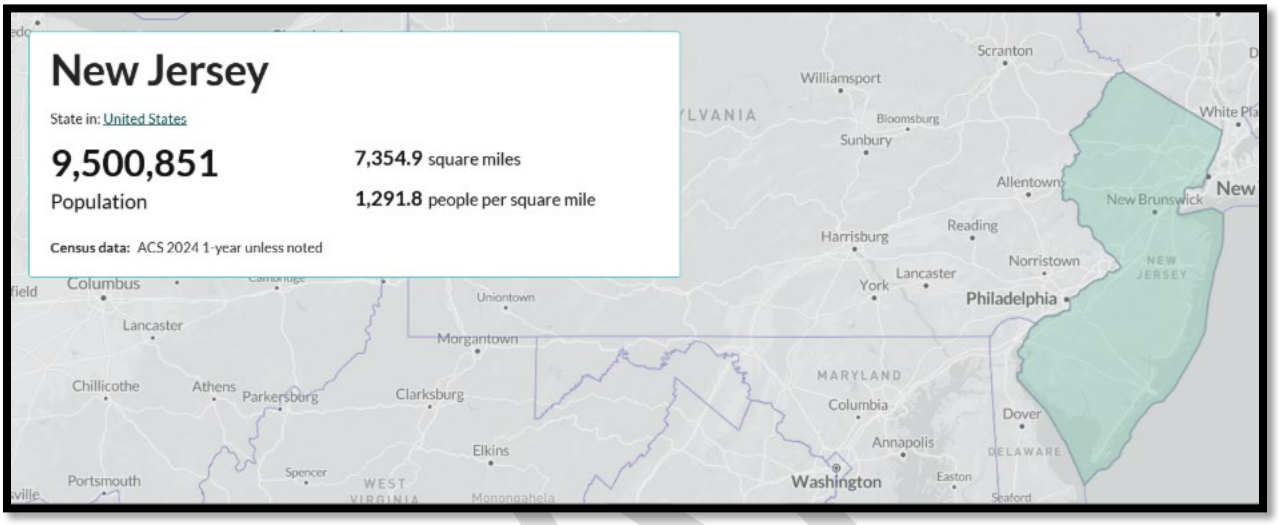
III.B. Overview of the State

III.B.1. State Description

While NJ is the fifth smallest state in land area in the United States (7,354.9 square miles), the state houses over 9.5 million residents, making it the most densely populated state in the nation, and ranking it as 11th most populous overall (Figure1). Furthermore, NJ is the only state in which every one of its 21 counties is deemed “urban” by the US Census Bureau. Moreover, the state boasts the privilege of housing residents from different countries and cultures. In addition to this rich demographic population comes a geographical difference, with different regions experiencing various levels of density per square mile. For example, the central and northern counties of NJ are very densely populated; especially the counties that are situated in the mid-

north, and north-east of the state and are closer to New York City. The most northwestern counties, and the southern and northwestern counties are more rural and agricultural, and where transportation, health care and educational services are not as frequently, or proximally, available to residents.

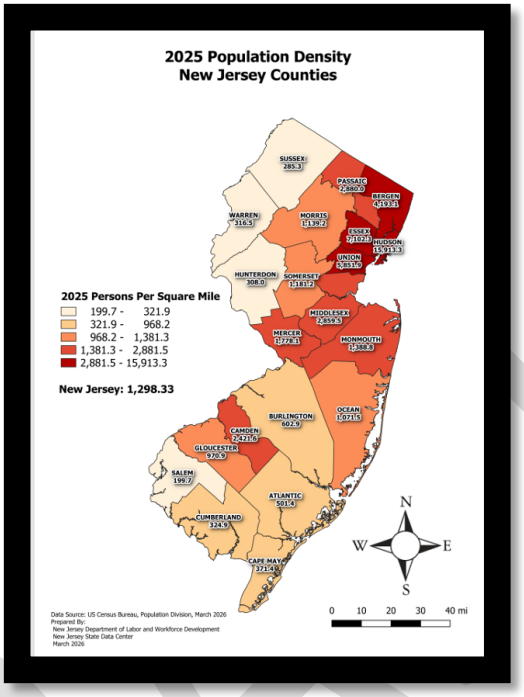
Figure 1. NJ's Geographic Land Area and Total Population



Data from: U.S. Census Bureau, 2026

In 2025, NJ's population density, persons per square mile, was 1,298.33 to 1. NJ is comprised of 564 municipalities and 21 counties. As of 2025, the most populated counties are Hudson, and Essex, each with a population density of 15,913.3 and 7,102.3to 1, respectively (Figure 2). Hudson County has a total population of 736,185.

Figure 2. 2025 Population Density: NJ Counties



Data source:Popden.pdf

According to the 2024 NJ Population Estimates of race, 52.0% of the population were White, Non-Hispanic; 13.0% were Black; 10.7% were Asian; 0.7% were American Indian and Alaska Native; and 12.1% reported two or more races. In terms of ethnicity, 23.5% of the population was Hispanic. The 2024 American Community Survey estimates identified that 34.3% of NJ residents (5 years and older) speak a language other than English compared to 23% nationally, and which include Spanish, Polish, Italian, Bengali, Mandarin/Cantonese and Haitian. Approximately 25% of all NJ residents are foreign-born people, which is considerably higher than the national average of 14.8%. A similar pattern is seen among women of childbearing age.

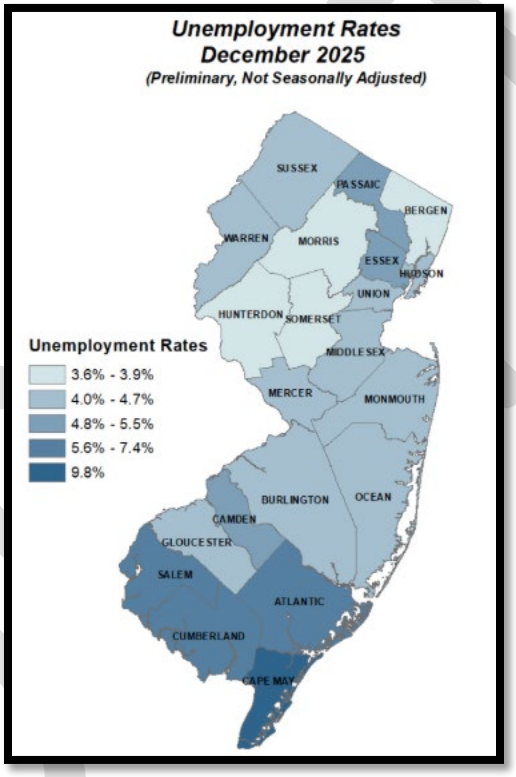
Unemployment and Uninsured Rates

Unemployment rates are impacted by market factors (ex. GDP, inflation) and individual and social factors (health, educational attainment). Unemployment rates in NJ have been variable over the course of the past five years, although rural areas of the state experience higher rates of unemployment than the more suburban, peri-urban and urban locations in the state (Figure 3). The most recent seasonally adjusted data published by the US Bureau of Labor

Statistics indicates that NJ has an unemployment rate of 5.4%, a 0.8 percentage point increase from the year before. The national unemployment rate is 4.4%.

The income spectrum in NJ is quite large, with the median household income just below $105,000, but with an average per capita income of $53,818. These integers demonstrate the large gap between the upper socioeconomic status populations in the State, and the lower-and-impoverished populations in the State. Approximately 9% of all NJ residents live at or below the poverty line, which is slightly less than the national average of 12%.

Figure 3. NJ Unemployment Rates 2025



NJDOL Website: Feb 2026

The NJDOH prioritizes the health needs of all its residents, centering on populations that need the most support. This strength is evidenced by a strong public health infrastructure and health care delivery system whose activities are rooted in a contemporary evidence base, are trauma-informed and high quality. The NJDOH partners with local Federally Qualified Health Centers (FQHCs), Community Based Organizations, academic institutions such as Rutgers University and The College of NJ, as well as with service recipients, to create and deliver MCH programming in the state. Moreover, to ensure services are funded appropriately,

NJ commits a state match that is higher than the dollar-for-dollar match expected of Title V Block Grant funding, with approximately $70 million dollars of state funds invested in MCH services each year, above-and-beyond the approximate $11.5 million Title V funds granted to the NJDOH.

Additionally, NJ has a low uninsured rate compared to the national average, with 4.7% of children under the age of 19 years old uninsured versus 6% nationally. NJ's expansion of Medicaid has also facilitated the decrease of health access differences across populations statewide. The State continues to engage in outreach and enrollment efforts to ensure the number of uninsured children continues to decrease over time.

Apart from direct health care access and insurance coverage, many supportive services are available to families in NJ, to address all CHF. A multimillion-dollar investment has been made across various workforces, chiefly, the State's allied professional workforce, to enhance their training and draw more people into the maternal and child health professions. This includes funding for Community Health Workers (CHWs) from pre-conception to 365 days post-partum, as well as funding for midwifery education to increase midwife enrollment and accommodate more midwives into the clinical fold. Additionally, the doula workforce is growing with a larger investment in developing a workforce that specifically supports NJ FamilyCare families.

While there are numerous and growing strengths of the NJ health system, persistent gaps in health outcomes continue. While health care services exist in all 21 counties of the state, providers are not equally distributed across the state. Rural areas exist where providers are clinically saturated and unable to attend to the health care needs of the populations surrounding them. This issue is further compounded by the fact that the number of practitioners specializing in family health care and pediatrics has decreased in recent years, with a dearth of providers available to service the needs of the state's approximately nine million residents. For CSHCN, specialists that are needed to attend to this population are facing challenges with the demand far exceeding the availability of services. Further complicating this matter is the decline in the primary care workforce over the past few decades, which creates a smaller pool of practitioners for whom special child health becomes a vocation. While the differences in access to practitioners, and the dearth of providers in the state, creates a difficult landscape, NJ continues to commit its resources to the populations in greatest need. These and other challenges are addressed by the State's lead health agency, the NJDOH.

The NJDOH is the lead state agency providing core public health services to its residents, and whose mission is to protect the public's health, promote healthy communities, and continue to improve the quality of health care in NJ. Undergirding this mission is the vision of the department to ensure that all New Jerseyans live long, healthy lives and reach their fullest potential, which NJDOH takes as its primary responsibility. This vision is supported by a public health infrastructure that is growing and strengthening as the state hires more health and allied health professionals. The DOH's leaders are dedicated public servants who are committed to

supporting all residents in NJ in achieving their highest health potential, and full actualization. Because the reach of the department is so vast, many types of essential health care services are rendered each year. These targeted services include:

- Disease Prevention and Control
- Health Promotion and Education
- Emergency Preparedness
- Licensing and Regulation
- Health Data Collection and Analysis
- Health Regulation and Policy Development

The NJDOH has a long and strong history of coordinating and implementing a statewide system of services that is community-based, comprehensive and one which leverages community partnerships to enhance the work of the public health agency. Partnerships are critical in meeting the varied needs of the state's population. Additionally, NJ has several public health initiatives in progress, all aiming to address the community health factors that impact people's health trajectories. These evidence-based and community driven plans work synergistically to support the shared goals of preventing illness, promoting wellness, and addressing any gaps that exist between populations.

The NJDOH additionally oversees several advisory boards, councils, and commissions, all which play a crucial role in shaping policy decisions and providing recommendations to the NJDOH. This list includes, but is not limited to:

Health Care Administration Board

The Board advises the Commissioner on issues related to health care policy and reviews and makes recommendations with respect to rules and regulations necessary to implement the Health Care Facilities Planning Act.

State Health Planning Board

The Board acts as an advisory panel to the Commissioner concerning recommendations on *certificates of need* applications to create certain new health care facilities or to expand existing services; holds public hearings in the service areas for certificate of need applications regarding transfer of ownership or closing of a health care facility.

Public Health Council

The Council ensures the reasonable protection of the health of the public-at-large; reviews and consults with the Commissioner regarding the regulations for the State Sanitary Code; reviews the administration of funds under the Public Health Priority Funding Act of 1977.

The Governor's Council for Medical Research and Treatment of Autism

The Council was created by State appropriation in 1999 and has been issuing research, clinical and educational enhancement grants since 2000. The Council's vision is to enhance the lives of individuals with 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.

The NJ Maternal and Infant Health Innovation Authority (NJMIHIA)

NJMIHIA was created in July of 2023 to oversee the NJ Maternal and Infant Health Innovation Center. NJMIHIA is governed by a Board that adopts recommendations for action to reduce maternal mortality, morbidity, and disparities from the NJ Maternal Care Quality Collaborative. The Board also coordinates with a Community Advisory Committee that represents diverse community groups to support and inform the work of NJMIHIA.

The NJ Maternal Care Quality Collaborative (NJMCQC)

NJMCQC is an advisory group that works with multiple departments and is currently residing within NJMIHIA. The NJMCQC acts as a strategic thought partner to NJMIHIA.

The work of the NJDOH is guided by a State Health Improvement Plan (henceforth referred to as the "Healthy NJ Initiative" or HNJ). The NJDOH aims to improve the health of all New Jerseyans through evidence-based, community participatory-research, attending to the varied and changing needs of the populations. Every ten years, the HNJ Strategic Plan includes establishing a framework for the initiative, determining topic areas to organize the project, developing goals, creating action plans, identifying new objectives, setting targets values, and implementing action plans to achieve those targets by the end of the decade. A group of subject matter experts, community participants, organizations, and members of the public participate to co-create the goals of the plan, which anchor the four pillars of access to quality care, healthy communities, healthy families, and healthy living.

Alongside the community-created initiatives borne out of the HNJ are collaborations with NJMIHIA in its role in continuing to move forward the NurtureNJ goals and objectives set forth though the strategic plan. NurtureNJ was a statewide initiative out of the previous First Lady's Office (2019-2025) committed to reducing maternal and infant mortality and morbidity, as well to ensuring health care for support for all women in the state and make NJ the safest place for women to give birth and raise a child, and to eliminate gaps in care.

Primary Objectives of NurtureNJ:

1. Reduce maternal and infant mortality and morbidity;
2. Ensuring no gaps exist in maternal and infant morbidity and mortality across the state

Proximal Objectives of NurtureNJ:

1. Ensure all women are healthy and have access to care before pregnancy.
2. Build a safe, high-quality system of care and services for all women during prenatal, labor and delivery and postpartum care.
3. Ensure supportive community environments and contexts during every other period of a woman's life so that the conditions and opportunities for health are always available.

NJMIHIA is currently working on a strategic plan that will be released in late summer of 2026 and will include the major tenets of the NurtureNJ work as it transitions to become part of NJMIHIA.

The HNJ Initiative aligns with the national Healthy People 2030 goals, which identifies five key areas of CHF of which to focus: *economic stability, education, social and community context, health and health care, and neighborhood and built environment.* In consideration of CHF, there is a heightened need for integrating both health and non-health partners, as well as state, and external partners, in addressing infant and maternal mortality, the opioid crisis, and other public health issues facing NJ residents. See Figure 4. for a comprehensive stakeholder network list.

Figure 4. Stakeholder Network

As a result, partners from the DHS, health Systems and providers, various academic institutions, the NJDOH, community and grassroots organizations, and the community are strategically

collaborating and using MCH block grant funds to implement culturally responsive public health interventions in NJ.

Children with Special Health Care Needs

NJ's CSHCN program is known as Special Child Health Services. The purpose of the unit is to identify children with special health care conditions through the NBS programs, register them via the mandated reporting systems, and link them to resources and services via the county-based case management system. In this way, the programs work with each other, other governmental agencies, medical providers, social services, and families to ensure that the CSHCN population can access services and thrive in NJ (Figure 5).

Figure 5. Special Child Health Services

The ability to screen and monitor certain conditions goes back to 1928, when NJ became the first state to have a BDR. While the laws and regulations have been modified over time, the State's ability to surveil certain diagnoses is rooted in the State public health surveillance laws. The BDR mandates that all NJ residents' birth through the age of five who have a congenital birth defect are registered with the DOH. Due to the CDC's prevalence of autism studies, a law was passed in 2007 to require all children through the age of 21 with an autism spectrum disorder to be registered. As this registration is mandated by law, parental consent is not required. The SCHS staff work with licensed health care providers and facilities to identify their role and responsibility in this process. NJ also has a robust NBS program which requires birthing facilities to obtain blood-spot samples for 61 inborn metabolic and genetic disorders, conduct newborn hearing screening, and perform pulse oximetry screening before newborns leave their birthing facility. These laws not only mandate the screening and registry programs

but also protect the data from use other than their original purpose or the purpose to provide aggregate data about the health of the CSHCN population.

These programs work as an integrated continuum of care and work within the larger health care system of 45 birthing hospitals, four birthing centers and community-based midwives, a system of tertiary care facilities that provide specialized pediatric care services, and over 3,000 pediatricians. NJ also has a very robust Early Intervention Part C program that provides services to over 40,000 families per year. Medicaid is also an important partner and provider of services to the CSHCN population. The NJ Department of Children and Families (NJDCF) also provides services to children under 21 with emotional and mental health care needs, substance use challenges, and/or intellectual/developmental disabilities. In terms of primary care, there are also 24 Federally Qualified Health Centers in NJ and a network of 104 local health departments that serve 565 municipalities, including cities, townships, and boroughs. While the CSHCN population is connected to specialist communities, many of these other agencies provide primary care, services, and funding.

Within NJ, several children's hospitals and hospitals with specialized care units exist. These include:

- RWJ Barnabas Health Children's Health Network is NJ's largest academic health system, with four acute care hospitals, Children's Specialized Hospital, and over 35 community-based locations, and includes NJ's first pediatric trauma center.
- Hackensack Meridian Children's Health includes Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center located in the northern end of the state and K. Hovnanian Children's Hospital at Jersey Shore University Medical Center located in the southern end of the state.
- Cooper University Hospital is in Camden across the Delaware River from Philadelphia, housing a large Pediatric Tertiary Care Center.
- The Children's Hospital at Newark Beth Israel Medical Center has a large Pediatric Tertiary Care Center.
- Rutgers Health - Robert Wood Johnson Medical School Children's Health Institute of NJ has a Pediatric Tertiary Care Center in New Brunswick which is in the center of NJ.

With support from the State and Title V funds, health service grants are distributed to multiple facilities throughout NJ. Located across the state, these child evaluation and tertiary care centers serve approximately 58% of the children who are uninsured or are covered via Medicaid/Medicare programs. These grant-funded centers leverage these funds with their other funding streams to ensure that the CSHCN population has access to important services in a timely manner.

Special Child Health Programs also work with their community partners and families. The SCH Unit at thNJDOH has a long-term relationship with the NJ Chapter of the American Academy of

Pediatrics (NJAAP), family advocacy organizations such as Autism NJ, SPAN Parent Advocacy Network, and University-based programs such as the Boggs Center on Disability and Human Development. Working closely with these services are the county-based case management organizations. Grants are provided to local health departments and/or non-profit entities to provide free resources and referral services to all families with children with special health care needs. These agencies work to connect families to Medicaid, provide support to families as they access medical, social, and educational services for their children.

NJ State Legislation and Regulations relevant to the MCH Block Grant

The following laws aimed at improving maternal health and access have been adopted by the NJ Legislature and enacted by the Office of the Governor since 2018. Nearly a dozen additional maternal health-focused bills remain under consideration, reflecting the whole-of-government focus on maternal mortality and morbidity:

- P.L.2018, c.82 - Entrusts the NJDOH to develop an annual NJ Report Card of Hospital Maternity Care. The report is required to include rates of cesarean births, infection, laceration, hemorrhage, and severe maternal morbidity for all birthing hospitals.
- P.L.2019, c.75 - The original public law that created the NJ Maternal Data Center, NJ Maternal Mortality Review (NJMMRC) Committee, and NJ Maternal Care Quality Collaborative, later revised under P.L.2023, s.3864.
- AR2019 - Encourages the NJDOH to develop set of standards for respectful care at birth and to conduct public outreach initiatives.
- P.L.2019, c.85 - Provides Medicaid coverage for doula care.
- P.L.2019, c.86 - Establishes perinatal episode of care pilot program in Medicaid.
- P.L.2019, c.87 - Prohibits health benefits coverage for certain non-medically indicated early elective deliveries under Medicaid program, State Health Benefits Plan, and School Employee Health Benefits Plan.
- P.L.2019, c.88 - Codifies current practice regarding completion of Perinatal Risk Assessment (PRA) form by certain Medicaid health care providers.
- P.L.2019, c.133 - Establishes pilot program to evaluate shared decision-making tool used by hospitals providing maternity services, and by birthing centers.
- P.L.2021, s.4229 - Establishes doula directory in the NJDOH; requires a doula directory to receive reimbursement for doula services rendered to Medicaid beneficiary.
- P.L.2021, c.187 - Establishes a newborn home nurse visitation program (universal home visiting), supplementing various parts of statutory law, and making appropriations.

- P.L.2021, c.79 - Requires that every hospital that provides inpatient maternity services and every birthing center licensed in NJ shall implement an evidenced-based training for all health professionals who provide perinatal treatment and care to birthing mothers at the hospital or birthing center. Members of various medical licensing boards must also complete a program related to community health factors and approved by the Department of Law and Public safety.
- P.L.2023, s.3864 - Establishes the NJ Maternal and Infant Health Innovation Center Authority and moves the Maternal Care Quality Collaborative to the Authority.
- P.L.2023, s.4119 - Requires hospitals and birth centers to develop doula access policies and procedures.
- P.L.2023, a.4223 - Increases Medicaid reimbursement rates for primary care services and aligns with midwifery and physician rates.
- S912/A3887 - Establishes certain requirements for postpartum care, pregnancy loss, and stillbirth information and develop personalized postpartum care plans.

NJ State Legislation and Regulations relevant to the CSHCN Population

The following laws are aimed at ensuring screening and services for CSHCN. These laws are amended over time to include new services, additional mandated conditions, and/or changes in process or reporting procedures.

- P.L.1977, c.321, s.1; amended 1981, c.357, s.2; 1988, c.24, s.2; 2019, c.296, s.1.

  NJSA 26:2-110 through 26:2-112, as amended and supplemented - Establishes the newborn blood spot screening program
- P.L.2001, c.373, s.3 N.J.S.A. 26:2-103.3 through 26:2-103.9 as amended and supplemented - Establishes screening for hearing loss in all newborn children.
- P.L. 2021, c.413 - Requires all infants born in NJ to be screened for congenital Cytomegalovirus (cCMV).
- P.L.1983, c.291, s.2; amended 2005, c.176, s.2; 2012, c.17, s.351

  N.J.S.A 26:8-40.21- Mandates reporting to the NJ BDR all children diagnosed with a birth defect from birth through five years of age.

  N.J.S.A 26:8-40.22 - Mandates confidential reports of abortions of fetus with or infant affected by birth defect or severe neonatal jaundice.
- P. L.2007, c.170, s.3; amended 2009, c.204, s.5; 2012, c.17, s.141. N.J.S.A 8:20-2.3 - Mandates the reporting to the NJ Autism Registry any person, from birth through 21 years of age, who is a resident of the State of NJ and is diagnosed with autism based on DSM criteria, and who is not known to be previously registered.

III.B.2 State Title V Program

III.B.2.a. Purpose and Design

The NJ TVP addresses health care needs of pregnant and parenting mothers, children, CSHCN and adolescents in the state. Through collaboration with families, health care organizations and other local, state and federal entities, and subsequent iterative and refined work activities, the TVP continues to grow and strengthen in its work. Thus, the health care activities actualized in NJ are borne of strategic program design and consistent performance management.

In partnership with state agencies and organizations including the SPAN Parent Advocacy Network, the NJAAP, the NJ Hospital Association, the state's Maternal and Child Health Consortia (MCHC), and other local non-profit and community-based organizations, the NJ TVP is committed to advancing creative and evidence-based solutions to the complex health issues facing mothers, infants, and children across the state, with a particular focus on CSHCN. These critical partnerships help improve access to health care by enhancing the ways services are coordinated, financed, and delivered to MCH populations. Additionally, these partnerships create space for strategic development, including thinking through ways to optimize resources, improve access to quality care, and sustain joint efforts over the course of the grant period. TVP engages with health care leaders at various organizations such as the NJ sections of the American College of Obstetricians, the Association of Women's Health, Obstetric and Neonatal Nurses, and the American College of Nurse-Midwives; the NJ Perinatal Quality Collaborative; the NJ Health Care Quality Institute; Federally Qualified Health Centers; hospital associations; regional NJ MCH consortia; foundations; and birthing hospital facility Chief Executive Officers, maternal health, and quality improvement experts (Hall et al., 2024). These profound partnerships are essential in improving pregnancy outcomes, especially to reduce infant mortality and maternal mortality (Li et al., 2022).

The TVP recognizes the complex interplay of individual, interpersonal, organizational, community, and societal factors that influence human behavior and health outcomes. For this reason, Bronfenbrenner's Socioecological Model (1974; Figure 6) scaffolds the work of the TVP. The Socioecological Model postulates that human development occurs within the context of multiple and interacting systems of influence, emphasizing the synergistic nature of these forces as the driver of all human behavior. The interrelated nature of these overlapping and synergistic forces complicates interventions as all levels need to be considered; this includes individual, organizational, communal and societal.

Figure 6. Bronfenbrenner's Socioecological Model

The approach to identifying the MCH priorities has been borne out of numerous endeavors, with extensive collaboration between the systems; the TVP has been an effort involving various stakeholders with numerous skill sets and perspectives, which coalesce to produce a blueprint for action. The culmination of insights from the various players, undergirded by a rigorous landscape analysis, has helped the TVP to chart a course of program action, from the planning stage to the completion stage. Punctuating these efforts is the dynamic work of process evaluation, which ensures both that the programs align with the timeline and budget set forth, while remaining consistent with the strategic aspirations of the project.

While NJ has invested resources to address the MCH crises that exist in the state, the proposed plans will take time to produce results. NJ continues to experience high rates of maternal mortality and morbidity events and deaths, disproportionately impacting women and children of color. The continued TVP efforts promote the health and well-being of families across the state, with an acute focus on the populations on the margins and at highest risk of experiencing preventable morbidity and mortality events and deaths. With continuous fiscal and political state support, NJ is in a strong position to improve on MCH work being done and engage in innovative endeavors that complement and enhance the services being provided.

In 2024, NJMIHIA leadership, alongside the NJ Economic Development Authority and other state officials, identified a site for a center near downtown Trenton. This site is centrally located in Trenton, the state capital, reflecting a priority expressed by community members during focus groups on the center's development. The U.S. Department of Treasury awarded NJ $25 million to support the center's construction, with the development of the center led by the NJ Economic Development Authority.

Within the TVP, several initiatives have grown in reach over the period of the past calendar year. One such program is the HWHF Initiative. This initiative works toward improving maternal and infant health outcomes for women of childbearing age and their families while

reducing population gaps in those outcomes through a collaborative, coordinated, community-driven approach. This coordinated approach uses CHWs to complete social needs assessments, and Connecting NJ Hubs, or county-specific "points of entry," for clinical assessments. Referrals and tracking occur through a central data management platform. To improve upon this innovative endeavor, HWHF re-launched in 2023 with a renewed focus on CHW and postpartum doula support, with doula care expanding to serve postpartum women for the first 12-months after delivery, including breastfeeding education and support for nontraditional groups such as partners, grandparents, and siblings.

Concomitantly, the community doula training program continues to grow, starting as a regional training collaborative and growing into a statewide network of training, doula mentorship, and service provision for Medicaid families and families seeking community doula support. Various state entities, including the NJDHS, the NJDOH, and the MIHIA are working together to create new pathways for doulas to enter the workforce and to enroll as NJ Family/Medicaid Care practitioners. A newly released Request for Application (RFA) in July 2025 included training and mentorship opportunities, including billing support, for these vital allied professionals to be integrated into the care fabric of NJ.

Additionally, NJ TVP partners with other HRSA funded maternal and child health programs including the NJ MIECHV Program and the NJ Maternal Health Innovation (MHI) Team at the NJDOH to augment the work of the TVP (HRSA, 2023). In 2024, the MHI team secured a five-year, 7.5-million-dollar competitive funding award from HRSA to continue efforts to address maternal mortality, morbidity, and health gaps in maternal health care in NJ. Funding will support completion of the three-year legislated Shared Decision-Making pilot program and scale-up of TeamBirth, a process to improve communication, teamwork, and shared decision-making throughout the birthing process, in birthing hospitals and birthing centers across the state through 2029. Data collected over time from patients giving birth in TeamBirth hospital sites suggest that patients who participate in a TeamBirth huddle with their care team report higher levels of autonomy and involvement in their care, compared to patients who do not participate in a TeamBirth huddle. Additionally, Alliance for Innovation on Maternal Health (AIM) bundles are funded to enhance patient safety and, ultimately, health outcomes. One of the AIM bundles is related to postpartum discharge and ways to enhance safety in the postpartum period. These AIM bundles prioritize patient safety and clinical care coordination in a trauma-informed, patient-centered environment.

Moreover, in response to the substance use crisis in NJ, TVP applied for and received in-depth technical assistance support from the National Center on Substance Abuse and Child Welfare to develop a State Action Plan. In September 2022, NJ was selected by the Center to participate in the two-year, 2023 Policy Academy: Advancing Collaborative Practice and Policy & Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. The Policy Academy was supported by The Children's Bureau, Administration on Children, Youth and Families, the Substance Abuse

and Mental Health Services Administration, and the Health Resources and Services Administration (HRSA). From 2023-2025, various state entities worked on the State Action Plan to actively prevent maternal mortality and child morbidities and mortalities related to substance use.

This project, led by NJ TVP staff and composed of representatives from the Governor's Office (GOV), the Office of the First Lady, theNJDCF, the NJDHS, and theNJDOH included a State Action Plan, developed collaboratively, to increase awareness of and capacity to address substance use disorders during and after pregnancy for birthing individuals in NJ. The State Action Plan included four overarching goals; all related to enhancing support for pregnant women with substance use disorders. The project aimed to augment the screening, referral, and follow-up services pathways in the state substance use treatment systems of care. The goal of the in-depth technical assistance group was to understand where resource gaps exist and to craft a protocol for birthing hospitals and other providers to strategically support pregnant women with substance use disorders during and after delivery. A formal Family Care Plan, formerly known as a Plan of Safe Care, was also developed for statewide distribution to pregnant women. The initiative ended at the start of calendar year 2025, although the work of the Family Care Plan is carried on by theNJDCF and the NJDOH.

NJ was also the recipient of the Transforming Maternal Health Model and the Rural Health Transformation grant in 2025. Transforming Maternal Health funding is designed to focus exclusively on improving maternal health care for women enrolled in Medicaid and the Children's Health Insurance Program. The model will support grantee Medicaid agencies in the planning and development of a whole person approach to pregnancy, childbirth, and postpartum care that addresses the physical, mental health, and social needs experienced during pregnancy. The $17 million in funding, over a ten-year period, will fund efforts to ultimately reduce differences in access and treatment for Medicaid members.

These efforts will provoke enhanced collaboration between the state's Medicaid agency and the MCH Unit. Many of the goals within the new model's pillars are aligned with ongoing efforts within Title V, including the community doula work.

The Rural Health Transformation funds are positioned to strengthen NJ's ability to improve health care in 11 rural counties by increasing the clinical and nonclinical workforce, enhancing outreach, and building an infrastructure to improve access. Rural New Jerseyans face unique access challenges and carry a disproportionate burden of health conditions, making targeted investment essential.

Children with Special Health Care Needs

Within the SCHS organizational unit, there are four programs: Newborn Screening Follow-up and Genetic Services, Early Identification and Monitoring (EIM), Data Systems and Emerging Threat Response (DSET), and FCCS. These programs work together to accomplish three main

goals. The first goal is to identify children with special health care needs. Secondly, the identified children are referred to services and support. And lastly, there is a focus on the epidemiology of the mandated conditions that are monitored.

These programs work as an integrated continuum of care. Newborns are screened for metabolic and genetic conditions via dried blood spot testing, hearing, and pulse oximetry is used to detect underlying congenital heart defects. If a baby screens positive, they are referred for diagnostic testing, and if the newborn has a congenital condition, they are registered with the BDAR. All children below the age of six who are born with congenital birth defects, and children up to 21 years of age, are registered if they are diagnosed with permanent hearing loss or autism. Once registered, these children are referred to the FCCS program for county-based case-management services and referred to other providers and agencies to ensure that their needs are met. Long-term follow-up began in the first quarter of 2025 for selected disorders to ensure that they have their needs met and to reengage families if they continue to need services.

Special Child Health Services uses a mixture of HRSA Block grant funds, other federal funds, and state funds. In total, approximately 20 million dollars support the SCHS program. Approximately one-fourth of the funds are from Title V (see Figure 7). Other federal funds such as the HRSA EHDI and RWPD grants, and the CDC EHDI and Birth Defects Prevention grants, are also used to sustain SCHS infrastructure and core activities.

Of the total funds, about 40% is used for staffing and infrastructure costs and 60% is provided to health service providers and other community-based agencies. State funds are primarily used for grants, services, and infrastructure of the newborn screening follow up program. This NBS program is funded by the sale of blood spot collection kits to the hospitals. These revenue funds are used by both the lab and to provide critical follow-up for newborns who had positive blood-spot lab results for one of the 61 conditions. Infrastructure costs also include staff who work on the various registries, oversee the case management system, and all the data and epidemiolocal needs of the program. The flexibility of the Title V funds in supporting the infrastructure allows stability in the program and expands the flexibility in the community.

Over 50 staff members from varying disciplines such as nursing, public health, and epidemiology work together to fulfill the mission. The diagrams below highlight some of the successes (Figure 8).

Figure 7: SCHS Funding

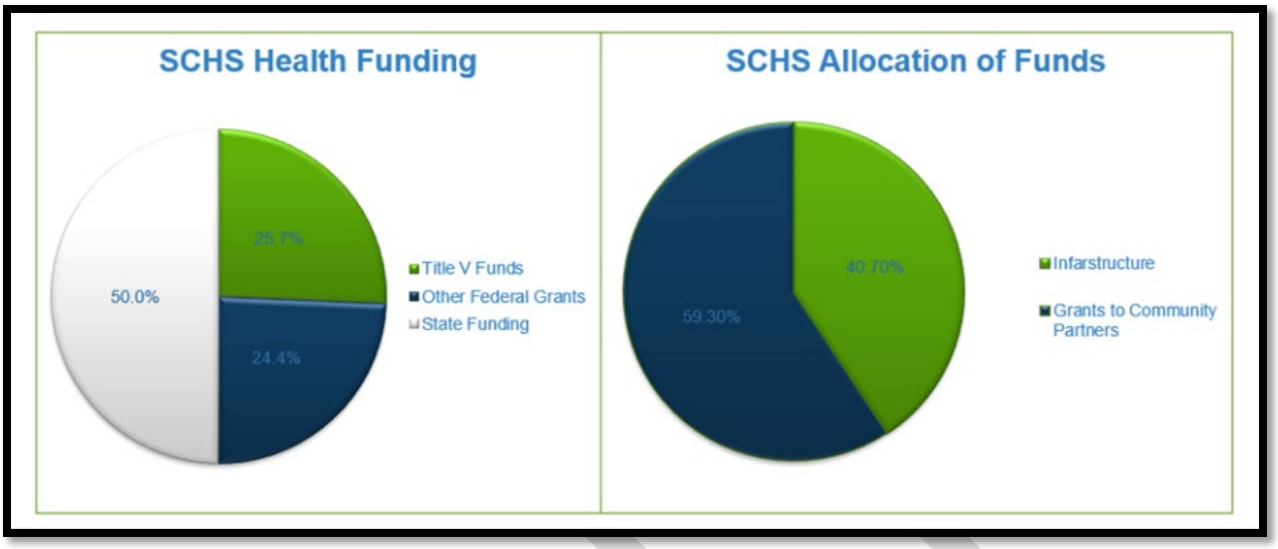
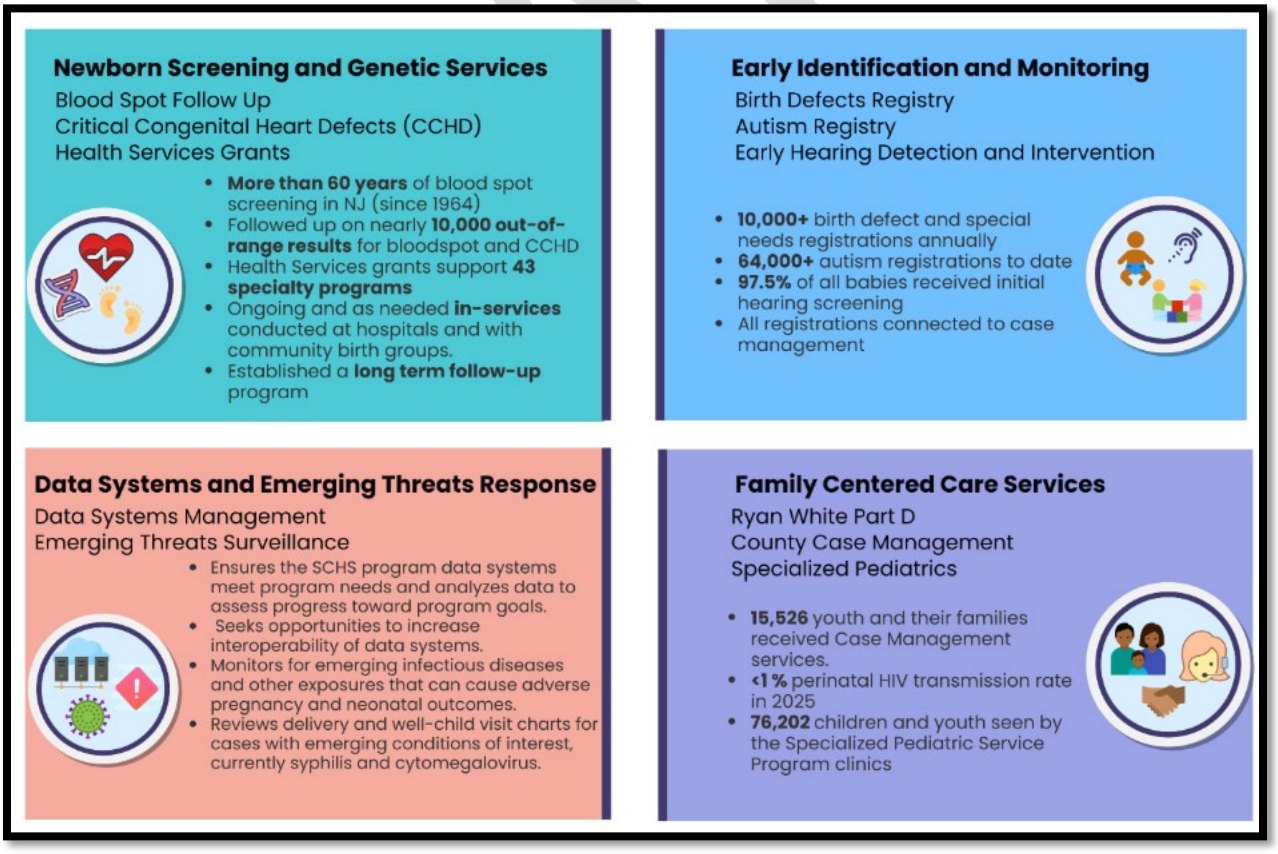


Figure 8. Special Child Health Services Program Highlights



Newborn Screening and Genetic Services

Each year, the NBS Laboratory tests blood spots from approximately 100,000 newborns for 61 disorders. The NBS program ensures timely Follow-up for all out-of-range results. The NBS Lab and NBS Follow-up are both funded through the sale of testing kits to birth providers.

Due to the critical nature of many of the disorders for which NJ newborns are screened, follow-up staff act on presumptive positive results identified by the NBS Laboratory for these disorders six days per week and most holidays to maximize timely referral to the appropriate specialists. The transition to a private courier has allowed the lab and follow-up to remain open on Memorial Day and Labor Day in 2025, improving sample processing timelines and eliminating seasonal delays. The Newborn Screening Short-Term Follow-Up staff contact primary care providers and specialty care providers to ensure timely evaluation, confirmatory testing, connection to ongoing treatment and care, as needed, and to obtain a final diagnosis.

To ensure NJ's program is up to date and effective, staff meet and communicate regularly with several advisory panels composed of parents, physicians, specialists, and other stakeholders. The overarching group is the Newborn Screening Advisory Review Committee (NSARC) and the seven established subcommittees of NSARC.

Additionally, the NBS program holds one federal grant to enhance the information processing infrastructure and support efforts to establish long-term follow-up. Active long-term follow-up (LTFU) began in March of 2025. Outreach to families is done using a survey distribution tool through a public facing REDCap application, while data collection and analysis is conducted within a secure NJDOH REDCap environment. The current Laboratory Information Management System (LIMS) was configured to include a dedicated LTFU module which is used for record organization and workflow documentation.

Early Identification and Monitoring (EIM)

The EIM program has three components: the EHDI program, the Birth Defects Registry, and the Autism Registry. In addition to the HRSA Block grant, this program has three other federal grants and dedicated autism funds to support the registration, follow-up, and quality assurance of the data collected. Once children are registered, they are referred to the Family Centered Care Services program. Registry staff create reports and resources for both providers and families and continue to update systems to improve data accuracy and overall surveillance efforts.

Early Hearing Detection and Intervention (EHDI)

The NJ EHDI program abides by the national 1-3-6 Guidelines which ensures that all babies born in NJ receive a newborn hearing screening before one month of age, complete diagnostic audiologic evaluation prior to three months of age for infants who do not pass their hearing screening and enroll in Early Intervention by no later than six months of age for children diagnosed with hearing loss. The EHDI program offers technical support to hospitals on their newborn hearing screening and follow-up programs. NJ EHDI works with health care providers, local and state agencies that serve children with hearing loss, and families to ensure that infants

and toddlers receive timely hearing screening and diagnostic testing, appropriate habilitation services, and enrollment in intervention programs designed to meet the needs of children with newly identified hearing loss.

The Birth Defects Registry

Dating back to 1928, NJ is proud to have the oldest requirement in the nation for reporting birth defects. Over the years, NJ's BDR has become a robust population-based registry for children

through the age of five with birth defects and provides invaluable surveillance and needs assessment data for service planning and research. All 46 birthing hospitals and hundreds of non-hospital-based practices report to the BDR through the electronic registry-the Birth Defects and Autism Registry System (BDARS). Fetal deaths with birth defects are also registered to ensure the accuracy of the birth defects reporting, and death certificates information is also added to assist with long-term follow-up efforts.

The NJ Autism Registry

One of only a handful of mandated registries in the country, the NJ Autism Registry provides useful information about the prevalence of autism across time and across different populations. To date the registry has more than 64,000 children registered and provides important data about the prevalence of autism over time and by race and ethnicity as well as explores the epidemiological and perinatal risk factors associated with autism.

Family-Centered Care Services (FCCS)

FCCS has three component programs: Special Child Health Services Case Management, Specialized Pediatric Services Program, and Ryan White Part D. Staff ensure that all children with special health care needs are offered free resource and referral services, have a medical home, and are provided with transition to adult care services.

Special Child Health Services Case Management (SCHSCM)

SCHSCM oversees and provides approximately four million dollars in funding to 21 county-based Case Management Units (CMUs). These units provide resources and referrals to CSHCN and their families from birth up to their 22nd birthday. FCCS plays a central role in ensuring that all counties provide robust services and collects key information to establish quality and equity across NJ. SCHSCM staff also educate all CMUs about relevant federal, state, and community partners.

SCHS also refers children aged to three to the NJEIS, which serves the developmental and health-related needs of eligible children. Early Intervention services are designed to address a problem or delay in development as early as possible. NJEIS provides quality services in a child's natural environment (settings in which children without special needs ordinarily participate and that are most comfortable and convenient for the family) by enhancing

the capacity of families to support their child and creating a partnership between practitioners and families. NJEIS provides several services, some of which are: occupational, physical, and speech therapy, as well as developmental intervention.

Specialized Pediatric Services Program (SPSP)

The SPSP aims to provide access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services. With support from the State and Title V funds, almost four million dollars was distributed to Child Evaluation Centers, Pediatric Tertiary Care Centers and Cleft Lip/Palate Craniofacial Centers. Approximately 62% of the children served are uninsured or are covered via Medicaid/Medicare programs.

Ryan White Part D (RWPD)

The Ryan White Part D program aims to provide comprehensive, culturally competent, coordinated care for women, children, youth, and families with HIV infection throughout the State of NJ. The RWPD Network offers HIV specialty care, family medical case management, access to clinical drug trials, referral and follow-up services, outreach, counseling, and testing. Since 1988, the RWPD Network has focused its efforts on developing family centered care facilities designed to provide or arrange for comprehensive treatment for women, children, youth, and families infected with or affected by HIV disease. The centers have become highly skilled in providing psycho-social services, and medical and nursing care to families dealing with HIV as a chronic illness. Over 2,000 families receive services at seven sites throughout the State of NJ. The RWPD Network clinics have also helped reduce the overall NJ perinatal HIV transmission rate to less than 1% with some years with zero reported mother-to-baby HIV transmissions. Since 2014, the work of the RWPD Network providers has prevented 1,316 perinatal transmissions. . That represents a cost savings of $553,095,060. This cost savings is calculated by multiplying the total number of HIV-negative babies born to a HIV-positive pregnant person by the estimated lifetime cost of HIV care ($420,285).

Data Systems and Emerging Threat Response (DSET)

The DSET unit works to improve data access and data quality. DSET staff ensure that the SCHS program is capturing data to measure outcomes and meet goals. This includes maintaining systems created specifically for the BDARS, and the Case Management Referral System (CMRS). Staff also work to receive data from external systems and software, like the Revvity/SpecimenGate Patient Care system used to track newborn bloodspot screening follow-up and REDCap used for surveys and data collection. Collection of outpatient hearing screening data for the EHDI program is built into the state's immunization registry and the program works with the Office of Vital Statistics and Registration for access to birth, death, and fetal death certificate data. Over the past year the program has worked to incorporate the use of a Master Person Index (MPI) unique identifier to link individuals across the NJDOH data systems.

The program is currently exploring the incorporation of electronic case report data for capturing of birth defect cases.

An important function of SCHS is to identify and respond to trends in exposures to pregnant people that have the potential to fuel rising rates of children with special health needs. Between April 2020 and August 2023, the SCHS work in this area included monitoring outcomes of pregnancies complicated by COVID-19 infection. The COVID project ended in July 2023 because of declining infection rates. However, the SET-NET project was expanded in August 2022 to include surveillance of congenital syphilis and congenital cCMV infections. Syphilis infections during pregnancy and cases of congenital syphilis have been rising significantly in NJ and nationally.

III.B.2.b. Organizational Structure

The TVP sits within the NJDOH; specifically, within the FHS Division. However, TVP funding supports a variety of programs aimed at improving MCH, including programs that sit outside of the FHS Division, such as the Children's Oral Health Program, which is situated in the Division of Health Promotions (formerly Community Health Services). Additionally, the NJDOH works closely with private foundations, such as the Burke Foundation, to augment the allied professional workforce that directly serves women, children and families in the state. The NJDOH is also supporting efforts initiated at NJMIHIA, the state's new central hub for coordinating important clinical, research and policy innovations related to the MCH populations in the state. Lastly, the Title V Director serves on the Universal Home Visiting Advisory Board, offering an MCH lens to the important nurse home visiting programs implemented throughout the state.

III.B.3 Health care delivery system

III.B.3.a System of Care for Mothers, Children and Families

The NJ system of care for mothers, children and families in the state is robust and includes a large hospital and health care infrastructure, numerous teaching hospitals, and various medical, physical, behavioral health entities across the State. These systems work independently and in tandem to address the needs of the state's large population. TheNJDOH, along with public and private entities, collaborates on programs which ensure outreach to impoverished populations, and populations who infrequently access services. The genesis of the efforts to address the various health issues that populations face in the state comes from various data sources. Concomitantly, the data collected are examined to understand gaps in service provision and understand the contemporary needs of populations to inform intervention and prevention efforts moving forward.

NJ Hospital Information:

- There are 113 total hospitals in NJ, including specialty hospitals. There are 72 acute care hospitals in NJ.
- The NJ Hospital Association's membership includes 108 hospitals, plus affiliate members including nursing homes, home health agencies, long term care hospitals and other health care providers, bringing the total member count to more than 400.
- NJ hospitals employ more than 150,000 individuals. Collectively, health care is the largest private sector employer in NJ and ranks second only to government as the state's largest employment sector.
- NJ hospitals provide $23.6 billion in jobs, spending and other economic benefits to the state's economy
- NJ hospitals provide about $1.9 billion in free and discounted health care annually to the uninsured, senior citizens and those in financial need
- NJ hospitals care for more than 15 million patients each year
- NJ hospital emergency departments provide care and comfort to 3.8 million individuals annually.

Overview of Delivery Hospitalizations for NJ Births

- The racial/ethnic profile of NJ mothers is changing over the last quarter century. Racial and ethnic groups other than Non-Hispanic White represent 55% of all births in 2024 (the same proportion as in 2023), compared to 46% in 2000.
- There were 95,385 deliveries (singleton/first of multiple live births) at licensed birthing general acute care hospitals compared to 95,106 deliveries in 2023.
- The number of pregnant women covered by private insurance was 58,443 compared to 59,597 in 2023, and those covered by Medicaid was 33,504, compared to 32,508 in 2023.
- The rate of cesarean birth in 2024 was 32.5%, which was nearly the same as the 2023 rate (32.6%). The rate of vaginal births was 67.5%, also similar to the 2023 rate (67.4%).
- The rates of obstetric hemorrhage increased from 58 to 59 per 1,000 delivery hospitalizations in 2023, and severe maternal morbidity (SMM) with transfusion increased from 25 to 26 per 1,000 delivery hospitalizations in 2023. The rate of postadmission infections remained stable at 22 per 1,000 delivery hospitalizations in 2024: the same rate as in 2023.

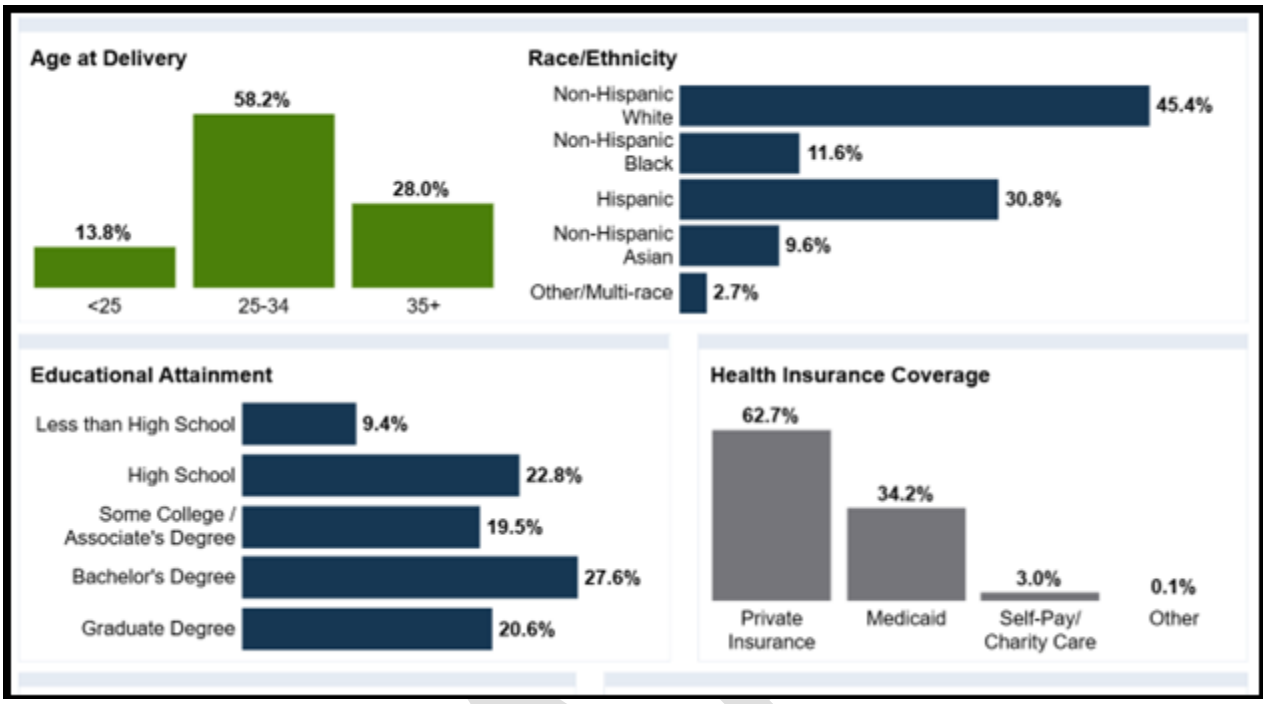
- There were higher rates of cesarean deliveries with complications as compared to vaginal deliveries per 1,000 delivery hospitalizations: obstetric hemorrhage (130 cesarean versus 25 vaginal); post-admission infections (28 cesarean versus 20 vaginal); and SMM with transfusion (48 cesarean versus 16 vaginal).

Delivery Complication Rates by Race/Ethnicity

- Non-Hispanic Black mothers continued to have the highest rate of SMM with transfusion (43.6 per 1,000 delivery hospitalizations, an increase from 41.2 per 1,000 delivery hospitalizations in 2023). Hispanic mothers had the second highest rate of 31.3 per 1,000 delivery hospitalizations. The lowest rate was among Non-Hispanic White mothers at 19.1 per 1,000 delivery hospitalizations.
- Non-Hispanic Black mothers had the highest rate of obstetric hemorrhage (68.8 per 1,000 delivery hospitalizations, a slight increase from 68.2 per 1,000 delivery hospitalizations in 2023). Hispanic mothers had the second highest rate of 63.1 per 1,000 delivery hospitalizations. The lowest rate was among Other/Multi-race mothers at 54.1 per 1,000 delivery hospitalizations.
- Hispanic mothers had the highest rate of post-admission infection of 30.0 per 1,000 delivery hospitalizations. In 2023, Non-Hispanic Asian mothers had the highest rate (32.9 per 1,000 delivery hospitalizations), which decreased to 29.5 per 1,000 delivery hospitalizations in 2024. The lowest rate of post-admission infection in 2024 was among Non-Hispanic White mothers at 14.3 per 1,000 delivery hospitalizations.
- Non-Hispanic Asian mothers had the highest rate of third- and fourth-degree perineal lacerations without instrument (4.3%, a slight decrease from 2023). Multi-race/other race mothers had the second highest rate of 1.7%. The lowest rate was among Non-Hispanic Black mothers at 0.8%.
- Non-Hispanic Asian mothers had the highest rate of episiotomy (7.3%) delivery hospitalizations, a continued decrease from 8.9% in 2023, and 10.3% in 2022). Non-Hispanic White mothers had the second highest rate of 3.2%. The lowest rate was among Non-Hispanic Black mothers at 1.3%. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Births in 2024
- The rate of cesarean births among nulliparous (first time mothers), with a term (37 or more completed weeks of gestation), singleton (one fetus), in a vertex position (head-first presentation of the fetus), or NTSV cesarean births, slightly decreased to 24.9% in 2024 from 25.4% in 2023. The percentage of birthing acute care hospitals in NJ that achieved the U.S. Department of Health and Human Services Healthy People 2030 target of 23.6% or fewer NTSV cesarean births increased to 41.3% in 2024 from 38.3% in 2023.

Data source: NJ Hospital Maternity Care Report Card: January 2026

Figure 9: Birthing Mothers Key Demographics



In the past five years, NJ has taken critically important steps to address the acute issues in the health care system such as: 1) improving the data available through the nationally recognized Report Card of Hospital Maternity Care, 2) expanding investment in community-based doulas through training and Medicaid reimbursement, and 3) non-payment for early elective deliveries through Medicaid and State Health Benefits Plans. The TVP, in conjunction with the work of HNJ 2025 and NJMIHIA, continues to build on this excellent foundation by ensuring women have consistent access to evidence-based care framed in quality improvement measures for accountability, and ensuring improved preventive health and wellness for women across the life course.

Federally Qualified Health Centers (FQHC)/Community Health Centers:

FQHCs, also known as *Community Health Centers*, operate 138 sites in all 21 counties of the State. These Centers provide comprehensive and high-quality primary and preventive health care services to NJ's communities.

The NJ Primary Case Association (NJPCA) supports the FQHCs and Community Health Centers by providing technical assistance and other supports to encourage quality improvement activities, systems changes, and promising practices. NJPCA's Clinical Quality Programs seeks to improve both access and quality by increasing the effectiveness, efficiency, and safety of primary care that is provided to at-risk populations at service sites located in the urban and rural communities throughout the State.

NJPCA Quality Programs and Initiatives align with the National Quality Strategy and support the efforts of NJ Health Centers to achieve the "Triple Aim" (a framework developed by the Institute for Healthcare Improvement) of:

- Better care for patients – improving the experience of care
- Healthy communities – improving the health of populations
- Lower health care costs

The NJPCA Quality Program infrastructure consists of several subcommittees that work together to improve the delivery of care and health outcomes. These committees are charged with the development and modification of clinical practice systems and protocols to improve both access and quality of the primary care services provided by NJ Health Centers.

NJPCA Clinical Quality Communities

- Medical and Dental Directors Committee
- Directors of Nursing Committee
- Quality Assurance Committee
- NJPCA Statewide Quality Improvement Committee

How clinical systems provide services in NJ to pregnant women and mothers:

1. High-Risk Medical Needs are addressed at hospitals & health centers. Moderate-Risk Medical Needs are managed at FQHCs, urgent care centers, and through visiting medical services. Preventive care is provided through Preconception & Family Planning Services, Prenatal & Postpartum Care Programs, and MCHC.
2. The NJDOH MCH programs support a range of clinical services, including preconception services, STI prevention, family planning, prenatal and postpartum care, high-risk infant follow-up, newborn screenings, lactation support, doula services, CHWs, Home Visiting services, maternal mental health services. These programs collaborate with hospitals, outpatient clinics, and community organizations to reduce infant and maternal morbidity and provide support to vulnerable populations.
3. Some populations are vulnerable to unplanned pregnancy, sexually transmissible infections (STIs) and sexual and intimate partner violence including human trafficking. Adolescents and young adults can access the system of maternal and reproductive health care through family planning services throughout the state including access to Title X clinics where parental consent is not required for services including birth control, STI testing and treatment, other sexual and reproductive health care, and counseling and treatment for sexual and intimate partner violence and human trafficking.

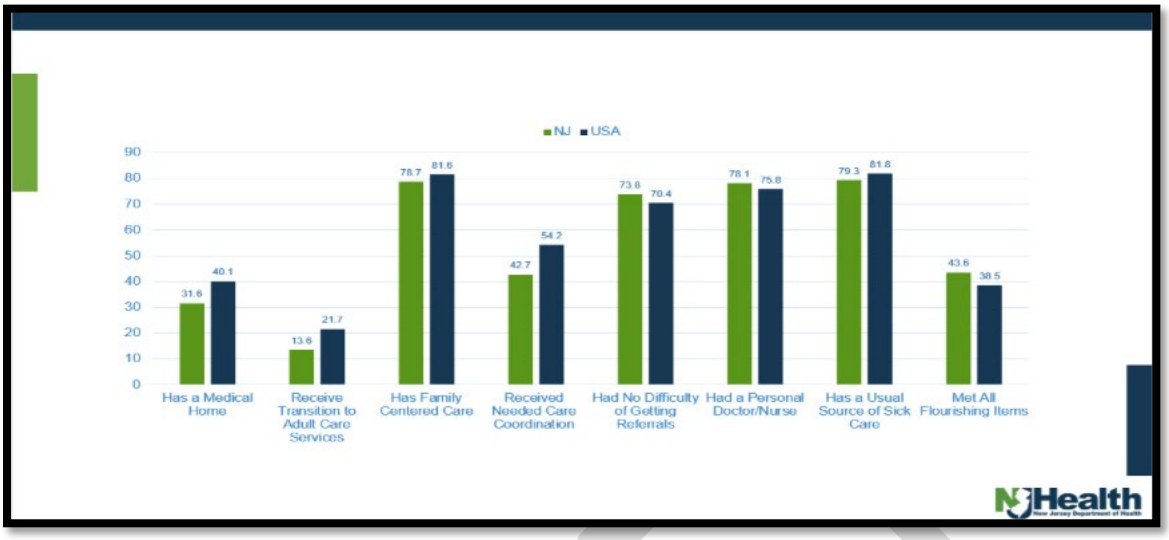
The Child and Adolescent Health Program specifically administers two sexual health grants that address pregnancy/STI prevention, sexual and intimate partner violence and human trafficking awareness/prevention and provide referrals for services. With the recent availability of birth control at local pharmacies in NJ and statewide access to emergency contraception, teen pregnancy and unplanned pregnancies to young adults carried to term are very low in NJ. In 2023, the teen birth rate in NJ was 7.5 births per 1,000 females aged 15–19, which is much less than the national average of 13.1 per 1,000 births to females ages 15-19. This is a record low for this age group and a 3% decrease from 2022. A focus on access to all maternal and reproductive health services in NJ could improve the maternal and reproductive landscape for adolescents and young adults in NJ.

III.B.3.b System of Care for CSHCN

The system of services for NJ's CSHCN population is very robust. Comprised of many hospitals and specialty providers, many community-based organizations and family-led organizations, Medicaid, a vast network of over 6,000 Early Intervention service providers, over 3,000 pediatricians, and a TVP that supports screening programs, service grants to support the infrastructure, registries, a strong county-based case management program, and a newly developing long-term outcome focus.

The National Survey of Children's Health estimates that NJ has approximately 415,000-535,000 (20.8-26.8%) children, birth through 17 years of age, have a special health care need according to the traditional and expanded CSHCN criteria. In the 2023-2024 survey, 448 families identified as having a child with a special health care need using the expanded criteria. Title V staff examined core metrics for the CSHCN population to better understand the health and well-being of NJ's CSHCN population. Figure 10, illustrates that most families described having family-centered care and a usual source of sick care. Interestingly, only a third described having a medical home. While NJ's results are not markedly different than the national results, there is still work to be done. Only a quarter of families said they have no difficulty getting referrals, and only 43% said they have the care coordination they need. For children transitioning to adult care, less than 15% received transition support. Although NJ has many providers, about 20% had no personal health care provider or a usual source of sick care.

Figure 10. National Child Health Survey (2023-24) CSHCN Measures



While the latest survey did not parcel out adequate insurance coverage, the 2017-2018 survey indicated that 95.8% of the CSHCN were insured, but only 62.3% felt the insurance was adequate and continuous. Additionally, only 10.3% of respondents felt the system was functioning effectively.

Through the State's Title V-funding programs, care coordination is a priority, as well as establishing medical homes for CSHCN through the FCCS. Additionally, service grants are provided to strengthen the network of specialized pediatrics services. The NBS programs and the Early Identification and Monitoring programs work to connect children to the health care delivery system and the family centered support networks that they need to work within the state.

NJ System of Care for CSHCN

Newborn Screening and Genetic Services

The NBS Follow-up program is dedicated to ensuring that all newborns and their families receive timely and appropriate follow-up services when a screening result falls outside of the normal range. This effort is supported by a robust infrastructure of internal and external stakeholders which relies on ongoing relationship building to keep the system strong. Key players in this network include hospitals, birthing centers, providers of community births, courier services, the state lab, the software vendor (Revvity), pediatricians, specialists, and the follow-up team. The Newborn Screening Advisory Review Committee (NSARC) and its subcommittees are vital to keeping the program up to date, efficient, and effective in the management of dried blood spot screening. Equally essential to the program's success are the grantees of the health services

grants, access to community-based services, and assistance with transition to adult care. This entire complement of services from specimen delivery, screening for 61 disorders, through reporting of abnormal results and the grant awards to the community, is all funded by the sale of dried blood spot kits (the filter paper used for the screening). These services are all completed at $150 per initial kit, where the initial kit fee also includes any repeat testing and associated follow-up. Additionally, the NBS program has a State NBS System Priorities Program (Propel) award; in year three of the funding opportunity HRSA-23-065 (budget period 07/01/2025 – 6/30/2026, with the potential for a total of five years of funding). This funding has allowed NBS to begin implementing a LTFU component for the Program. In year one, the team collaborated with and collected information from multiple states that are further ahead of LTFU for NBS and completed an IRB application. The IRB responded in December 2024 with a notice of determination of non-human subject. Since then, the team has moved forward with plans to use REDCap to manage the LTFU surveys and data collection and began outreaching families in March of 2025. The plan is to conduct an annual survey with families on their child's sixth birthday, via email or over the phone.

Some challenges within the NBS program are keeping up with the dynamic landscape of health care, communication with primary care providers (PCP), an increasing number of parents declining screening, and data management and coordination. While the program and the NJ NBS Lab regularly collaborate, they did create a 2025 workgroup focused on communication with pediatricians to help us better communicate on all fronts, from the wording on lab mailers to phone conversations. In January, the information on the website was made more user-friendly for both pediatricians and families. To further improve data management, follow-up staff hold bi-weekly meetings to ensure data accuracy and quality. Additionally, follow-up staff meet monthly with the lab team to review and discuss key data points. Both the lab and follow-up programs contribute data to the Association of Public Health Laboratories (APHL/NewSTEPs). Additionally, ensuring interoperability remains a continuing challenge as we work toward streamlining processes across the system.

Since 2011, NJ has mandated newborn pulse oximetry screening to detect critical congenital heart defects disorders. The screening mandate was enacted to prevent babies, who seem healthy, from being discharged only to become critically ill later. Originally, all babies who failed the screening were registered with the BDR's Pulse Oximetry module. BDR nurses would then follow up with the hospitals. The goals were to validate that all failed screenings were registered, that the children received appropriate follow-up, and that any subsequent diagnoses were reported. To better facilitate the screening results and follow-up, the pulse oximetry screening data were eventually integrated into the population-level screening results section of the Vital Events Registration & Information System (VERI). This system collects all birth-related data on babies born in NJ and includes perinatal risk factors, birth characteristics, demographics, and other maternal and newborn related data. We established a robust surveillance system to cross-

reference the findings. Ultimately, by working collaboratively and integrating systems we can better evaluate the complete CCHD screening process in birthing facilities, including the effectiveness of and adherence to the screening algorithm. The CCHD program continues to collaborate with BDR staff on Component C of a Cooperative Agreement with the Centers for Disease Control and Prevention's (CDC) (Advancing Population-Based Surveillance of Birth Defects; CDC-RFA-DD21-2101). Component C focuses on the timing and method of CCHD detection.

Early Hearing Detection and Intervention (EHDI)

The NJ EHDI Program ensures that all babies born in NJ receive a newborn hearing screening before one month of age, complete diagnostic audiologic evaluation prior to three months of age for infants who do not pass their hearing screening and enroll in Early Intervention by no later than six months of age for children diagnosed with hearing loss. The EHDI program offers technical support to hospitals on their newborn hearing screening and follow-up programs. NJ hospitals are very successful in ensuring newborns receive hearing screening, with 97.5% of babies screened. Babies who fail their screening are referred for follow-up diagnostic service with an audiologist. The program staff track these referrals to ensure babies receive timely and appropriate follow-up. NJ EHDI works with health care providers, local and state agencies that serve children with hearing loss, and families to ensure that infants and toddlers receive timely hearing screening and diagnostic testing, appropriate habilitation services, enrollment in intervention programs designed to meet the needs of children with newly identified hearing loss, and connection to Deaf/Hard of Hearing adult to family programs.

Birth Defects Registry

Title V fully supports NJ's Birth Defects Registry which ensures that children who have congenital birth defect are linked to resources and supports. All 45 birthing hospitals and hundreds of non-hospital-based practices report to the BDARS through the online registry. Annually, the CSHCN program receives an average of 5,500 birth defect registrations and 4,500 autism registrations. BDARS allows providers to verify if a child has already been registered by another provider; thus, significantly reducing the burden on the reporting agencies and improving the system's efficiency. This is significant as the mandate requires all children through the age of five with a birth defect and all children 0-22 with ASD to be registered, and since children see many health care providers; each needing to verify registration or register the child. Moreover, if a child has been registered, their providers can know any new diagnosis including an autism diagnosis, and review and update the child's contact information.

Since 2021, the BDR expanded its case ascertainment efforts by abstracting charts of NJ children with birth defects who were born at, transferred to, or diagnosed by the Children's Hospital of

Philadelphia. This was an important step forward as these children have complex health care needs and would not only be included in surveillance of birth defects, but families would be offered case management services. We anticipate future agreements with other border state hospitals so that more children will be included and served. NJ has the statutory authority to capture fetal deaths due to birth defects at 15+ weeks of gestation, and these data have improved the overall quality of the data, thus providing a more accurate understanding about the prevalence of the most serious birth defects. Additional data needs to be collected on fetal demises with congenital anomalies from other licensing facilities throughout NJ besides the 46 birthing hospitals to know the true prevalence rate of the major birth defects. Limitations to case ascertainment include the de-identification of fetal death cases in the BDR, which makes it difficult to further validate the data.

NJ Autism Registry

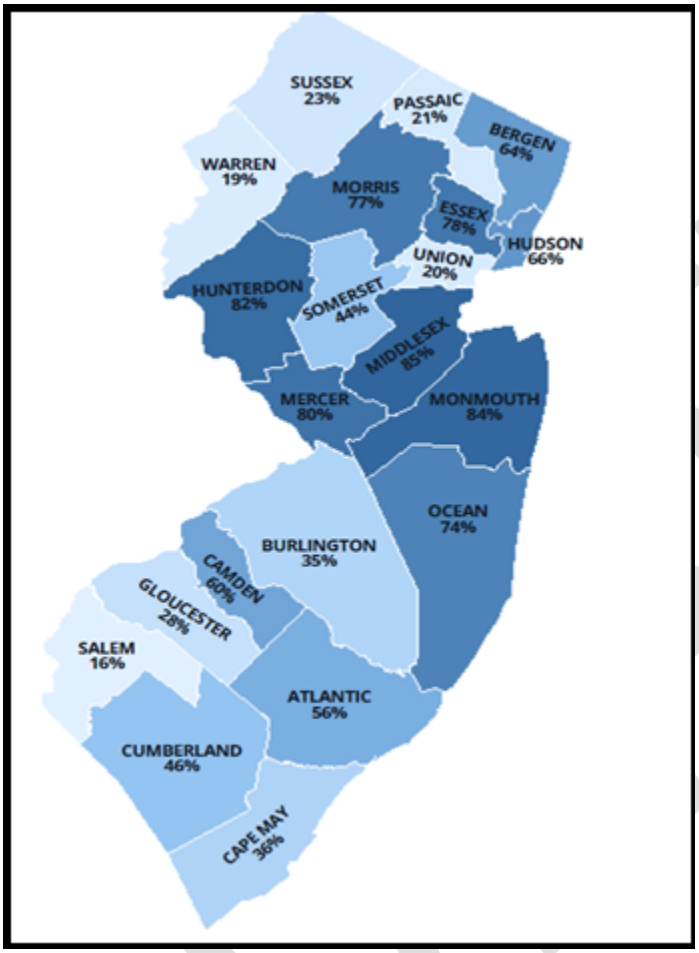
Since 2009, the Autism Registry has received more than 64,000 registrations. Each year, health care providers submit between 3,000 and 5,000 new registrations. The Autism Registry is included in the BDARS platform. The autism data collection pages are designed with check-off options rather than asking providers to use text fields to provide information about comorbidities, symptoms, and other pertinent information. It is the only registry in the country that includes children up to the age of 22 and refers them to their local county case management services. We serve as a model registry and continue to provide technical assistance to other states considering a registry. The Autism Registry provides quality prevalence information for the entire state and information about any population differences. Current national studies such as the Autism and Developmental Disabilities Network estimate that the rate of autism in NJ is 1 in 34 (based on review of records of a cohort of 8-year-old children in four counties who meet criteria for autism). The National Child Health Survey also reports that 3.4% of families reported that their child currently has ASD.

The Autism Registry has shown similar prevalence rates. The autism rate for children born between 2009 and 2014 showed a rate of 1 in 41 statewide, with some significant differences by county. Additionally, the Autism Registry collects and analyzes known perinatal risk factors and how they influence the NJ prevalence rates.

The Autism Registry interfaces with developmental pediatricians, pediatric neurologists, psychologists and psychiatrists and other licensed providers who diagnose autism. NJ also has several large multi-disciplinary autism diagnostic and treatment specialty centers. While there are many diagnostic opportunities, there continue to be long-wait times for diagnosticians, and areas in the state where there are many fewer resources. Based on the Autism Registry data, approximately 61% of children are diagnosed within their home county, however, the range is large (15% to 85%). Facilities and services are clustered in the more urban northeast, in

Middlesex, Hunterdon and Monmouth counties which have several hospitals focusing on children's specialty services (Figure 11).

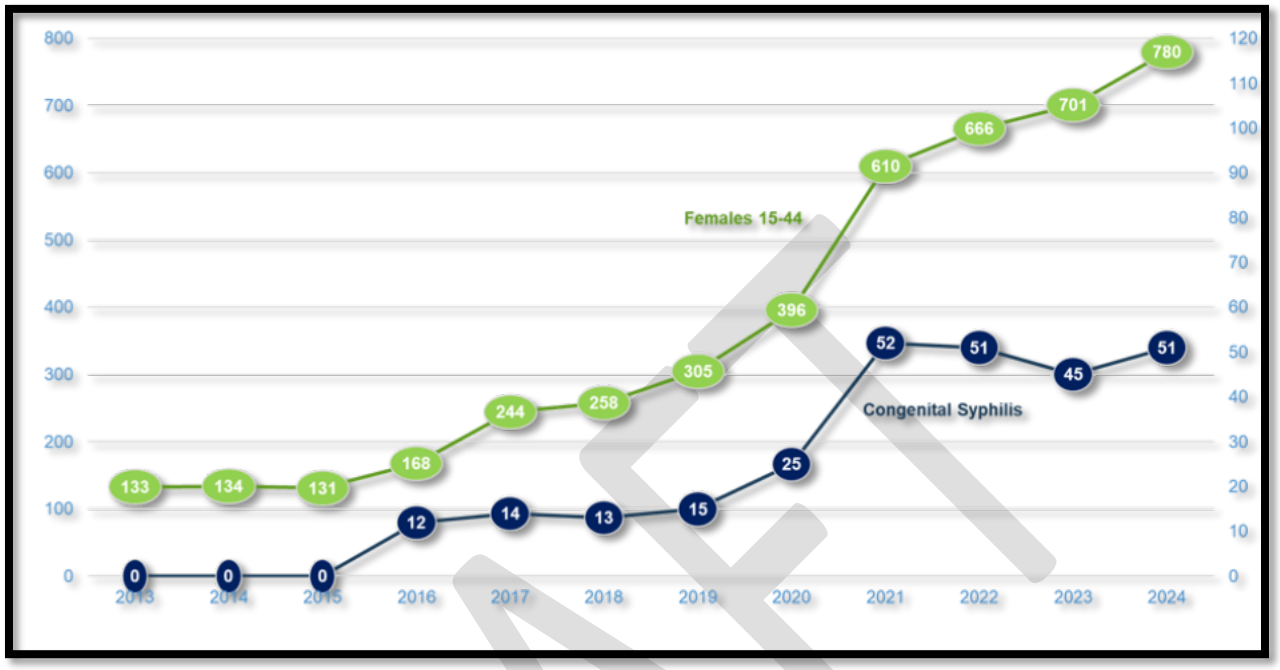
Figure 11. Percent of Children who Receive an ASD Diagnosis Within their County of Residence: Year of births 2003-2021 (NJ Autism Registry)



Data Systems and Emerging Threat Response (DSET)

An important function of the SCHS unit is to identify and respond to trends in exposures to pregnant mothers that have the potential to fuel rising rates of children with special health needs, receiving funding from CDC's program. The SCHS work in this area began in 2020, monitoring outcomes of pregnancies complicated by COVID-19 infection from 2020 through 2023. The project expanded in 2022 to include surveillance of congenital syphilis and cCMV infections. Syphilis infections during pregnancy and cases of congenital syphilis have been rising significantly in NJ and nationally (Figure 12).

Figure 12. Reported Syphilis Cases among 15-44 yr old Females and Congenital Syphilis cases in NJ 2012-2024



Source: NJDOH STD program, Communicable Disease Reporting and Surveillance System

The project began by tracking 313 pregnancies with delivery outcomes in 2018-2021 that were complicated by syphilis infection with maternal/newborn chart abstraction and infant follow-up tracked through age two; data were then submitted to the CDC. During FY25, 145 additional cases with delivery outcomes in 2022 were reviewed. Approximately one-third of infections during pregnancy resulted in a diagnosis of congenital syphilis, with risks for congenital infection including lack of prenatal care, substance use, and infection or reinfection during the third trimester. During FY26, the program will be reviewing 197 cases with 2023 delivery dates. To date, the CMV project reviewed medical records for 242 pregnancies with deliveries beginning in 2018 to identify 91 cases meeting case definition criteria. Since postnatally acquired CMV infection can be a complication of NICU infants, an initial chart review is required to accurately identify congenitally acquired cases. Those cases then receive more detailed review and infant follow-up to age three with data submitted to CDC. The DSET program is looking at strategies to identify additional exposures appropriate to this model.

Family Centered Care Services (FCCS)

FCCS plays a central role in ensuring that all counties provide robust services and collect key information to establish individualized resources and referrals to eligible families across NJ.

FCCS SCHSCM oversees and provides approximately four million dollars in funding to 21 county-based CMUs. These funds include Title V funds and state MCH Block, Casino-revenue, and Catastrophic Illness in Children Relief funds. Each CMU also receives funding from its respective county government. The amount of funding provided is determined by each county. These units provide resources and referrals to families of children from birth up to their 22nd birthday. Annually, over 15,000 families receive services from SCHSCM.

SCHSCM staff educate all CMUs about relevant federal, state, and community partners. FCCS's ongoing intergovernmental and interagency collaborations include, but are not limited to, the NJ DOH Children's Oral Health Education Program, Social Security Administration, NJ Department of Children and Families (DCF), Department of Banking and Insurance (DOBI), the Boggs Center/Association of University Centers on Disabilities, NJ Council on Developmental Disabilities, and community-based organizations such as Autism NJ, New Jersey Chapter of the American Academy of Pediatrics, New Jersey Hospital Association, and disability-specific organizations such as the Arc of New Jersey, SPAN Parent Advocacy Network, and the Statewide Community of Care Consortium. Consultation and collaboration with the NJDOH's other programs such as the New Jersey Early Intervention System, Ryan White Part D, Maternal and Child Health, Women, Infants, and Children, Federally Qualified Health Centers, HIV/AIDS, Sexually Transmitted Diseases and Tuberculosis, as well as Public Health Infrastructure Laboratories, and Emergency Preparedness affords FCCS with opportunities to communicate and partner in supporting CSHCN and their families.

The CMUs remain successful connecting CSHCN to vital services. The following summary highlights one child and his family's journey in navigating multiple needs over the past decade, illustrating the critical role CMUs play in supporting the Title V CSHCN population.

Quote:

The SCHS CMU received a referral from the BDR for an infant with multiple congenital anomalies. The assigned case manager connected the family with the NJEIS and initiated a referral for a Private Duty Nursing Waiver. The severity of the baby's condition required one parent to leave full-time employment to provide care. The Case Manager (CM) linked the family to a charitable organization that provided critical financial support, helping them avoid losing their home. Over the years, the CM assisted the family with an array of needed services such as durable medical supplies, insurance, and nursing needs.

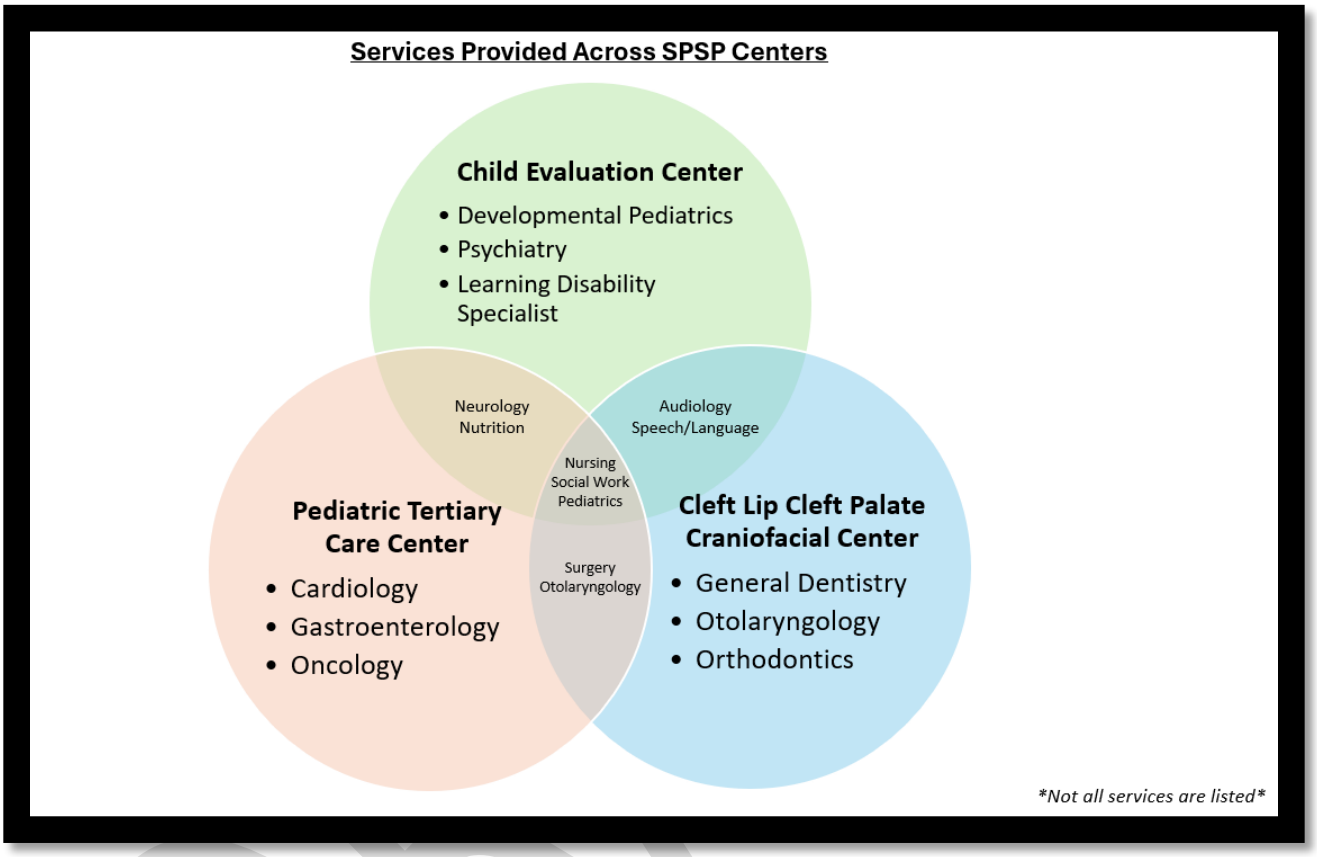
Equally important is that the CM served as the only person, outside of medical professionals, with whom the parents could speak candidly regarding their son's complex care. The parents had to make incredibly difficult decisions, and they relied on the CM for much-needed emotional support. Through a decade-long relationship built on trust and clinical expertise, the CM guided the family to work with a palliative care team, creating a bridge between them and the medical team, giving the child a voice in his own care.

One key factor that FCCS focuses on for SCHSCM is the level of engagement with children referred to Case Management from the BDARS. The level of family engagement provided by SCHS case managers encompasses a wide range of needs. For example, a child born with hypospadias, which can be surgically corrected and requires no further SCHSCM assistance, may require little to no continued engagement. In contrast, a child with a diagnosis of Charge Syndrome may have more extensive and lifelong needs, resulting in a greater level of engagement. Additionally, FCCS manages a Fee-for-Service program that assists eligible NJ families to purchase hearing aids, ear molds, orthotics, or prostheses through a State-approved vendor system. Family cost participation is calculated using a sliding scale based on family size and income, and the SCHSCM case managers support families in completing the application process. Since the passage of Grace's Law in 2008, which requires NJ insurance companies to cover medically necessary expenses incurred for hearing aids for children under the age of 15, most children served by this program are those who either do not have NJ-based health insurance or have no health insurance coverage at all.

Specialized Pediatric Services Program (SPSP)

The SPSP aims to provide access to pediatric specialty and sub-specialty services to families with CSHCN that are 21 years old or younger (Figure 13). The SPSP consists of eight Child Evaluation Centers of which four house FASD Centers, and three provide Newborn Hearing Screening follow-up. The three Pediatric Tertiary Care Centers and five Cleft Lip/Palate Craniofacial Centers provide clinical services. All centers provide services statewide across 21 counties in NJ and are partially funded via the health service grants. Patients receiving services at these locations may not be captured by BDARS due to their non-mandated diagnoses (i.e., speech delay/disorders) and/or parent/caregiver choice to decline participation in SCHSCM. In SFY25, $2,209,168 was awarded to CEC grantees, while $760,644 was distributed to Cleft Lip/Palate Craniofacial Centers and $942,137 to Pediatric Tertiary Care Centers.

Figure 13. Services Provided Across SPSP Centers



According to the CDC and the American Academy of Pediatrics (AAP), the rate of children identified with an Autism Spectrum Disorder is 1 in 31 children nationally and 1 in 29 in NJ. According to the American Academy of Pediatrics, there is one Developmental-Behavioral Pediatrician per 100,000 U.S. children ages 0 - 17. The SPSPs have been negatively impacted by this national pediatric subspecialty shortage. This national shortage is reflected in NJ by the Child Evaluation Centers' new patient waitlist that ranges from 1- 12 months. Feedback gathered from site visits indicates that some Child Evaluation Centers have spearheaded their efforts to train psychiatry fellows, implement Generalist as Specialist programs, and provide nursing support. However, low Medicaid reimbursement rates for specialized services are causing some specialized facilities to discontinue their Medicaid contracts. Statewide issues of insurance authorizations holding up services, and thus delaying treatment, are reported.

III.B.4. Emergency Planning and Preparedness

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

In collaboration with other NJDOH leaders, the Assistant Commissioner of FHS participated in developing the COOP. Moreover, all divisions, including the FHS Division where Title V primarily resides, are part of the COOP's development and maintenance. Title V leadership is involved in developing and implementing the COOP and is also part of the Rapid Mobile Response Team that the Division of Emergency Preparedness leads.

This COOP enables the Department to identify the essential functions that need to be preserved and to develop the requisite strategies that may be required to maintain these essential functions in the event of any disaster or emergency that could potentially disrupt governmental operations and services. The team developed a COOP decision process. The table below (Table 1.) depicts the different levels of emergency and the potential impact on the agency.

Table 1: Levels of Emergency and Impact

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

	May require activation of orders of succession for some key personnel.

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

The FCCS in Special Child Health is upgrading the current case management reporting system to enable the program to quickly reach out to all families with children with special health care needs receiving case management services. This system includes an "exceptional events" module that has been redesigned to allow more flexibility in collecting the family's needs and how they can be utilized and better serve the community during emergencies. Additionally, case management units utilize email, phone calls, text messaging, and letters for direct communication and emergency situations. To expedite communication with families, the upgraded system will include SMS text messaging capability and email functionality. This will allow case management units to efficiently communicate with families regarding their individual needs and distribute mass communications in real time in case of an emergency event.

The NBS Follow-Up program, has plans for how to continue operations when staff is not able to report to a given worksite, when the Laboratory Information Management System (LIMS) is not available, and for when the NJDOH network is down. These plans are coordinated with the NJ NBS Laboratory. The NJ Public Health and Environmental Laboratories, NBS Laboratory, has a laboratory coverage agreement for backup services to ensure continuity of operations.

The COVID-19 pandemic highlighted key gaps in data and surveillance that were quickly rectified with an emergency response dashboard that highlighted COVID-19 positive rates and vaccination rates among NJ residents. Since then, NJDOH has been committed to continuing surveillance and data management by creating a centralized data hub and a maternal data center that specifically focuses on NJ families' health indicators. These indicators are successively reviewed and scrutinized to ensure the right information is being collected to best understand the populations the NJ TVP serves considering pregnant women, infants, and children have unique risks during public health emergencies.

The discontinuation and/or scaling back of lifeline services during the pandemic is believed to have exacerbated preexisting socioeconomic and emotional challenges. Some of the key lessons that TVP learned through the pandemic is the need to be flexible on how resources and services are delivered to the MCH population in NJ. For example, many health centers offered telehealth/telemedicine during the pandemic to accommodate patients and be compliant with CDC and hospital guidelines. Additionally, during the COVID-19 pandemic's peak, NJ WIC shoppers were provided with the option to purchase a wider variety and sizes of WIC foods, including contracted (Mead Johnson, maker of Enfamil) infant formula products. The team also updated the WIC WOW MIS system WIC Shopper app, UPC codes, and grocery systems to make them more accessible and easier to use for clients. WIC also secured the ability to send text messages to all WIC participants and WIC authorized vendors to notify and alert of any emergencies or changes if needed. These modifications to service provision continue.

The NJ TVP has learned from the disruption the COVID-19 pandemic created in health care. As of January 2025, many health care providers continue to offer a telehealth option for NJ residents who need connection to care, but have mobility issues or are too ill to attend in-person appointments. Moreover, hospitals and long-term care facilities are enhancing services developed in response to the COVID-19 pandemic to ensure that people's needs are met, particularly those facing challenging CHF.

III. Needs Assessment

III. C. Needs Assessment Summary and Annual Update

In 2025, the five-year Title V Block Grant Needs Assessment data further informed NJ's ongoing efforts to bolster the MCH service landscape of the state. Many of the SPNs have remained the same from last grant cycle, reflecting sustained programmatic efforts and a long-term goal of improving health outcomes across the five population health domains. In other words, the needs assessment reiterated the state's continued mandate to address major health outcomes in our state for women, infants, children, CSHCN and adolescents and young adults.

For example, *Increasing Healthy Births*, and *Reducing Maternal and Infant Mortality by Expanding & Strengthening Evidence-Based Programs Addressing Infant Mortality* remain high on our state's priorities as the outcomes between populations in both categories continue to persist. Additionally, *Promoting Healthy Youth Development over the course of Childhood, Adolescence and Young Adulthood (AYA)* remains a focus for our state as there has been a positive impact of early education related to sexual health, emotional health, and physical well-being in producing well-developed and integrated young adults. Similarly, the SPN of *Improving Nutrition, Food Security & Increasing Physical Activity* aligns with the SPN of *Promoting*

Healthy Youth Development from Childhood Through Adolescence & Young Adulthood (AYA) insofar that supporting early nutritional and physical development buffers against negative health outcomes over the course of life.

While teen pregnancy rates in NJ have declined significantly overall over the last twenty years, rates have plateaued for some populations in the State. Maintaining a focus on the SPN of *Promoting Healthy Youth Development by Reducing Teen Pregnancy & Sexually Transmitted Infections (STIs)* is paramount to continuing the decrease of teen pregnancy in the state and further diminishing the pregnancy and health issues, affecting some populations more than others.

Lastly, *Increasing Food Security* has been newly added to our *Improving Nutrition and Physical Activity* SPN as we see the close correlation between food security and overall health. Food security is influenced by a complex mix of systemic level economic, social, and environmental factors. The New Jersey Office of the Food Security Advocate works to improve food security across the state through collaborative efforts informed by rigorous research, evaluation, and community-driven program design.

Food insecurity, particularly poor nutrition, is associated with poor maternal health outcomes, including:

- Insufficient or excessive weight gain during pregnancy
- Mental health challenges, such as depression and anxiety
- Obesity
- Pregnancy complications, such as high blood pressure, anemia, or gestational diabetes
- Delaying or forgoing medical care due to competing financial demands, such as the need for food

For infants and children, food insecurity can contribute to:

- Birth defects
- Poor mental health and chronic conditions, such as asthma and obesity
- Behavioral, developmental, and emotional challenges

Low Access Scores indicate the extent to which residents are underserved by supermarkets due to the lower income profile of their neighborhoods. Residents of a block group with a higher Low Access Score typically travel longer distances to access a major supermarket than residents of a block group with a lower Low Access Score.

In other efforts to support women and their families in the state, our Maternal Data Center has focused recent analysis on food insecurity as a well-known CHF. Multiple regions of NJ experience the two-pronged issue of limited access to health food sources and inconsistent or no access to a private vehicle for transportation. These intersectional issues which disproportionally impact impoverished communities and communities of color demand programmatic intervention and have promoted the newly added SPN related to nutrition and food access.

SPNs linked to NPMs

The SPNs related to *Improving Birth Outcomes and Reducing Infant Mortality* link to the NPMs of *Postpartum Visit, Postpartum Mental Health Screening* and *Perinatal Care Discrimination*, as the highlighted NPMs address the most important issues which directly impact women in the perinatal period and their infants. Additionally, the SPN related to *Improving Differential Outcomes in Health care for Specific Populations* relates to all the NPMs of *Postpartum Visit, Postpartum Mental Health Screening* and *Perinatal Care Discrimination* is squarely directed to the populations on the margins and with worse health outcomes than counterparts who fare better.

The SPN of *Improving Breastfeeding Rates* links directly to the NPM of *Breastfeeding*, as the benefits of nursing a baby after delivery are well known and have a variety of benefits for both baby and mother. The SPN related to breastfeeding also links to the *Safe Sleep* NPM as scholarship has established a correlation between breastfed babies and lower incidences of Sudden Unintended Infant Death (SUID).

The SPNs related to the *Promotion of Healthy Youth Development*, with a focus on *Reducing Teen Pregnancy and Sexually Transmitted Infections (STIs)*, link to the *Adult Mentor* and *Bullying* NPMs, as both NPMs telegraph health and wellbeing in the adolescent and young adult populations. The SPN of *Improving Access to Quality Care for CSHCN* relates to the NPMs of *Medical Home, Transition to Adult Health Care and Developmental Screening* as the improvement of quality care access is predicated upon factors such as finding a consistent medical provider, ensuring services are age-appropriate, and ensuring a timely diagnosis of any developmental issue which demands intervention.

In NJ, we recognize the importance of preventive dental visits and are contemporarily gathering data on any correlations between preventive dental care for children and mothers, and health outcomes in the short and medium term. For this reason, the NPM of *Preventive Dental Visit* was included.

Several themes that emerged as priorities of the respondent populations during the primary data collection phase ultimately did not become part of the final list of state priority needs. These

identified themes including *transportation and mobility help*, need for *greater linguistic capabilities of providers*, and *appointment and workplace flexibility*. While some efforts are currently underway to pilot transportation programs, and work with providers to enhance their ability to reach various populations in a client-centered way, the prioritization process revealed that our State is currently limited in both the capacity to act on the issues, and the overall number of resources available to address the issues.

The Needs Assessment data further informed NJ's ongoing efforts to bolster the MCH service landscape of the state. Many of the state priority needs remained the same from last grant cycle due to the continued efforts of many of our programs, strategized on in past years and with a longitudinal aim of decreasing rates of negative health outcomes and increasing positive health outcomes for the five population health domains. For example, *Increasing Healthy Births*, and *Reduce Infant Mortality by Expanding & Strengthening Evidence-Based Programs Addressing Infant Mortality* remain high on our state's priorities as the outcomes between populations in both categories continue to persist, leaving women of color at higher risk for negative health outcomes during pregnancy and after delivery as compared to their White Non-Hispanic counterparts. Additionally, *Promoting Healthy Youth Development over the course of Childhood, Adolescence and Young Adulthood (AYA)* remains a focus for our state as we have seen the positive impact of early education related to sexual health, emotional health and physical well-being pay dividends

During the Needs Assessment process, several MCH population health strengths and needs were noted during primary and secondary data collection efforts. The overall strengths included some of the themes, while population health domain-specific themes are delineated below.

Women/Maternal Health: Despite increases in connection to perinatal care services in the state, as well as more robust offerings of allied professional accompaniment including home visiting services offered to all pregnant and parenting women, there remain unmet needs of women in the state. The following needs affecting women and maternal health populations were identified during NJ's needs assessment process:

- Transportation and mobility help
- Need for accessibility and communication support
- Care before, during, and after pregnancy and delivery

Perinatal/Infant Health: While more than 80% of the service recipients answered "yes" to the question, "Since your baby was born, have you attended a check-up with your doctor/nurse/midwife?", there remains a need for connection to perinatal and postpartum care in our state. The following needs affecting perinatal and infant health populations were identified during NJ's needs assessment process:

- Workplace flexibility
- Appointment flexibility
- Breastfeeding education and resources

Child Health: In review of state level data from the National Survey of Children's Health, one can see that 72% of children and adolescents <17 years of age have a personal doctor or nurse. However, only 63% of children and adolescents <17 years of age who are referred for specialty care receive the needed referral or care coordination, which demonstrates a void in service provision. The following needs affecting child health populations were identified during NJ's needs assessment process:

- Connection to appropriate and timely clinical care
- Access to timely developmental screening
- Oral health care

Adolescent Health: Ongoing efforts to bolster the health and well-being of adolescents and young adults in the state have led to increased access to youth programming which includes sexual health education, bullying prevention, and positive youth development curricula that supports the overall growth and development of adolescents and young adults in the state. The following needs affecting adolescent and young adult populations were identified during NJ's needs assessment process:

- Opportunities for physical activity
- Education of young adults
- Education and support of parents

CSHCN Health: Approximately 20% of NJ children ages 0-17 years old have special health needs. These needs are varied and include physical, developmental, behavioral, and emotional needs which often demand attention over the course of a child's life. While the Title V Block Grant-funded activities exist to improve the systems that serve this vulnerable population, many families continue to report difficulty in navigating a system with few numerically insufficient special health care providers and ultimately gaining access to services that are needed to help this population fully actualize. The following needs were reported during the conversations with CSHCN professionals, and service recipients managing CSHCN.

- Increase access to services
- Coordinated care between practitioners
- Transition to adulthood services

The Title V Block Grant Needs Assessment process offered the NJDOH Title V staff an opportunity to engage in the review and assessment of current Title V programming reach and effectiveness. Moreover, stakeholders were given an opportunity to provide important feedback regarding the SPNs, helping to guide the re-thinking of priority needs for MCH populations in the state. The needs assessment process considered the statewide MCH landscape, which informed each step of the process, including during the prioritization period. The needs assessment process aimed to be comprehensive and statewide. However, while efforts were made to hear from representative samples of the various populations impacted by Title V funding, there were limitations in the reach of primary data collection efforts. Nevertheless, ongoing engagement with the various State initiatives in MCH will ultimately bolster the work of Title V in NJ and create a healthier state for all residents.

III.C.1.b. ii. Title V Program Capacity

III.C.1.b.ii.a. Impact of Organizational Structure

The NJDOH is one of 18 state departments in NJ which houses ten divisions. One of the divisions is the Division of FHS, which has overall responsibility of the TVP. The Assistant Commissioner of the FHS Division is also a senior leader who reports to the Deputy Commissioner. The Division of FHS works closely with various divisions, including the Health Promotion Division, from where the Oral Health Services are managed, as well as the state's Division of Medical Assistance and Health Services. Additionally, FHS works closely with the Office of Minority and Multicultural Health and the Office of Workforce Development to strategize on relevant efforts across units.

Over the past year, a few leadership changes have occurred at the FHS Division level. For one, the previous Executive Director of the MCH Unit transitioned out of her role. Additionally, a new Assistant Commissioner joined the team. On the FHS fiscal team, an Assistant Director joined the team and will play an important role in managing the Title V fiscal processes alongside the Title V Fiscal Analyst.

Strengths, Opportunities, and Challenges

With TVP situated in FHS, a diverse and varied group of state program staff support MCH initiatives. Within FHS, a rich tapestry of programming has been created and endorsed. For example, while the WIC and Early Intervention programs do not receive Title V funding as they are supported by federal funds primarily, TVP is able to leverage the program's client base to give and gather information and feedback on new or modified programs and resources throughout the state. Furthermore, the staff that work on related, yet distinct, MCH programming offer unique perspective and expertise on the engagement of the MCH populations

throughout the state. In addition to programmatic collaboration, the TVP is situated within the Population Health Branch of the NJDOH. The main service of the Population Health Branch comes from local and county health departments. This collaboration between the state and local health officials facilitates the transfer of health communication and information. This, in turn, promotes timely transfer of information to address the most immediate needs of the residents of NJ.

One example of nurtured internal partnerships includes the work of FHS alongside the Health Promotions (formerly Community Health Services) Division and with their Diabetes Prevention and Control program's efforts to expand the impact under CDC DP23-0020, A Strategic Approach to Advancing Health for Priority Populations with or at Risk for Diabetes, Strategy 12. Improving and expanding the CHW workforce by building and strengthening a supportive infrastructure will help to expand their involvement in evidence-based diabetes prevention and management programs and services. This collaboration across divisions strengthens the program and effectively meets the aims proposed as each division offers certain expertise to the work.

Additionally, the position of the TVP within the NJDOH acts as a strength of the program. This is due to strong and seasoned workers that are committed to creating, modifying and evaluating the Title V Block Grant endeavors over time. This strength-of-skill is not limited to FHS, but rather includes many staff employed at the NJDOH in the MCH realm, and who have some contact with Title V-funded programs and/or services recipients of TVP funding. The combination of skills within the divisions and experience help to bolster the efficiency and effectiveness of the Title V endeavors and includes nursing professionals, experts in adolescent and pediatric mental health, social work professionals, experts in perinatal mood disorders and perinatal substance use and researchers and data specialists.

While the NJDOH leadership promotes internal collaboration on projects and grants, there remain additional opportunities for more robust partnerships to form within the NJDOH branches and with other state entities. One of the opportunities that continues to grow is between the NJDOH and the newly legislated Maternal and Infant Health Innovation Authority (NJMIHIA). In July 2023, Governor Murphy signed S3864, also known as the "NJ Maternal and Infant Health Innovation Center Act", which created the NJMIHIA.

The one-of-a-kind Authority is governed by a 15-member Board and employs an appointed President and Chief Executive Officer who is a cabinet member. The Board adopts recommendations for action to reduce maternal mortality, morbidity, and disparities from the NJ Maternal Care Quality Collaborative (NJMCQC). The Board coordinates with a Community Advisory Committee to support and inform the work of the Authority. The 11-member community advisory committee will represent diverse community groups with relevant experience as providers or recipients of maternal, infant, and child health services. NJMIHIA is an incubator for research and development, an academic and perinatal workforce training center, and a data collaborative. The trauma-informed and patient-centered authority will offer

comprehensive clinical services to serve moms before, during, and after pregnancy, while hosting research and wrap around community services to residents.

Although the NJDOH and FHS work closely with many local, state and community-based entities to address MCH issues, there remain challenges to the work. One of the primary challenges associated with the rules and procedures that govern decision-making, including reporting systems, is the pace at which information is gathered and shared. While there exists a level of interconnectedness between state agencies, and even between programs within a division, organizational boundaries established by bureaucracy complicate processes to create new programming in the state as well as to modify existing programming. This organizational interdependence is a necessary feature of the state offices while naturally impacting the full actualization of work. Furthermore, the response cannot be full decentralization of individual office or unit procedures due to the mandate of appropriate approval pathways. Nevertheless, this organic feature of large bureaucracies can delay program modification and innovative implementation or programming even with an organizational culture that values innovation and efficiency, as is the case in NJ.

III.C.1.b.2.b. Impact of Agency Capacity

Through rigorous research, collection of primary data, and consultation with key staff, the capacity of the TVP to meet the varied needs of the MCH population in NJ are consistently being analyzed. NJ is situated in a unique geographic location more so than almost any other state. Concomitantly, NJ has a near-constant stream of new residents each year, with varied needs to be assessed and addressed. For this reason, the TVP has positioned itself to respond to the varied needs of its residents by committing funding to the various initiatives of the TVP, the hiring of skilled civil servants, the prioritizing of community interests, and adhering to evidence-based standards across programs to ensure effectiveness of programming.

Several key changes in the past years have been vital for the full functioning and efficient running of the many MCH activities being deployed throughout the state. Chiefly, the creation of key legislation that aims to address the myriad issues impacting women, children, adolescents and young adults, and CSHCN across the state. This legislation has, in effect, increased the offering of, and demand for, vital services. The demand for these services has been so overwhelming that the NJDOH is working hard to meet the need and effectively carry out the activities as they are legislated. One example of this is the Family Connects NJ Universal Nurse Home Visiting program. Under this new law, NJ is providing all new parents with access to Home Visiting services – including those welcoming a newborn into their home and family through adoption, foster home, or kinship placement. NJ is the first child welfare jurisdiction in the nation to make Home Visiting available to families that have suffered the tragedy of stillbirth. Families that participate in the Family Connects NJ Universal Home Visiting program will receive a free session with a registered nurse or advanced practice nurse in

the comfort of their home. The promoting of the program, and subsequent hiring and training of nurse home visitors takes time and is in the early stage of gaining traction. Therefore, the State is working hard to meet the demand as the program grows simultaneously.

Strengths, Opportunities and Challenges

The TVP within the NJDOH has been promoting and protecting the health and wellbeing of MCH populations in the state for generations. The TVP has committed resources to both training professionals and referral and follow-up services to connect residents with programs that will meet their needs. These efforts have been borne out of a department-wide commitment to hire, train, and maintain skilled staff within public health and with MCH expertise. The FHS Division of the NJDOH is committed to providing comprehensive, community-based, family-centered care. This is done by working closely with private and public partners who have access to individuals and communities throughout the state.

One of the key relationships that has been created and nurtured in the state is that of the NJDOH and Maternal and Child Health Consortia (MCHC). The NJDOH licenses and regulates these consortia, which are private, non-profit organizations, licensed and regulated by the NJDOH as central service facilities. They include, as members, perinatal and pediatric providers, hospitals, consumers, and community-based agencies, including any group or individual with an interest in health services for families.

The MCHC's primary functions are to provide prevention activities, consumer and professional education, total quality management, data analysis, infant and pediatric follow-up, coordination of perinatal/pediatric transport systems, and the development of comprehensive perinatal/pediatric regional plans. These services reach each corner of the state, as the consortia sites are conveniently located in the Northern Region, The Partnership for Maternal and Child Health of Northern NJ; in the Central Region, The Central Jersey Family Health Consortia; and in the Southern Region of NJ, The Southern NJ Perinatal Cooperative. This collaborative work enhances the State's capacity to reach populations in need, while maintaining a focus on the policy work that is so vital. These consortia are an extension of the NJDOH and amplify the TVP capacity to reach all MCH populations throughout the state.

The agency's capacity has also grown as quality improvement efforts are being created to better track, analyze, and strategize on programmatic outcomes. These efforts align with the larger NJDOH aim to improve quality assurance across programs with the newly created Performance Management Unit. This augmented focus on quality improvement extends to process evaluation and outcome evaluation, as necessary parts of the larger quality improvement landscape. The investment in the unit, and the acquisition of staff with quality improvement skills, positions the agency to more efficiently and effectively meet the goals of each program.

An additional strength of the agency's capacity is the provision of services to the MCH populations that transcend health issues and include micro interventions as well as mezzo and macro interventions. Some of these services include:

- Oral health programs for families across the state
- Pediatric Mental Health Care grant
- New state legislation signed by the governor to extend Medicaid benefits up to 365 days postpartum
- A new Department of Justice grant was awarded to the CAHP program from the Department of Justice (Bureau of Justice Assistance Stop School Violence grant)

The opportunities that the NJDOH must create for additional impact in the state are numerous. For one, the Title V agency has been consulting with other states on innovative ways to address some of the CHF as service respondents report issues such as lack of transportation and childcare, which prevent connection to health care. For this reason, the NJDOH is working closely with partners to identify ways to improve service accessibility. One such program is Project MyRide. One of the consortia partners, the Southern NJ Perinatal Cooperative, has begun an initiative to offer free medical and social service-related rides to service recipients in the Southern region of the state. Although a small-scale initiative, this service helps connect people to vital care.

Recruitment and retention of core staff, including but not limited to clinical and allied professional staff, continues to prove difficult. The TVP is working closely with partners to ensure that the demand for specific and tailored services is met with sufficient funding and resource allocation. And that recruitment of professionals, and their ongoing training, remains a priority.

CSHCN

Within the TVP CSHCN program, support services for children through grants to specialty providers and facilities persist. These service grants support infrastructure, staff and/or direct services. These specialized centers and providers can flex these funds and use them where the need is highest. While Medicaid provides a significant source of funding, there are still gaps in coverage by Medicaid or other insurance programs. Regional gaps in service access also exist because two major specialized care providers in the southern region of the state discontinued their participation with Medicaid. Low reimbursement rates were cited as a major cause. While the Title V funds cannot replace the Medicaid funds, these grants can provide the agencies with support for other facilities who are growing their capacity to serve this population. Although the NJDOH strives to eliminate disparities of all kinds within the state, there are regional differences in access to providers. Specialized services and facilities tend to be in more urban areas, creating access and transportation issues. While NJ is a geographically

small state, travel from the more rural areas can be a significant barrier. The case management units work closely with families to ensure that they can access services and other programs such as Catastrophic Health Insurance for major treatment costs which are not covered by insurance.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

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

Most FHS staff recognized the need to incorporate the perspectives of families and family representatives into the MCH workforce under the broader umbrella of systems integration. Continued family involvement in health transformation is essential for effective program and policy development related to newly aligned systems. As a result, the NJDOH collaborated with community partners through advisory boards and steering committees. FHS implemented the development of succession planning to ensure essential functions were considered in long-term planning. During this past fiscal year, cross-training of staff was implemented to provide the ability to maintain key roles in the event of short-term staffing shortages. Changes in the workforce funded by Title V reflect staff's long-standing MCH priorities and core functions.

Title V staff also pursue other training opportunities offered at national conferences, including Association for Maternal and Child Health Programs (AMCHP), the MCH Epidemiology Conference, and the MCH Public Health Leadership Institute. Departmental training has been offered on ethics, grant writing, and grants management. Opportunities to supplement staffing through student internships, special temporary assignments, fellowship programs, and state assignees have also been successful. Recruitment and retention of qualified TVP staff are ongoing goals of NJ TVP.

A focus on filling key positions and building the public health infrastructure is a key focus of the NJDOH. The recently awarded CDC grant (CDC-OE22-2203), which created an Office of Workforce and Professional Development, gained traction between 2024 and 2025, posting and hiring for positions vital to reach the mission of the office, engaging primary data collection efforts to understand challenges of the current workforce, and crafting plans to address retention issues to invest in a more comprehensive future talent pipeline. In January of 2026, various pilot programs to enhance workplace morale and offer support to staff have been initiated. The growth of this office is a direct result of feedback from staff regarding the need for additional

guidance and support within the public health workforce at the NJDOH. Lastly, the Director of this office who is leading these vital efforts was selected from the MCH Unit, Division of FHS.

MCH Workforce & Training

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

The recruitment and retention of Title V staff is an ongoing effort by the leaders of the FHS Division at the NJDOH. MCH leadership has been working closely with academic institutions through participation with the Montclair State University MCH Workforce Catalyst Advisory Committee and the National MCH Workforce Development Center to continue to cultivate relationships and to offer training opportunities for those clinical and macros professionals interested in working in the public health and social service sectors. The FHS Division of the NJDOH has an ongoing relationship with the Rutgers School of Medicine, to host resident interns who have an interest in MCH initiatives. Additionally, in January of 2026, staff from the TVP attended the National Workforce Development Center's Title V Learning Journey at the University of North Carolina-Chapel Hill campus, to further develop a Strategic Plan related to creating a Title V Steering Committee constituted by service recipients' representatives of the five population health domains.

Adolescent Health

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

Currently, CAHP is staffed by five master's level professionals, and an administrative assistant. Staff expertise consists of sexual health education, youth mental health/counseling, public health, health science administration, education, and social work with a range of backgrounds, including direct service provision, program management, public school education, and community-based services. The Program Manager has been with the Division, and within the CAH Program for ten years, with all other staff having been hired over the past five years. Training is an essential part of the CAHP. In addition to training in the evidence-based models implemented through programs, staff also receive training in subject matter including but not

limited to youth mental health, social and emotional learning, positive youth development, mentoring, and parent/caregiver engagement.

Current assessments of the adolescent workforce participating in the NJDOH programs suggest that most providers/professionals working with adolescents feel confident in their skills and knowledge needed to serve this vulnerable population effectively. Through continuous and effective training addressing youth mental health/ suicide, sexual health, school health, and social emotional learning (SEL), the CAHP continues to assist youth serving professionals in obtaining essential training and education. Over 70% of providers surveyed biannually over the course of five years, indicated that they had obtained training to address areas they previously felt poorly equipped to address, related to suicide screening and intervention.

Given the current landscape of adolescent health education, support, and service needs, continued training and education of adolescent health professionals and providers is an important goal for the CAHP and the professionals/providers who work with the adolescent population.

CSHCN

The SCHS unit has been focusing on workforce development in several ways. First, the unit leadership has envisioned what the internal organizational chart needs to look like in the future and build towards that vision. As vacancies open, more data analytical staff and clinically trained staff have been added. This shift relates to the additional data reporting and epidemiological work required by federal funders and state providers who are mandated to report. Secondly, there is a focus on diversifying and building out the FCCS-funded county case management staff to include more types of professionals as well as ensuring family participation. Additionally, many people who are interested in working in special child health positions often have a personal connection to a child with special needs. This is true of staff whereby over 60% of staff who work in this program have a personal connection with a child with special health care needs.

Within the Data Systems and Emerging Threats (DSET) program, data staff report to a single data coordinator who ensures that the data work across the programs is met, while also being embedded in other content program areas. By cross-training and having staff work on multiple data systems, they can ensure that the data demands are met even when staff are out, leaving, or retiring. Additionally, the Coordinator runs a monthly data group across the division to bring staff from MCH, WIC, NJEIS, and SCHS together. These training meetings expose staff to new ideas and information.

Meeting the needs of emerging threats such as COVID-19, ZIKA, and natural disasters has often happened in an ad hoc manner. This team is designed to look at ways more prospectively to address developing issues. The focus has been on bringing in different types of staff that are able to write and execute funding opportunities, work with medical records, and organize and manage projects with quick turnaround times. Having the staff means the unit can be more strategic and

timelier in collecting data and producing results and recommendations for changes. Along with bringing in new staff, the CSHCN Program is looking for more opportunities to capitalize on existing staff expertise. A survey was conducted, asking staff about needs for training, desired areas staff want to expand, and hidden "talents". One staff person reported that she had learned SAS in her master's program and would be interested in more data work. Her supervisor reallocated data tasks to her and paired her with a colleague who was struggling with data-centered tasks.

As a part of the 2026 Workforce Development Center Title V/CSHCN Learning Journey, the NJ MCH and CSHCN programs are exploring how individuals with lived experience are engaged throughout program creation and modification. The CSHCN program has incorporated staff both internally and externally with lived experience with children and youth with special health care needs into this project. CSHCN staff is comprised of individuals who are family members of individuals with special health care needs who assist the programs with identifying gaps within the NJ health care system. Furthermore, both the MCH and CSHCN programs will be leveraging the family voices of those who access Title V/CSHCN services to ensure they are meeting the needs of the families enrolled.

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

The TVP engages a myriad of approaches to further create, adapt, and strengthen the capacity of the existing MCH workforce while continuing to invest in training rookie MCH workforce professionals preparing to enter, or just entering, the professional landscape. This is accomplished through recruitment strategies, staff training, and professional development, partnering with fellowship programs and the innovative academic-practice partnership with universities across the nation including Rutgers University, The College of NJ, Emory University School of Public Health, Drexel University School of Public Health, and the MCH Workforce Development Center at UNC Chapel-Hill. See section *III.E.2.b.i. MCH Workforce Development* of the Title V Application and Annual Report for more detail on this critical work.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

The Maternal and Child Health Epidemiology (MCH Epi) team promotes the health of mothers, infants, and children by analyzing trends in MCH data and facilitating efforts to develop strategies that improve MCH outcomes through the provision of data and the execution of applied research projects. Moreover, the MCH Epi provides MCH surveillance and evaluation

support to Maternal and Child Health Services while advancing data-driven MCH programming. The State Systems Development Initiative (SSDI) project, which resides in the MCH Epidemiology TVP, focuses on enhancing and expanding the NJ TVP data capacity by improving data exchange for linkages within the department and between other agencies. The NJ SSDI project focuses on integrating information systems that are deemed necessary to ensure the availability of timely information for decision-making in all priority areas. The NJ SSDI project seeks to build, strengthen, and expand NJ's MCH data capacity to support Title V MCH Block Grant program activities. During the five-year needs assessment process, NJ SSDI staff contributed to data-driven decision-making in MCH programs, including assessment, planning, implementation, selection of state priority needs, and the development of the five-year State Action Plan. To ensure the continued effectiveness of data to inform Title V needs assessment, NJ SSDI staff within TVP established a robust data structure that includes data linkages using 'provisional' real-time data. By improving the MCH data structure, NJ is better able to support informed decision-making, provide effective and efficient resource allocation, and improve the quality of programming for NJ's MCH population.

NJ TVP staff utilized the linked datasets to conduct analyses and produce reports (e.g., data briefs and topic reports). These reports are available on the MCH Epi webpage, the NJ Department of Health's State Health Assessment Data (NJSHAD) system, and the NJ Mortality Reviews Webpage. Thus far, TVP has demonstrated success in accessing and linking data across several data sources. Progress in completing the SSDI work plan for the budget period 12/1/25 to 11/30/26, and future plans are delineated.

Accomplishments

MCH Epidemiology staff continued conducting MCH health data analyses and evaluation projects to provide comprehensive data-informed recommendations to improve access to health services and reduce disparities in health outcomes. Key accomplishments for this reporting period are listed below.

1. Shared 2024 annual birth file via State and Territorial Exchange of Vital Events (STEVE) with the CDC to support the Pregnancy Risk Assessment Monitoring System (PRAMS) data-weighting process.
2. Data collection for the 2024 Postpartum Assessment of Health Survey (PAHS) was completed in February 2026.
3. The pilot NJ Fatherhood Survey is being implemented online.
4. Developed the data brief, "Breastfeeding Education and Initiation Amongst WIC Users (PRAMS 2019-2023)," and posted it on the NJ PRAMS webpage in January 2026. The data brief, "Maternal Oral Health Study, NJ PRAMS 2018-2023," was developed in December 2025.

5. Submitted two PRAMS Data-to-Action/Success Stories to the CDC.
6. The manuscript, “Impact of Maternal Health Education and Support on Select Postpartum Behaviors in NJ, PRAMS 2018-2022,” was co-authored by NJ PRAMS staff and Montclair State University researchers and submitted to a peer-reviewed journal. MCH Epi staff also wrote the manuscript, “Physical Abuse as a Risk Factor for Adverse Mental and Behavioral Maternal Outcomes,” which is awaiting approval and journal submission.
7. NJ PRAMS staff presented, “Physical Abuse as a Risk Factor for Adverse Mental and Behavioral Maternal Outcomes,” at the Northeast Epidemiology Conference in November 2025.
8. Provided MCH data for MCH Block Grant report/application and provided data-related input in the process of selecting state priorities.
9. NJ Fetal Infant Mortality Review (FIMR) teams continued entering data into the National Fatality Review Case Reporting System (NFR-CRS).
10. Completion of Phases 1 and 2 of the Perinatal Periods of Risk (PPOR) analysis.
11. Continuous engagement with the PPOR workgroup, composed of a multidisciplinary group of stakeholders and people with lived experience who participated in developing a strategic action plan to strengthen existing and/or launch new prevention strategies.
12. Managed the NJ Maternal Mortality Review Committee, which reviews all pregnancy-associated deaths of persons with an indication of pregnancy up to 365 days, regardless of cause.
13. Published the 2019-2021 NJ Maternal Mortality Report on the Mortality Reviews webpage.
14. Developed a public-facing interactive dashboard depicting maternal mortality data from 2016 to 2023. Users can filter the data by race/ethnicity, preventability, region, and more.
15. Participated in the 2025 Harvard T.H. Chan School of Public Health and CDC Program Evaluation Practicum and developed two evaluation plans, one for the NJDOH’s Postpartum Resources and Support Network and the other for NJ Maternal Mortality Review (NJMMRC).
16. Hosted 2 interns from the 2025 Harvard T.H. Chan School of Public Health and the CDC Program Evaluation Practicum to support the implementation of the evaluation plan.
17. The NJMMRC’s work on advancing data dissemination strategies through their work with the Harvard T.H. Chan School of Public Health was presented at the 2026 AMCHP

Conference as a poster entitled, "NJ Maternal Mortality Review Committee: A Community-Centered Approach to Data Dissemination Strategies."

18. Partake in the development of a longitudinal data collection for public health initiatives (e.g., HWHF within the unit to track and evaluate key indicators.

Goals and Objectives

Table 2: SSDI/NJ MCH Epi Alignment

Goals and Objectives	**Progress for Reporting Period**
GOAL 1 – Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming	
Objective 1.1 - Use SAS/Link Plus to link and analyze available datasets to support tracking of NJ's priority needs, selecting and refining outcome measures, performance measures, and strategy measures, Title V needs assessment activities, and provide analysis to inform the Title V MCH Block application/ annual report.	• provided data support to the 2026 State Title V MCH Block Grant Report and Needs Assessment. • provided data analysis to inform Title V MCH Block application/annual report and the selection of state priorities.
Objective 1.2 - Update the SAS program when necessary and utilize SAS to pull 1. PRAMS samples monthly from birth certificate data. 2. Maternal Mortality sample from death certificate data. 3. Fetal and Infant samples from birth certificate and death certificate data	• pulled 2024 and 2025 death certificates, hospitalization, and birth records based on pregnancy status to be reviewed by the NJMMRC. • pulled 2025 fetal and infant death records and securely transferred them to fetal infant mortality review teams for comprehensive reviews of cases.
Objective 1.3 - Continue securing and utilizing Perinatal Risk Assessment (PRA) and Connecting NJ files, along with other relevant data sources, to conduct mortality reviews.	MCH Epi has access to the PRA. The PRA is part of the dataset used to conduct maternal mortality reviews. Additional data sources used for MMR are: • Birth/Fetal death certificate • Maternal death certificate • Universal billing/hospital discharge data • COVID-19 testing database • COVID-19 vaccine database • Department of Child Permanency and Protection/child welfare) records • Emergency Medical Services records • Perinatal Risk Assessment • Family conversations (family/support persons identified in medical record)

	• Autopsy, toxicology, and report of investigation by medical examiner (RIME) reports • Prenatal care records • CDC community vital signs dashboard FIMR grantees have access to the PRA
GOAL 2 - Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability	
Objective 2.1 1. Support all activities related to implementing the PRAMS survey. 2. Complete data collection for the 2024 PAHS, link PAHS data to the 2024 PRAMS dataset (if available), and send the linked dataset to Columbia University for weighting and analysis. 3. Provide support to Lurie Children's Hospital to implement a pilot of the NJ Fatherhood Survey. 4. Develop two PRAMS Data-to-Action examples.	• due to the CDC's shutdown of the PRAMS data collection system in January 2025 and uncertainty about survey operations, the PRAMS contractor was unable to collect 2025 PRAMS data • negotiated a Memorandum of Agreement, scope of work, and budget with a new contractor for 2026 PRAMS survey operations • data collection for the 2024 PAHS was completed; 2024 PAHS data will be linked to 2024 PRAMS data and sent to Columbia University after the 2024 weighted PRAMS dataset is received • NJ Fatherhood Experiences Survey pilot is being implemented online through Lurie Children's Hospital in collaboration with the NJ Department of Children and Families and the MCH Consortia • submitted two PRAMS Data-to-Action/Success Stories to the CDC • worked with the Rutgers University, Center for State Health Policy, to add 2002-2023 NJ PRAMS datasets to the statewide Integrated Population Health Data (iPHD) project.
Objective 2.2 - Continue to initiate key data sharing agreements as needed for access to files for analysis.	• obtained access to hospital discharge data annually • continued to advance the utilization of the minimum/core indicators data sets for Title V MCH programs • use hospital discharge data for maternal mortality reviews • developed new data sharing agreements with the Office of Vital Statistics, Columbia University, and the new PRAMS contractor

	• All other remaining data sharing agreements needed to effectively perform both the FIMR and MMR remain active.
Objective 2.3 - Keep track of and renew, when necessary, any Memorandums of Understanding (MOU), Data Use Agreements (DUA) with all relevant partners.	• continued to renew MOUs as needed for the MMR project as their expiration date approaches • Updated new data sharing agreement with Office of Vital Statistics, to retain access to birth, death, and hospital discharge records for the NJMMRC to review. • Updated the current data sharing agreement with the Department of Children and Families (DCF) to receive reports of child abuse and neglect, records, and case-related material maintained by DCF • the NJMMRC established an MOU/DUA with the NJ Department of Law and Public Safety's Fatal Accident Investigation Unit to obtain records of fatal motor vehicle incidents involving women who died within one year of the end of their pregnancy • the NJMMRC established an MOU/DUA with the NJ Department of Law and Public Safety's Office of Drug Monitoring and Analysis to obtain overdose-related records involving women who also died within one year of the end of their pregnancy
Objective 2.4 1. Continue to link and improve SAS programs used for birth and infant death certificate data to sample and identify mothers who have lost their infants. 2. Continue to link birth certificates and Special Supplemental Nutritional Program for WIC files to complement PRAMS data with important information on a large segment of the low-income "at-risk" MCH population. 3. Continue to link datasets and improve the SAS programs used for MMR.	• used key identifiers and linked birth certificates to infant death data for FIMR • used birth certificate and fetal death certificate data to conduct PPOR analysis. PPOR is a community-driven data approach to identifying key periods between the pregnancy and infancy period to drive recommendations and policy • used birth and fetal death certificate data to identify maternal deaths, which are reviewed by a multidisciplinary committee, and confirm positive pregnancy statuses • Used key identifiers across multiple data sources (birth, death, DCF, state police, etc.) to ensure a comprehensive review of maternal mortality cases
GOAL 3 –Enhance the development, integration, and tracking of community health factors to inform Title V programming	

Objective 3.1 1. Conduct evaluations and generate reports to inform the development of new or the revision of current RFAs, as needed. 2. Continue to monitor and improve data tracking mechanisms of the REDCap forms to support the programmatic needs, evaluation of key health indicators, and program outcomes	• developed evaluation plans for the NJDOH's Postpartum Resources and Support Network and the MMR project in collaboration with CDC and the Harvard T.H. Chan School of Public Health to enhance dissemination activities • maintain and continuously improve predeveloped REDCap forms, a tool to collect individual-level data in a secure environment to support live data analysis, technical support, and customization to meet the programmatic needs, improve data tracking mechanisms, and data capacity to implement, support, and evaluate health indicators and track program outcomes of multiple programs funded by the MCH Title V Block Grant
GOAL 4 - Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.	
Objective 4.1- Continue to convene a multidisciplinary team for continuous implementation of PPOR in NJ.	• standardized the NJ FIMR case identification process • established the PPOR Committee (a multidisciplinary team that includes someone with lived experience)
Objective 4.2 - Continue to support staff at the grantee organizations in utilizing the NFR-CRS for timely data collection.	• renewed IRB approval for the FIMR protocol • continued to support FIMR committees in the process of uploading data to the NFR-CRS
Objective 4.3 - 1. Develop data reports to inform MCH programs that can potentially impact policy and practice. 2. Submit abstracts for session and/or poster presentations at 2026 national conferences. 3. Draft the upcoming MMR report for deaths that have a temporal relationship to pregnancy between 2021-2023. 4. Develop interactive and public-facing MMR dashboards in Tableau for cases from 2016 to 2023.	• developed data reports (e.g., data briefs, manuscripts) on 1) breastfeeding education/ initiation among WIC users 2) maternal oral health 3) physical abuse and adverse mental and behavioral maternal outcomes and 4) impact of maternal health education/support on select postpartum behaviors • presented, "Physical Abuse as a Risk Factor for Adverse Mental and Behavioral Maternal Outcomes," at the Northeast Epidemiology Conference in November 2025 • the maternal mortality report for deaths that have a temporal relationship to pregnancy (within 365 days) between 2019-2021was approved and posted on the Mortality Reviews webpage

	• MMR dashboards were developed and are approved for publication

Plans for the Upcoming Budget Year

The plan for the upcoming budget year will ensure the continued effectiveness and readiness of Title V-supported programs in responding to these needs. MCH Epi will seek to improve the MCH data structure to better support informed decision-making, provide effective and efficient resource allocation, and improve the quality of programming for NJ's MCH population. Plans for each objective for the upcoming budget year are described below.

Objective 1.1 - Use SAS/Link Plus to link and analyze available datasets to support tracking of NJ's priority needs, selecting and refining outcome measures, performance measures, and strategy measures, Title V needs assessment activities, and provide analysis to inform the Title V MCH Block application/annual report.

Objective 1.2 - Update the SAS program when necessary and utilize SAS to pull:
1. PRAMS sample monthly from birth certificate data.
2. Maternal Mortality sample from death certificate data.
3. Fetal Infant Mortality sample from birth and death certificate data.

Objective 1.3 - Continue securing and utilizing Perinatal Risk Assessment (PRA) and Connecting NJ files to conduct mortality reviews.

Objective 2.1
1. Support all activities related to implementing the PRAMS survey.
2. Complete a DUA with Columbia University for the return of the weighted, 2024 PAHS-PRAMS dataset to the NJDOH for analysis.
3. Support Lurie Children's Hospital with the implementation of the pilot of the NJ Fatherhood Survey in NJ.
4. Develop two PRAMS Data-to-Action examples.

Objective 2.2 - Continue to initiate key data sharing agreements as needed for access to files for analysis.

Objective 2.3 - Keep track of and renew, when necessary, any Memorandums of Understanding (MOU), Data Use Agreements (DUA) with all relevant partners.

Objective 2.4
1. Continue to link and improve SAS programs used for birth and infant death certificate data to sample and identify mothers who have lost their infants.
2. Continue to link birth certificates and Special Supplemental Nutritional Program for WIC files to complement PRAMS data with important information on a large segment of the low-income "at-risk" MCH population.
3. Continue to link datasets and improve the SAS programs used for MMR.

Objective 3.1

1. Conduct evaluations and generate reports to inform the development of new or the revision of current RFAs, as needed.
2. Continue to monitor and improve data tracking mechanisms of the REDCap forms to support the programmatic needs, evaluation of key health indicators, and program outcomes

Objective 4.1 - Continue to convene a multidisciplinary team to aid in the implementation of PPOR in NJ.

Objective 4.2 - Continue to support staff at the grantee organizations in utilizing the NFR-CRS for timely data collection.

Objective 4.3

1. Develop data reports to inform MCH programs that can potentially impact policy and practice.
2. Submit abstracts for session and/or poster presentations at 2027 national conferences.
3. Draft the upcoming MMR report for deaths that have a temporal relationship to pregnancy between 2021-2023.
4. Update the interactive and public-facing MMR dashboards in Tableau, as new data becomes available.

III.C.1.b.ii.e. Other Data Capacity

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

Title V data capacity efforts that are funded by sources other than SSDI include updating the annual MCH Block Grant performance measures, supporting other maternal and child health programs such as Maternal Health Innovation (MHI) and providing customized data to internal and external partners for program planning and evaluation. In addition, the CDC provides funding to the NJDOH to implement the NJ PRAMS. NJ PRAMS is housed within the MCH Epi program and is a crucial surveillance tool necessary to improve the health of NJ mothers and infants.

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

Moreover, to increase the NJ data capacity, MCH Epi staff established multiple other agreements not funded by the SSDI or Title V grants. The table below (Table 3) depicts two of MCH Epi's agreements in this grant cycle.

Table 3. MCH Epi's Agreements and Contracts

Agreement(s) and Contract(s)			
Type of Agreement	Project(s)	Between	Description
Data Use Agreement	Fetal and Infant Mortality Review	NJDOH (SSDI Program) & Michigan Public Health Institute	The purpose of this agreement is to establish the terms and conditions for the collection, storage, and use of data obtained from the fatality case reviews submitted by Fatality Review teams in the State of NJ and entrusted to the NFR-CRS.
Data Use Agreement	Postpartum Assessment of Health Survey study, formerly known as Postpartum Assessment of Women Study (PAWS)	NJDOH (SSDI Program) & Columbia University in the City of New York	This agreement aims to enable researchers at Columbia to utilize 2024 NJ PRAMS survey data for the PAWS observational cross-sectional study and to return the link dataset to MCH Epi TVP for analysis.
Data Use Agreement	NJ Maternal Mortality Review Committee	NJDOH (SSDI Program) & NJ Department of Law and Public Safety's Fatal Accident Investigation Unit (FAIU)	The purpose of this data use agreement is to provide the NJMMRC with secure reports from the FAIU to be incorporated into the case narratives of individuals who meet the criteria for NJMMRC review (in-state residents who died during pregnancy or within one year of the end of pregnancy) and died as a result of a motor vehicle injury.
Data Use Agreement	NJ Maternal Mortality Review Committee	NJDOH (SSDI Program) & NJ Department of Law and Public Safety's Office of Drug Monitoring and Analysis	The purpose of this data use agreement is to provide the NJMMRC with secure data from the drug monitoring database. The data provided is incorporated into the case narratives of individuals who meet the criteria for NJMMRC review (in-state residents who died during pregnancy or within one year of the end of pregnancy) and died as a result of a drug overdose.
Memorandum of Understanding (MOU)	NJ Maternal Mortality Review Committee	NJDOH (SSDI Program) & NJ	The purpose of this MOU is to provide the NJMMRC with reports of child abuse and neglect records. The reports provided are incor

		Department of Children and Families (DCF)	porated into the case narratives of individuals who meet the criteria for NJMMRC review

Several CDC survey supplements have been included in the NJ PRAMS survey to collect data on emerging MCH issues. For example, in response to the COVID-19 pandemic, a COVID-19 supplement was added to NJ PRAMS in October 2020, a COVID-19 vaccine supplement was added in April 2021, and an Opioid Use supplement was added in May 2024 will continue to be administered to survey respondents in 2026.

Adolescent Health

CAHP uses five separate databases/dashboards to collect program performance measures and program fidelity information. The Personal Responsibility Education Program uses the Performance Measures Management System and SRAE Program uses the SRAE (Performance Analysis Study (SRAE-PAS). Wyman Connect serves as a data entry and data dashboard for the Teen Outreach Program (TOP®) and Teen Connection Project implementation, HRSA eBOOKs captures data for the Pediatric Mental Health Care Access Grant, and the final dashboard is with LightSpeed Solutions for the SAFENJ Data Dashboard. These systems serve to collect, house, and report data regarding program reach, metrics, outcomes and pre-and-post survey data.

CSHCN

All Special Child Health Services programs work routinely with close to real-time files from the VERI system containing all birth and fetal death certificates via a Data Use Agreement with the Office of Vital Statistics and Registration. NBS data capacity is centered on the PerkinElmer Laboratory Information System (LIMS), Specimen Gate, and Patient Care modules. This is a shared data system used by the Newborn Screening Laboratory and the Newborn Screening Follow-Up program. Additionally, the program has a Memorandum of Understanding with the Association of Public Health Laboratories, Inc., regarding the NewSTEPs data repository.

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

The BDARS and CMRS are developed and maintained via funding through a Memorandum of Agreement with Rutgers University. The CMRS system recently completed a major overhaul to improve the system's ability to be flexible in responding to new situations, such as future pandemics and natural disasters that will impact the service needs of CSHCN. As part of a cooperative agreement, SCHS programs provide CDC with de-identified hearing screening and follow-up data on all NJ occurrent births, case data for certain congenital disabilities, critical congenital heart defect screening results, and both maternal and newborn data, including infant outcomes up to six months of age for cases with pregnancy complicated by syphilis or cCMV infection.

The BDARS and EHDI programs have implemented use of a Master Person Index (MPI) to improve data linkages. The NJ Innovation Institute is receiving hospital admission data, VERI, NJIIS, and BDARS records to create MPIs for millions of individuals with records across these multiple data systems.

SCHS is currently working to implement use of electronic Case Reporting (eCR) to improve BDARS interoperability. CDC has been partnering with the Association of Public Health Laboratories (APHL) and the Council of State and Territorial Epidemiologists to implement the APHL Informatics Messaging Services platform. This platform allows hospitals using electronic health records systems to automatically report case information for selected diagnosis that are then shared securely with state health departments. The NJDOH Communicable Disease Services (CDS) program has been actively receiving eCR reports for COVID-19 cases. Several hospitals in NJ are sending all available conditions to the APHL platform which include several congenital anomalies. BDARS staff are working with APHL and CDS staff on making these eCRs available to SCHS to allow electronic ascertainment of these cases to replace current manual registration processes for these facilities.

III.C.1.b.iii. Title V Program Partnerships, Collaboration and Coordination

The NJDOH prioritizes partnership over singular work as we recognize the work is enhanced when in collaboration with others. We work closely with various entities across the state that engage the MCH populations. The TVP's internal collaborations include with Women, Infants and Children unit on breastfeeding initiatives and coordinating on a Nutrition Coalition. Interdepartmentally, NJ endorses cross-collaboration with the Youth Mental Health initiative between programs, led by the CAHP Program, and the Governor's Council, participated in by the CSHCN Executive Director.

Moreover, the newly received MHI grant continues to bolster the important, evidence-based work we have been engaging in. This work will continue to be cross-collaborative, engaging

state professionals and clinical professionals to meet the shared aims of educating and training service recipients and professional stakeholders. Furthermore, the initiatives of the MHI grant link to the ongoing Maternal Mortality Review (MMR) work and the recommendations made by the committee. The data produced in the Maternal Data Center also inform the initiatives crafted and modified by the MHI.

Public Comment Stage

***Scheduled for June 26th, 2026. Final written comment due July 11th, 2026.**

Results Dissemination Stage

To be determined, and based on the finalization of the manuscript, integration of public comments and submission of full documents in July of 2026.

FY 2026 Application/FY 2024 Annual Report Update

III.D. Financial Narrative

III.D.1 Expenditures

III.D.2 Budget

***Financial and Budget Narrative Section to be completed by July 2026 submission date**

III.E. Five-Year State Action Plan

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

Five Years State Action Plan Table to be updated for posting before June 26, 2026, Public Comment Period

III.E.3. State Action Plan Narrative by Domain

Women/Maternal Health Annual Report

The selection of the NPMs during the Five-Year Needs Assessment process recognizes the impact the life course approach will have on increasing healthy births and improving women's health across their life span. The Life Course Perspective helps to conceptualize health care needs and services for various populations, and which evolved from research documenting early

life events' important role in shaping an individual's health trajectory. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influences health throughout one's lifetime. NJ has prioritized improving women's health and has utilized several evidence-based strategies to increase the NPMs of Postpartum Visit, Postpartum Mental Health Screening, and Perinatal Care Discrimination, including Healthy Women Healthy Families (HWHF), NJ Post-Partum Resource and Support Network (NJPRSN), ConnectingNJ, and partner programs such as Maternal, Infant and Early Childhood Home Visiting (MIECHV) and Maternal Health Innovation (MHI).

The NJPRSN is designed to provide education and access to services for birthing individuals experiencing perinatal mood and anxiety disorders and their families, enhance responsive and trauma-informed care across NJ, and identify strategies to better support pregnant women. The NJDOH awarded funding to four community-based organizations to implement interventions aligned with established NJPRSN objectives. These efforts aim to strengthen postpartum mental health resource networks through a statewide approach, improve screening for postpartum depression, and ensure referrals to appropriate support services, while delivering education and training for providers. In Fiscal Year 2025, 1,008 pregnant women participated in support groups, 1,976 support people for mothers were trained and engaged in training, and 1,739 professionals completed training, equipping a multidisciplinary workforce—including health educators, OB-GYNs and midwives, therapists, nurses, community health workers (CHWs), doulas, and social workers—to better serve their communities.

Evidence-Based/Strategy Measure (*ESM): Percentage of women who attend a postpartum visit within the first four to six weeks after birth*, was selected for its positive impact on NPM: Increase Postpartum Medical Visits, and State Performance Measure SPM: *Increasing Healthy Births*. *Postpartum Mental Health Screening* was also selected as an NPM, which relates to the SPN *Increase Healthy Births and Bridge Gaps in Birth Outcomes*, and the NPM of *Perinatal Care Discrimination* as the endeavors overlap with the SPN of *Reducing Differential Outcomes in Maternal Health care for Specific Populations*.

In 2023, the overall percentage of adequate prenatal care in NJ based on the American Health Rankings is 73.4%. However, more needs to be done to improve care. This aligns with the need for TVP to improve the SPN *Increase Healthy Births and Bridge Gaps in Health Outcomes* by focusing on preconception care and early prenatal care. Improving access to prenatal care is essential to promoting the health of NJ mothers, infants, and families. Early and adequate prenatal care is an important component of a healthy pregnancy and birth outcomes 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 contact with the health care system and to provide general preventive visits. with the health care system and to provide general preventive visits.

Moreover, preconception care is a critical component of prenatal and health care for all women of reproductive age. NJ has a targeted focus on preconception care through the family planning program. The NJ family planning grant delivers essential primary and preventative health care to patients. NJ's family planning providers provide a full range of reproductive health and family planning services, including contraceptive counseling and provision; education, testing, and treatment for sexually transmitted infections; screenings for breast and cervical cancers; and other sex education. Beginning in Fiscal Year 2023, $10.5m in additional funding was appropriated for expanded services and support to cover uncompensated costs, practical support, and a statewide needs assessment.

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

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

TVP staff on the project team have access to data collected on this secure system. CNJ is designed to simplify the referral process, improve care coordination, provide developmental screening, and ensure an integrated maternal, infant, and early childhood care system. From July 1, 2018, to January 1, 2026, more than 187,750 pregnant individuals were referred to CNJ and there have been over 132,480 service referrals given to these individuals. To better align the ESM with current initiatives, *Number of individuals trained to become community-based doulas* was selected for its positive impact on NPM *Postpartum Visit* and *Perinatal Care Discrimination*, and the SPN of *Increasing Healthy Births and Bridging Gaps in Health Outcomes*.

The NJ Doula Learning Collaborative (NJDLC) has focused on reducing maternal and infant mortality and eliminating any differences in health outcomes by providing training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to grow the community doula workforce.

To date, over 400 individuals have been trained to become community doulas. To ensure the sustainability of community doula services in NJ, TVP staff worked collaboratively with Medicaid to offer community doula services to women through NJ FamilyCare benefits.

NJ FamilyCare Medicaid benefits have been expanded to cover community doula services. Presently, a doula can serve pregnant women whom NJ FamilyCare covers as a covered benefit. As of December 2025, 190 individual doulas and 10 doula group agencies have enrolled as fee-for-service community doula providers.

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

Since 2020, the CLG-CHWI has successfully trained and integrated over 1,200 CHWs into NJ health systems and community-based organizations. (Figure 14 & Figure 15).

Figure 14. Program Outcomes Across Clients, Doula and Grantees Agencies, the NJDOH, and State Systems

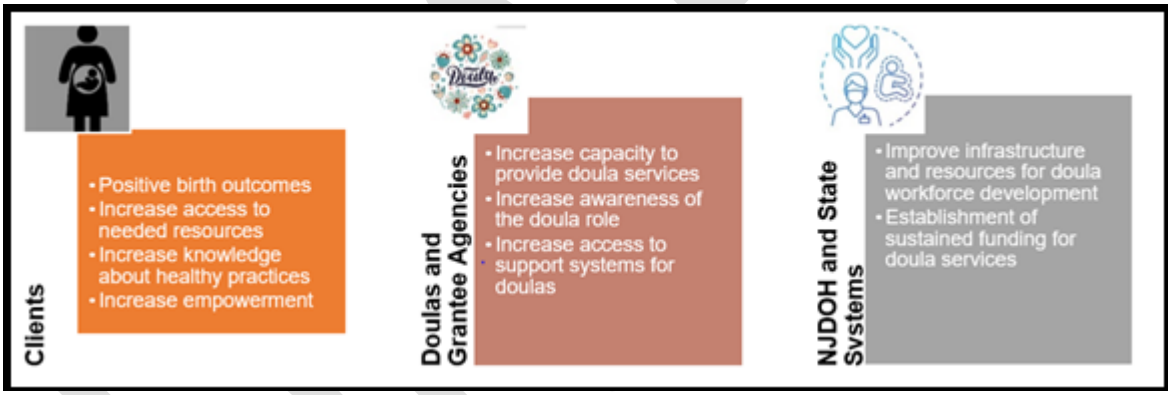
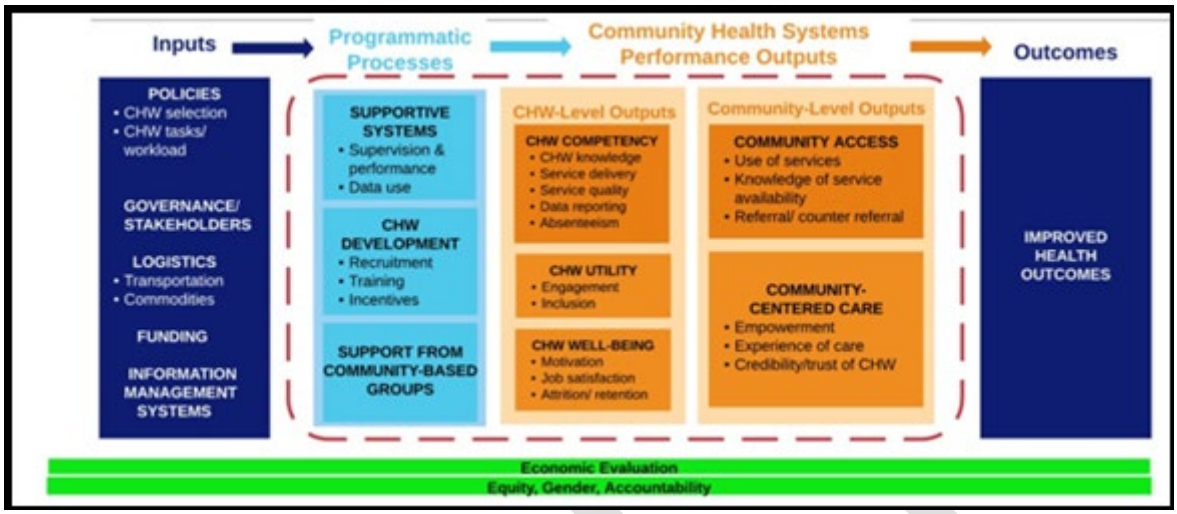


Figure 15. Overview of NJ Community Health Worker Workforce and Expected Outcomes



Moreover, TVP established the Colette Lamothe Galette-Community Health Worker Institute (CLG-CHWI) through a NJ Department of Labor (DOL) Apprenticeship to infuse additional services in the communities. The funding for DOL grant ended in 2023. TVP collaborates with community colleges throughout the state to deliver a standardized community health worker training program, resulting in a robust CHW workforce. The CLG-CHWI has allowed the state to educate an emerging and critical component of its workforce – creating a needed infrastructure to support CHWs, enhance CHW skill sets, and lead sustainable efforts to support this indispensable workforce. The first cohort was held in October of 2020, with 12-14 new cohorts continuously being held annually. CHWs and their supervisors, through Title V grantees, have received and continue to receive breastfeeding education. The CLG-CHWI Breastfeeding training took place in 2025 and over 100 CHWs attended the training. These grantees have been implementing breastfeeding education and support for lactating individuals and their families through educational sessions with local community partners including community-based organizations, churches, community colleges, and local high schools, Breastfeeding-support is also provided to participants by International Board-Certified Lactation Consultants (IBCLC), Certified Lactation Consultants and breastfeeding peer counselors either in groups or in one-to-one sessions.

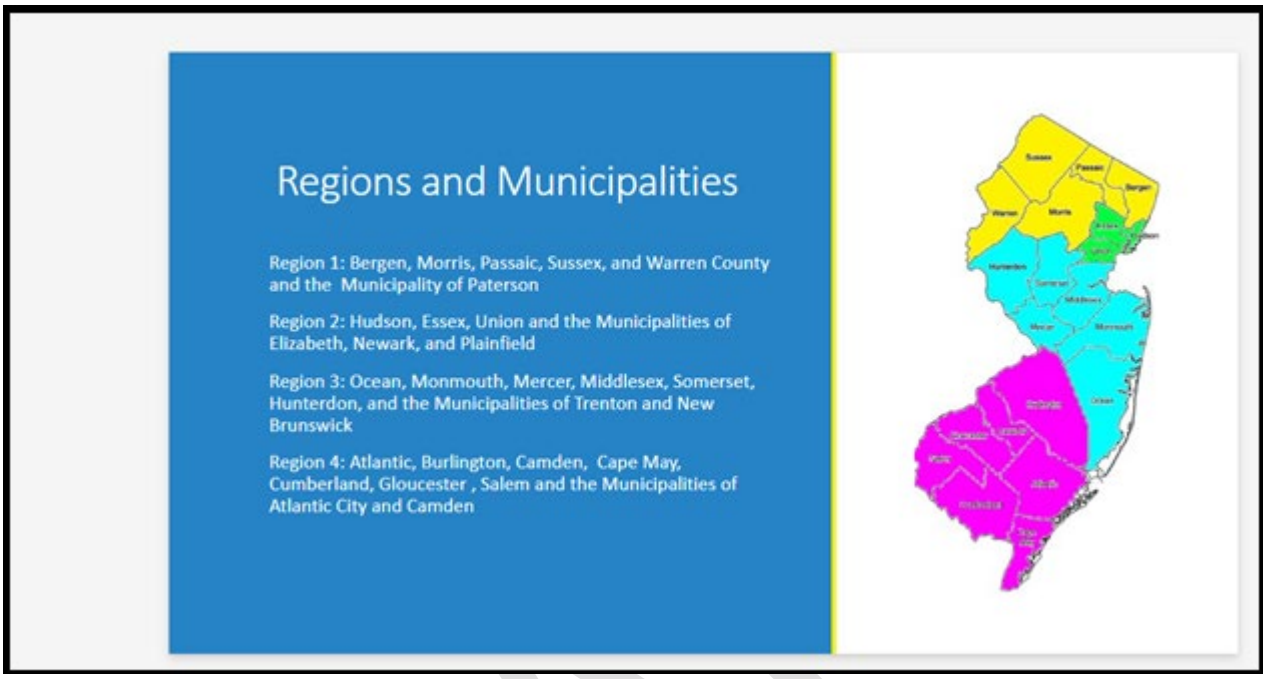
The Alma Program Expansion Project was established as an evidence-based peer mentoring program created with and for new and expectant mothers experiencing depression, anxiety, and stress. By providing tools that can be locally adapted to meet the needs and elevate expertise within communities, the overall goal of this pilot program was to provide new and expectant parents with knowledge, skills, and support from peer mentors who have faced similar challenges. Funding for this pilot program ended on June 30, 2025, with 69

mentees having completed the six-to-eight-week program. In February 2026, a pilot program for CHWs and doulas was conducted. The three-part session "Alma Peer Support Tools & Skills training" series demonstrated strong participation and outcomes, with 21 participants starting the program and 81% completing all sessions. Participants showed high knowledge acquisition, with post-training scores ranging from 89–100%, as well as clear retention of information, evidenced by 100% pre-training scores by Session 3. There was also measurable improvement in identifying effective support strategies, increasing from 55% to 74%, alongside increased confidence in applying key peer support skills such as problem-solving, communication, and maintaining boundaries.

The programs being implemented in the communities through the HWHF initiative allow TVP to implement specific activities to support communities with limited public health resources and the highest need where impacts will be greatest to improve population health outcomes and reduce health gaps (See Figure 16. For HWHF Regions). The HWHF Initiative addresses these gaps in birth outcomes through case management and assures that appropriate referrals are made and tracked including medical care referrals to promote healthy births. Between January 1, 2025, and September 2025, HWHF community health workers (CHW) served over 1,530 women and their families and made over 5,300 referrals to needed services and supports across the state. In addition, the Postpartum Doula Program addresses postpartum care in specific municipalities with high Infant and Maternal Mortality rates to ensure that clients are attending postpartum visits and receiving adequate postpartum care, relating to the NPM of *Postpartum Visit*. Approximately 85% of mothers enrolled in the HWHF Postpartum Doula program, from its inception to January 29, 2026, have attended their postpartum visit or have indicated that they had an appointment scheduled. From January 1, 2025, to December 31, 2025, 134 moms were participating in postpartum doula visits across 8 municipalities. Breastfeeding education efforts across the state continued with traditional breastfeeding groups, support, and education being provided to HWHF CHW and Postpartum Doula Program infant clients while an emphasis on holding nontraditional breastfeeding education sessions in the specific municipalities increased. For state Fiscal Year 2025 (July 1, 2024, to June 30, 2025) 33 breastfeeding education sessions and groups were held for nontraditional audiences including teens, fathers, grandparents, and other support people.

To ensure that all the initiatives under the NJ TVP are successful, TVP collaborates with various departments and engages with external stakeholders such as Advocates for Children of NJ and the recipients of the Pritzker fund for the Pritzker Children's Initiative. TVP established linkages and continues to connect with sister agencies, including theDepartment of Labor (DOL), the Department of Education (DOE), the Department of Transportation, etc. while seeking to address some of the barriers that exist in the scope of CHF.

Figure 16. HWHF Regions for Fiscal Year 2026



Women/Maternal Health Application Year

Improving the domain of Women's/Maternal Health continues to be an area of focus for the Title V staff in NJ. For this reason, the SPNs of *Increasing Healthy Births and Bridging Gaps in Birth Outcomes, Reducing Infant Mortality and Expanding & Strengthening Evidence-Based Programs Addressing Infant Mortality, and Reducing Differential Outcomes in Maternal Health care for Specific Populations* are areas of focus for the MCH Unit.

Plans for the coming year to address the NPMs of *Perinatal Care Discrimination, Postpartum Mental Health Screening, Postpartum Visit* as well as *Breastfeeding*, will involve the enhancement of HWHF, Postpartum Resource and Support Network (PRSN), ConnectingNJ, perinatal workforce (e.g., doulas, CHWs), and further collaboration with families, partners, and stakeholders that address these key components such as the MHI Program and MIECHV.

The goal of HWHF continues to be to improve maternal and infant health outcomes for women of childbearing age (as defined by CDC as 15-44 years of age) and their families through a collaborative and coordinated community-driven approach. The HWHF initiative will continue to develop partnerships with community-based MCH providers/agencies with proven capabilities

in implementing activities/interventions within a targeted community, chiefly, reproductive-age women and their families. The HWHF initiative focuses on implementing breastfeeding education and postpartum support, including connecting women in the acute postpartum period to clinical, follow-up care. Support programs for breastfeeding include 1:1 and group sessions by IBCLCs and peer counselors and the establishment of culturally and linguistically appropriate support groups. Breastfeeding educational sessions targeted to non-traditional groups such as fathers, support people, teenagers, and grandparents, which have received more funding to continue collaborations with fatherhood programs, local community colleges, and high schools.

To support the continued increase in breastfeeding initiation at birth, a statewide Breastfeeding Strategic Plan (BSP) was launched and funded. The BSP was launched in 2022 and is currently being implemented to address the 5-year goals and objectives. The BSP workgroup has been established and convened with an array of representatives including TVP staff, the DCF, HWHF CHWs, hospital representatives, state and local WIC staff, etc. Currently, the CLG-CHWI and the NJDOH HWHF team are collaborating with the NJ State Breastfeeding Coordinator to develop a statewide standardized breastfeeding training and curriculum for CHWs and doulas that was launched this past year.

Simultaneously, county-based consumer-driven advisory boards continue to contribute to the direction and progress of the HWHF initiative, in collaboration with the CNJ Hubs and other early childhood partners who meet quarterly to build partnerships and local referral systems. The HWHF and CNJ staff have been collaborating with the NJDCF's funded Universal Home Visitation Program, Family Connects NJ, which began providing universal postpartum home nurse visits to NJ residents in January 2024. Family Connects NJ began servicing five NJ counties in January 2024 with a yearly rollout plan to include all 21 counties by January 2027. Currently, they are present in 17 counties. CNJ hubs have served as the main source to refer new families to Family Connects NJ and dedicated Community Alignment Specialists housed at all the CNJ hubs serve as a coordinator for MCH resources and services. Family Connects NJ nurses also serve as touchpoints in the homes to refer to long term MCH services such as TVP like HWHF CHWs and postpartum doulas and other home visiting services. The MIECHV Programs and Healthy Start Programs will continue to case manage mothers and assure preventive medical visits through the monitoring of benchmarks, including a reproductive life plan, medical home, and well-women visits. These initiatives will support mothers in all stages of their perinatal journey, and with an acute focus on the NPM of Postpartum Visit, which connects to the NPM of *Postpartum Mental Health Screening*.

The NJDLC will enhance this grant cycle, as the NJDOH, NJ FamilyCare and NJMIHIA programs partner to increase the doula workforce and doula capacity, enrolling those trained into the NJ FamilyCare system. Additionally, the NJDLC will provide training, workforce development, mentoring, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ. The NJDLC provides

cultural competency training and education in NJ-specific community-based resources for doulas. The NJDLC is working with Medicaid to ensure that the NJ community doula training curriculum is approved for community doulas to enroll as NJ FamilyCare Community Doula provider to receive Medicaid reimbursement. The integration of doula care during a woman's perinatal journey will enhance opportunities for support, connection to resources, and advocacy. Furthermore, the involvement of community doulas, who the NJDLC actively recruits and trains, come from the same communities of which their clients/patients are part of. This characteristic parity between service professional and client/patient will help to decrease the potential for differential health outcomes for mothers from different racial categories, addressing the NPM of *Perinatal Care Discrimination*. With the addition of the Rural Health Transformation funding, NJ will focus on increasing the presence of doulas in rural areas of NJ, ensuring that hard to reach populations have the ability to access doula services.

The CLG-CHWI will continue to enhance the professional development of CHWs and allow for a stronger workforce. The CLG-CHWI will continue to expand its programs through state funding, an initiative to improve maternal-child health outcomes. In the Spring of 2026, the NJDOH will begin activities funded through the Rural Health Transformation Program. Organizations in rural NJ will focus on expanding and strengthening the use of CHWs to improve health care access, address social determinants of health, reduce health disparities, and support training and capacity building to improve health outcomes. To achieve this goal, the program supports targeted initiatives that deploy CHWs who are trusted members of the communities they serve and provide care coordination, social determinants of health screenings, and strengthen community-clinical linkages in rural communities throughout the state. These initiatives promote increased access to primary, preventative, and behavioral health services in rural communities and address social needs such as food insecurity, housing instability, transportation, and benefits navigation. Additionally, CHWs can improve care coordination and navigation, reduce barriers to care, and strengthen community-clinical linkages.

The Community Awareness, Resources, and Education Rutgers (ECHO) series ended in August of 2025. The series provided training for doulas and CHWs in conjunction with the CLG-CHWI to address the social determinants of health by equipping them with education and resources to improve the overall health of NJ communities. Since September of 2025, the CLG-CHWI has launched supplemental skill building sessions to foster collaboration and resource sharing across sectors. The most recent addition was an Alma pilot which trained 18 CHWs and doulas. Alma training focuses on building peer support, communication, and problem-solving skills to help birthing individuals experiencing perinatal mental health challenges and is designed for community health workers and women with lived experience who are compassionate, communicative, and ready to help families thrive. The components of the Alma model were delivered through the University of Colorado-Boulder.

Through the HWHF initiative and the interventions and activities, TVP will continue to develop partnerships with community-based MCH 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. In the 2027 application year, TVP will revisit the goals and objectives of the HWHF initiative by reviewing data and outcomes, especially for the HWHF municipality-level programs that aim to reach nontraditional groups for breastfeeding education and support and the postpartum doula program. TVP will analyze the successes and challenges in implementing the postpartum doula program in the assigned HWHF municipalities thus far, to possibly refocus based on assessed need.

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

Plan for the Application Year

NPMs of *Postpartum Visit, Postpartum Mental Health Screening* and *Perinatal Care Discrimination* and ESMs:

- ESM: *Percentage of women (ages 18–44) who report receiving a preventive medical visit in the past year*
- ESM: *Number of women screened for postpartum depression through the New Jersey Postpartum Resource and Support Network Program*
- ESM: *First trimester prenatal visit rate*
- ESM: *Number of births supported by community doulas*
- ESM: *Percentage of women who are involved in the HWHF program who attend a postpartum visit within the first four to six weeks after birth*

To address these national performance measures through the ESMs, the TVP will continue to:

- Increase the perinatal workforce (CHWs, Community Doulas, and Midwives) who work directly with clients in need of postpartum and mental health screening.
- Provide education, resources, and support through the post-partum resource and network initiative.
- Support the work through the HWHF initiative and Connecting NJ.
- Work with other initiatives in the state such as the Maternal Health Innovations grant, MIECHV, and Family Connects NJ, universal home visiting.
- Partner with Medicaid to ensure that post-partum visits coverage continues.
- Promote onsite trainings, orientations, and webinars to MCH professionals in Central and Northern NJ.

Perinatal/Infant Health Annual Report

Annual Report NPM - Infant safe sleep

NJ TVP utilizes block grant funding to Rutgers Robert Wood Johnson Medical School to fund the Sudden Infant Death Syndrome Center of NJ (SCNJ) which implements activities that seek to reduce NJ rate of Sudden Unexpected Infant Death (SUID), a leading cause of infant mortality in the first 12 months of life (Ostfeld & Hegyi, 2015; Ostfeld & Hegyi, 2016). The missions of SCNJ, established in 1987, include: 1) providing public health education to reduce the risk of sudden infant death, 2) offering emotional support to bereaved families, and 3) participating in efforts to learn about possible causes of and risk factors associated with sudden unexpected infant deaths and best practices for providing risk-reducing education, and identifying and addressing systemic challenges and barriers. These practices have contributed to NJ's low SUID rate (Ostfeld & Hegyi, 2014). SUID is comprised of Sudden Infant Death Syndrome (SIDS), Ill-defined and Unknown Causes, and Accidental Suffocation and Strangulation in Bed (Ostfeld et. al., 2010). While these are primarily deaths of unknown cause, and without pathognomonic findings, the associated risk factors for these largely sleep-related death are known and actionable, thus empowering parents and providers with risk reducing guidelines, as established in the evidence-based policy statements of the American Academy of Pediatrics. Research by the Rutgers Robert Wood Johnson Medical School faculty of the SCNJ contributed to these guidelines.

In association with SCNJ's risk reduction education programs and education tools for health care, social service, home visiting, managed care, and first responder institutions and providers, community groups and the public, NJ's rate of SUID has further declined from 0.52 per 1000 live births in 2022 to 0.48 in 2023, based on the most recently released linked birth/infant death data by the CDC, making NJ's rate second lowest of all 47 States meeting CDC statistical standards for confidentiality and reliability and half the national rate of 0.98 (Ostfeld & Hegyi, 2014; Ostfeld & Hegyi, 2015). Data for 2024, is currently only available in the CDC WONDER underlying cause of death file, show that NJ's SUID rate has further declined to 0.41 and remains second lowest (CDC, 2025). In addition, SCNJ monitors variations in rates among population subgroups, identifying and raising awareness of actionable public health risk factors, and targeting communities demonstrating higher levels of these conditions with additional bespoke educational interventions (Ostfeld & Hegyi, 2016; Ostfeld et. al., 2017). Here too, NJ population subgroups have among the lowest rates relative to other states. TVP plays a key role in monitoring the activities and ensuring they respond to the needs of the State's populations.

Risk factors consist of conditions related to the sleep environment (i.e., sleep position and location) and environmental factors (i.e., exposure to the delivery of nicotine by any device), which form the basis for education. Promotion of risk reducing behavioral choices such as breastfeeding and early access to prenatal care are also addressed. In addition, factors that

contribute to increasing an infant's vulnerability, such as preterm birth and poverty-associated conditions help direct enhanced outreach where needed. The selection of the ESM of *Promote Infant Safe Sleep Environments* monitors and focuses on the safe sleep environment (Healthy Sleep), including back to sleep, no co-sleeping, and no soft bedding. Over 10 years, there has been a largely upward trend in the use of back-to-sleep placement, from 58% in 2003 to 76.2% in 2022 (Ostfeld et. Al., 2007; Ostfeld & Hegyi, 2017). However, no one risk factor operates in isolation. Any "good outcome" is multifactorial (Mustafa et. al., 2016; Nepomnyaschy et. al., 2012). Therefore, SCNJ's education is inclusive of all factors, with outcome measured by the SUID rate. SCNJ develops and disseminates free multi-lingual mobile phone apps, education cards, short videos, live and on-demand webinars, and reaches providers and the public with extensive outreach. In FY25, 24,947 baby onesies with safe sleep messaging and 188,896 education cards were distributed, SCNJ's one-minute videos were accessed, 216 live presentations to 7,851 attendees were provided, and the mobile phone app was extensively downloaded along with the SCNJ safe sleep checklist (Ostfeld et. al., 2018; Ostfeld et. al., 2020).

NJ has also participated in the Sudden Unexpected Infant Death Case Review (SUID-CR) SUID-CR activities have standardized, and improved data collected at infant death scenes and promoted consistent case review, classification, and reporting of SUID cases. NJ TVP and SCNJ are represented on the multi-disciplinary SUID-CR Review Board, which meets monthly as a subcommittee of the Child Fatality and Near Fatality Review Board. The SUID-CR is staffed by the DCF and is an important statewide surveillance system for unexpected infant deaths. The SUID-CR makes recommendations to the statewide Child Fatality and Near Fatality Review Board con cerning infant safe sleep and promotes SUID prevention activities (Ostfeld et. al., 2010; Ostfeld et. al., 2023).

Close to 2,000 NJ DCF cases workers were trained by SCNJ in the first two months of 2025, and recordings were made to refresh knowledge and orient future staff. In addition, all other collaborators such as the Universal Nurse Home Visiting Program (Family Connects NJ) also receive presentations and material. SCNJ continuously provides education and training on safe sleep to expand awareness and knowledge.

NJ TVP utilizes block grant funding to fund the SCNJ which implements activities that seek to reduce NJ rate of SUID. Comprised of SIDS, Ill-defined and Unknown Causes, and Accidental Suffocation and Strangulation in Bed.

NPM Breastfeeding

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 of their life. Breastfeeding is a cost-effective preventive intervention with far-reaching effects for mothers and babies and significant cost savings for families, health providers, employers, and the government. Breastfeeding provides

biologically normal, appropriate nutrition and encourages normal infant development; lack of breastfeeding increases the risk of disease and obesity. FHS has developed many strong partnerships to strengthen breastfeeding-related hospital regulations, promoting breastfeeding education, training, and community support in the past grant cycle.

In 2022, in collaboration with TVP, the NJDOH released the BSP. Presently, TVP staff sit on the committee that participates in the implementation of the BSP. The Title V Director also secured funding from the FY24 Governor's budget for dedicated staff to lead implementation of the BSP. A statewide coordinator was hired effective March 2024, and a project associate shortly after. For the past two years, TVP staff have continued to participate in the BSP Steering Committee meeting monthly with the NJ State Breastfeeding Coordinator and other representatives of NJ's early childhood and MCH systems. Through the BSP Steering Committee, TVP staff provided valuable input towards the creation of a statewide breastfeeding education and resources website launched in August 2025, that is available in eleven languages. While the primary focus of this website is to provide evidence-based breastfeeding education and county-by-county lactation support resources, there are also sections for employers, health care providers, and childcare centers to better understand how to integrate breastfeeding-friendly approaches into their work. The ESM of *Increase the Percentage of Births in Baby-Friendly Hospitals* was selected for its positive impact on the health outcomes of mother and child, 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 Maternity Practices in Infant Nutrition and Care Survey.

According to the CDC's Early Childhood Nutrition Report - 2025, NJ rates for newborns ever breastfed was 85.7%. Breastfeeding rates in three categories of interest in 2022 are depicted in the table below (Table 4).
Nutrition, Physical Activity, and Obesity: Data, Trends, and Maps | DNPAO | CDC

Table 4. Breastfeeding Rates of Infants in NJ

Categories	2022
Infants who were exclusively breastfed through six (6) months	26.1%
Infants who were breastfed at twelve (12) months	48.0%
Infants who were ever breastfed	88.5%

Although breastfeeding rates increased across all indicators, exclusive breastfeeding rates at three and six (6) months are at or below the national average, impacted by NJ's early

supplementation rate at two days of life in 2022 (26.3%) compared to the national average (22.9%).

FHS has supported Baby-Friendly™ designation through training, technical assistance, and mini-grants. The Baby- Friendly Hospital Initiative is a global program launched by the World Health Organization and the United Nations Children's Fund to encourage and recognize hospitals and birthing centers that offer optimal care for infant feeding and mother/baby bonding. The Baby-Friendly Hospital Initiative recognizes and awards birthing facilities that implement the Ten Steps to Successful Breastfeeding (i) and follow the International Code of Marketing of Breast-milk Substitutes (ii). Sixteen NJ hospitals have earned the "Baby-Friendly" designation. About 35% of NJ Birthing Facilities have achieved Baby-Friendly status.

NJ hospitals participate in the national survey of maternity care practices and policies, conducted by the CDC every two yearssince 2007. In 2024, 40 of 46 (87%) eligible hospitals participated in the Survey, and the total score was 84 (above the national score of 82).

Existing Breastfeeding-related Programs

NJ State WIC services continue to provide breastfeeding promotion and support to participants through grants to its 16 local agencies for the WIC Breastfeeding Peer Counseling Program. International Board-Certified Lactation Consultants and breastfeeding peer counselors provide direct education counseling and support services, literature, and various breastfeeding tools including breast pumps. Moreover, WIC breastfeeding staff conduct professional outreach in their communities and education to health care providers who serve WIC participants. Close collaboration between Maternal and Child Health Services, WIC Services, and the Office of Community Health and Wellness is ongoing. All three programs, in addition to the Office of Minority and Multicultural Health, have an interest in breastfeeding protection, promotion, and support and have similar constituencies. In FY 2025, the U.S. Department of Agriculture’s Food and Nutrition Service awarded the NJ WIC program a Breastfeeding Performance Bonus award for the achievement of improving breastfeeding rates during FY 2024.

Through the HWHF initiative, TVP implements community-level programs that promote breastfeeding and potentially address persistent population gaps. For instance, one of the target outcomes of HWHF is increasing exclusive breastfeeding. Additionally, to address the differences in breastfeeding rates, implementing breastfeeding support and education to non-traditional audiences as a mechanism to increase support for Non-Hispanic Black and Hispanic women is one of the interventions/strategies of HWHF. Considering that breastfeeding is a “family affair,” fathers’ and other family members’ involvement in the process is a puzzle piece that is supported by the HWHF initiative through its focus on non-traditional audiences. Moreover, CHWs, postpartum doulas, and their supervisors receive breastfeeding education

through multiple trainings, educational sessions, and professional development opportunities to become Certified Lactation Consultants and IBCLCs. In 2025, the CLG-CHWI and the NJDOH HWHF team collaborated with the NJ State Breastfeeding Coordinator to develop a statewide standardized breastfeeding basics training and curriculum for HWHF CHWs and doulas. Additionally, the state's breastfeeding coordinator is training Family Connects NJ nurses, our state's Home Visiting nurses, to ensure there is an increase in breastfeeding education and support throughout the various NJDOH programs in the state. Furthermore, the breastfeeding coordinator is working to increase the number of lactation providers involved in the Zipmilk network, to ensure women and families across the state have the ability to locate local lactation consultants for support (Anstey et. al., 2017).

Perinatal/Infant Health Application Year

Plan for the Application Year - NPM Safe Sleep

Plan for the Application Year - NPM *Safe Sleep*, Objective: Increase the Percent of infants placed to sleep on their backs by 1%

- *ESM: Complete infant safe sleep environment (no co-sleeping, on back, no soft bedding)*
- *ESM: Rate of infant mortality in NJ per 1,000 live births*

The public health interventions and activities depicted in the section pertaining to safe sleep through the SIDS Center of NJ are supported through grant funding from TVP to Robert Wood Johnson Medical School, a part of Rutgers, The State University of NJ, New Brunswick. TVP plays a key role in monitoring these activities and ensuring they play a key role in bettering infant health outcomes in NJ.

Sustaining and Improving Upon NJ's Already Low SUID Rates: Protocols, Partners, and Methods

To raise awareness and adoption of SUID risk reduction practices, SCNJ will continue designing and providing bespoke educational programs, tools, and methodologies, and will continue promoting and sustaining discussions with the public to identify and address potential barriers to their adoption. And in a train the trainer model, SCNJ will continue educating health care, social service, childcare, and public health providers, institutions and programs, faith-based communities, nurse home visiting programs, doulas, maternal and child health consortia, first responders, and community health workers, along with other relevant providers and programs.

In association with risk reduction education, NJ's rate of SUID has dropped in 2023 from 2022 and is still half of the national rate of .98 per 1000 births (CDC, 2024). This finding is especially

compelling given the many cultures and associated infant care practices in the State. Further, NJ SUID rates for its population subgroups with statistically reportable occurrences also fall below the national average for each group. Relative to other states meeting statistical criteria for confidentiality, NJ's population subgroups have rates ranging from the lowest rate or in the lowest quintile of rates. However, variability in rates and in adherence of risk reducing behaviors among population subgroups persist.

In NJ, these challenges will continue to be addressed through data analytics leading to targeted professional and community education projects developed by SCNJ and advanced with its many collaborators, including the home visitor staff in the DCF and the NJ MIECHV Program, both of whose staff also receive training from SCNJ. Adverse public health variables also affect rates. These include poverty, defined here as coverage by Medicaid vs. private insurance. For NJ cases inclusive of the years 2021-2023, the SUID rate for the Medicaid group was 1.06 per 1000 live births vs. 0.25 for the private insurance group (Ostfeld & Hegyi, 2017). Poverty contributes to risk in multiple ways, including by its association with higher rates of smoking, a major risk factor for SUID (Ostfeld et. al., 2023). To enhance parent education on potentially compensatory actionable risk factors related to unsafe sleep factors by caregivers working with families covered by Medicaid, SCNJ established a comprehensive educational initiative involving stakeholders in Medicaid, Managed Care, FQHCs, and the Division of Child Protection and Permanency (DCPP) that includes the provision of onesies with back to sleep messaging in several languages. Education on risk reduction content for safe sleep and other behavioral factors, on methods for providing education, and on the use of SCNJ's supplemental and free educational materials in multiple languages (i.e., education cards, one-minute topic-specific videos, a mobile phone app) reached health care providers and case workers. Both vaping and NICU education were featured in a series of virtual lunch and learn sessions throughout SIDS Awareness Month, and SCNJ will continue to use that forum, as well, to bring attention to hot topics. SCNJ is also called upon and will continue to provide extensive and broad-reaching education at national medical conferences in response to interest in the initiatives being provided in NJ. SCNJ medical school faculty will continue efforts to identify new risk factors and potential causes that appear a sudden death in a seemingly health infant.

Through its many collaborations, SCNJ has developed the access and trust needed to raise not just knowledge but also the practice of safe infant sleep and other risk-reducing behaviors. In its work, SCNJ will continue to use data analytics to monitor variations in rates among population subgroups, identifying underlying factors, and raising awareness, where needed, of potentially actionable risk factors. Communities at great risk will be targeted with additional interventions. SCNJ is called upon by other states to share best practices and tools, and it will continue to respond to these invitations. TVP plays a key role in monitoring the activities and ensuring they respond to the needs of New Jersey residents. In summary, risk is multifactorial and cannot be viewed as a singular factor. The approach taken by SCNJ to address back to sleep along with

other safe infant sleep, environmental, behavioral factors and societal health risks have helped sustain NJ's low rates and will continue to be provided.

Safe Sleep: Addressing Challenges in Changing Knowledge into Practice

With respect to the adoption of risk-reducing practices, knowledge of risk factors does not automatically lead to changes in behavior or even to sustaining compliance over time. Working with community leaders and influencers to understand and support safe sleep practices also improves acceptance. SCNJ will continue seeking to reach grandparents and other audiences through presentations to faith-based organizations, community groups, and emerging collaboration with health care providers who serve them. Another challenge to the adoption of risk reduction practices can occur when parents believe that their infant is not in need of safe sleep practices because they were unincumbered by such precursor risk factors as preterm birth, poverty, and smoke exposure. Such a position would suggest the existence of a "no risk" population, and that does not exist. SCNJ will therefore continue to educate providers of all infants on how to identify and respectfully address potential barriers to adopting safe sleep guidelines.

The SCNJ also identifies risk factors more likely to be associated with specific age clusters in the first year of life, such as Sudden Unexpected Postnatal Collapse in the first days after birth and creates programs to highlight and address these. In this case, the initiative will reinforce the importance of hospital policies for supervised skin-to-skin care during this period. SCNJ programs are directed to institutions (i.e., schools, hospitals, clinics, hospital grand rounds programs, public health programs), organizations (i.e., WIC, HWHF grantees, NJAAP, Maternal, and Child Health Consortia, Nurture NJ), providers (i.e., pediatricians, obstetricians, nurses, family medicine practitioners, social service providers, home visitors, clergy, community workers, doulas, first responders), and the public (i.e., baby fairs, community programs). SCNJ will continue to provide its accredited on-line nurse education course. The SCNJ will continue to work closely with the Medical Examiner system to address issues related to the timely reporting of amendments to a cause of death provisionally marked as related to SUID. Timely updates of amendments to coding must meet the inclusion deadlines of NJSHAD and National Crime Victimization Survey (NCVS)to maintain accuracy of public health records.

Safe Sleep: Interventions and Tools

The work of the SCNJ is supported through grant funding from TVP. In addition to the systemic approaches described, plans for the coming year to promote safe infant sleep include continued education through the SCNJ, the NJ MIECHV Program, and the Sudden Unexpected Infant Death Case Review Workgroup which includes representation by the SCNJ. Staff from the MIECHV 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. Family Connects, NJ's universal home visiting program has extended its geographic outreach, and works collaboratively with SCNJ, using its education tools and measurements of improvements in knowledge and practice. The SCNJ is now planning a new cycle of staff education. The SCNJ's baby onesies with back-to-sleep messaging will be available to the extent permitted by funding, as these are highly valued by parents. Doulas and Midwives will also continue to be offered safe sleep education. Outreach education to the Division of Child Protection and Permanency (DCPP), Licensed Child Care, the Federally Qualified Health Centers (FQHCs), and the many providers' groups, health care and social service institutions, and community and public health organizations that work to improve outcomes and partner with the SCNJ will also continue to be offered.

Overall, SCNJ education programs address provider knowledge of safe sleep practices, skills for educating families and identifying barriers, and an understanding of conditions that underly population variability and the role played by compensatory risk reduction education.

The SCNJ has updated its free mobile phone app SIDS Info to include the new 2022 American Academy of Pediatrics inclusions to its risk reduction guidelines. It will continue to be available in English and Spanish with voice-over to overcome literacy challenges. Emerging changes in cell phone technology will require a coding update going forward to ensure continued functionality. Funding for the SIDS Info app was derived from health services grant from the TVP to the SCNJ. SIDS Info was accepted into the Emerging Practice section of the Association of MCH programs.

Receiving education from a trusted provider, such as a physician or nurse, increases parents' retention and application of the information. The SCNJ will continue working closely with provider groups and their relevant organizations and training programs. The SCNJ offers education programs to hospital nurses, who play a key role in modeling and teaching about safe sleep, via live and on-demand webinars. The SCNJ works with all three maternal and child health consortia to reinforce safe sleep messaging within their member hospitals and work closely with the BSP since breastfeeding reduces the risk of SIDS.

In addition to providing education, the SCNJ makes educational scripts, videos, behavioral check lists, and hospital safe sleep audit protocols available. Moreover, SCNJ developed electronic and hard copy educational materials that are translated into multiple languages. Many of the SCNJ resources, including live and on-demand webinars, Frequently Asked Questions, multiple one-minute videos on safe sleep topics, education summary sheets, information about its free safe sleep app, and flyers in multiple languages, are tools that can be accessed from the NJDOH FHS SIDS website which has been recently updated by SCNJ in collaboration with the NJDOH, the SCNJ website: www.rwjms.rutgers.edu/sids.

Plan for the Application Year - NPM Breastfeeding

- ESM: *Increase the % of infants exclusively breastfeeding for the first six months of birth*

Breastfeeding is the biologically normal and optimal way to feed human infants, and it significantly improves their health outcomes. Breastfeeding reduces infant mortality in the United States and is associated with a reduced risk of many conditions and illnesses of infants and children. Supporting lactation is also an extremely significant, but often overlooked, strategy for improving maternal health. Breastfeeding decreases women's lifetime risk of breast cancer, ovarian cancer, and Type 2 diabetes, and reduces their risks of hypertension and cardiovascular disease in the postpartum period and beyond (Anstey et. al., 2017). Breastfeeding success can be challenging and elusive for those who choose to provide human milk to their babies due to many factors including societal barriers, stigma, and insufficient access to evidence-based lactation support and information.

To address these barriers, the 2022-2027 NJ BSP was released in late 2022 to provide a blueprint of actions that can be taken across the state by families, communities, health care professionals, employers, childcare providers, state agencies, and others to improve lactation initiation and duration and to create a statewide environment that normalizes breastfeeding. To date, the BSP team has conducted an environmental scan of existing state breastfeeding-related laws, regulations and policies and has identified and compiled a catalog of existing community organizations providing lactation support and childbirth education and existing pregnancy and parenting resources that offer lactation support across the state by county. The BSP Team also drafted a patient "Breastfeeding Bill of Rights" outlining lactation care that is required to be provided in NJ maternity hospitals, embarked on a statewide "NJ Supports Breastfeeding" media campaign featuring a new statewide breastfeeding website, print, and video content for social media, launched in 2026 (https://www.njsupportsbreastfeeding.org/); and developed a basic lactation education curriculum for home visiting nurses, CHWs, and doulas. In addition, the BSP team provided technical assistance to NJ State agencies on donor human milk, workplace lactation rights, breastfeeding-related hospital licensing regulations, and Medicaid reimbursement for lactation consultants.

The BSP team plans to prioritize the following initiatives in 2026-2027: continue to sustain the NJ Supports Breastfeeding media campaign, engage stakeholders to develop the lactation workforce, facilitate creation of an interactive breastfeeding data dashboard, provide support to hospital-based lactation departments, and bolster lactation education during the perinatal period through collaborations with obstetric and midwifery organizations. The BSP team continues to partner with staff from the NJDOH, NJ WIC, the DCF, the Division on Civil Rights, the NJ Division of Medical Assistance and Health Services (Medicaid), the MCH consortia, and other

stakeholders to accomplish these goals. NJ has also created and elevated an SPN of *Improving Exclusive Breastfeeding Rates for the first Six Months after Birth* to further elevate the priority and use metrics to track success over the grant period. Efforts to promote Baby-Friendly Hospital Initiative designation through training, technical assistance, and mini-grants will continue to promote surveillance through the Birth Certificate file and the Maternity Practices in Infant Nutrition and Care (mPINC) survey will continue to identify areas of potential improvement.

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

The BSP's primary purpose is to provide a roadmap to identify and foster policy, environmental, and system changes to increase breastfeeding initiation, duration, and exclusivity in NJ. Since the release, TVP staff have been actively involved in the committee and worked on materials to support the implementation of the strategic plan. With the hiring of dedicated breastfeeding coordination staff, TVP staff remains involved in the implementation process of the strategic plan and continue collaborating with the BSP team on their breastfeeding work. WIC will continue to provide breastfeeding promotion and support services to pregnant and breastfeeding women who participate in the program and the BSP team works closely with WIC to ensure the increase in breastfeeding rates. Currently, the BSP team is serving on the planning committee for a statewide WIC Breastfeeding conference taking place in September which will feature the successes of the breastfeeding strategic plan.

Through HWHF, TVP continues to fund multiple community-level organizations to implement breastfeeding education and training, primarily focusing on non-traditional audiences such as fathers, grandmothers, teens, etc. For state Fiscal Year 2026, HWHF grantees have received increased funding to support the objective of increasing breastfeeding education and support for nontraditional audiences to expand the focus and support for breastfeeding success. The initiative aims to increase breastfeeding rates throughout the State with a high focus on Black mortality rates. Breastfeeding is known to have numerous protective factors for newborns and birthing parents. Increasing the rate of breastfeeding in marginalized and underrepresented groups will increase the likelihood of infants reaching their first birthday. CHWs are key stakeholders in educating new parents on breastfeeding. In collaboration with the NJ State Breastfeeding Coordinator, efforts will continue to produce a standardized statewide curriculum for breastfeeding education for CHWs and doulas.

CLG-CHWI is monitored and evaluated by TVP staff. TVP staff will continue to implement breastfeeding training in partnership with the Perinatal Foundation. The breastfeeding education

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

Child Health Annual Report

The domain of Child Health includes the SPN of *Improving Nutrition and Physical Activity*, and the selected NPM of *Developmental Screening*. This NPM was selected during the Five-Year Needs Assessment process for their impact on overall child health and wellness and the evidence-based strategies that the NJDOH and its partners implemented.

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

Increasing developmental screening rates across the state is an important focus in the domain of Child Health that seeks to improve overall child health and well-being. Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percentage of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine-month visit (see screening rates in Table 5 below).

Table 5. Developmental Screening Rates for children ages 9 months to 35 months

	2011-2012	2016	2017-2018	2018-2019	2019-2020	2020-2021
NPM 6: *Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool*	25.02	32.9	36.1	32.2	32.3	31.1

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

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

The NJDOH, through TVP, is an active interdepartmental partner with the NJ Council for Young Children (NJCYC), the ECCS P – 3, the CDC's NJ "Learn the Signs. Act Early. " (LTSAE) Ambassador (housed at the SPAN Parent Advocacy Network and is also NJ's AMCHP Family Delegate), and the NJCYC Infant-Child Health Committee that has established a priority of improving system connections for children and families with health care providers, community services, Early Intervention, child care, home visiting, and early care & education settings.

The CDC's LTSAE program aims to improve early identification of developmental delays and disabilities, including autism, by facilitating parent-engaged developmental monitoring and promoting developmental screening so children and their families can get early access to the services and support they need. The CDC's NJ LTSAE Ambassador shares LTSAE materials to encourage parents and providers to learn the signs of healthy development, monitor every child's early development, complete developmental and autism screening, and act early when there is a concern. The CDC's NJ LTSAE Ambassador leverages her multiple roles and partnerships as SPAN's Director of Early Childhood Initiatives, State Parent Lead for NJ DCF's Office of Early Childhood Services, and Division for Early Childhood Recommended Practices Ambassador to promote the messages and materials for parent-engaged developmental monitoring with families, professionals, programs, and systems that serve young children. SPAN's Early Childhood and Family Engagement Projects including the NJ Inclusive Child Care Project (training and technical assistance for child care professionals and families navigating the system), Rutgers Autism Detection-Connection-Intervention Project (peer support to families who participate in autism screening for their child), HRSA-funded Transforming Pediatrics for Early Childhood also known as NJ SEEDlings Project (oversee and support the family engagement components of the project to enhance early childhood development) also help implement/support developmental health promotion activities across the state.

Detection-Connection-Intervention Project update - From October 1, 2024 – September 30, 2025: 699 Total Children Screened with the Psychological Development Questionnaire (PDQ-1) and the Modified Checklist for Autism in Toddlers (MCHAT-R/F).

The PDQ-1 is a brief Autism Spectrum Disorder (ASD) screening tool, developed by Rutgers-NJ Medical School investigators, that is validated in low-risk populations. It is a parent-report questionnaire, estimated to take approximately 2-3 minutes to administer. Responses were designed to indicate delays in social-pragmatic development of children between 18 to 36

months of age. PDQ-1 consists of 10 statements about the child's behavior, with possible responses of "no," "sometimes," and "yes." Possible scores range from 0-20, with scores >15 indicating age-appropriate skills (negative screen) and scores ≤12 indicating higher risk of social-communication skill deficits consistent with ASD (positive screen).

The M-CHAT-R/F is a parent-reported screening tool designed to identify children at risk for ASD. It is typically used for toddlers between 16 and 30 months of age, and it aims to pinpoint early signs of ASD to enable prompt intervention. The checklist includes 20 yes or no questions about a child's behavior, which parents/caregivers answer. Based on responses, health care professionals can determine whether further assessment for ASD is warranted. Parents/caregivers whose answers are consistent with the risk profile are connected to SPAN peer support specialists who provide additional information, support, and assistance to navigate next steps based on each family's preferences and goals.

NJ SEEDlings Project update: The four participating pediatric practices - Newark Beth Israel Pediatric Health Center (Newark), Eric B. Chandler Health Center (New Brunswick), DePaul Pediatrics at St. Joseph's Medical Center (Paterson), and St. James Health Center (Newark) integrate Early Childhood Development experts, including Healthy Steps Specialists and SPAN Family Resources Specialists, into their care teams. These experts provide guidance and support to families with children from birth to age five, typically following well-child visits. They help families understand developmental milestones, share resources such as LTSAE milestone checklists and children's books, and assist with navigating the early childhood system. Based on each family's preferences and goals, they also connect families to services such as developmental evaluations, the NJ Early Intervention System, preschool special education program, and other community-based programs. In addition, SPAN Family Resource Specialists are supporting the development of a Patient and Family Advisory Council at each of the four practices. These councils engage parents and caregivers as active partners alongside care team members, creating opportunities for them to share feedback and provide recommendations. Their input helps drive quality improvements in clinic environments, services, and care processes to better meet the needs of families.

Improvements in early childhood systems continued through the NJ Early Childhood Comprehensive Systems preschool through grade three (ECCS P-3). A top priority through the grant is to continue to support universal access to evidence-based developmental screening through the early childhood Connecting NJ (formerly known as Central Intake) system (Help Me Grow Central Access point). Connecting NJ supports linkages and access to programs and services for families within their community. The NJ LTSAE Ambassador activities focus on promoting family-engaged developmental monitoring, screening and referral, and connection to services through training, presentations, and materials distributed across the state. As the State Parent Lead for ECCS P-3 and MIECHV programs, the LTSAE Ambassador activities also focus on the priorities of the NJCYC Infant-Child Health Committee and continues to support the CNJ Hub staff with accessing LTSAE materials as well as with family- engagement activities. NJ's Child Developmental Passport, was created in collaboration between the NJ LTSAE Ambassador

at SPAN and the ECCS team (available in English & Spanish), which includes a developmental tracker to empower parents to track their child's developmental screening information. In addition, the Roadmap for Advancing Family-Engaged Developmental Monitoring (The Roadmap) and related tools developed in collaboration between the CDC and the Help Me Grow National Center are shared with early childhood professionals so they can better understand what family-engaged developmental monitoring is, what it looks like in practice, and why it is important to improve child and family outcomes. Through the **"Read, Play, Grow" initiative**, funded by ECCS P-3, in collaboration with SPAN and Reach Out and Read (RoR) NJ, customized bilingual versions of Where is Bear? and Amazing Me books were developed and printed (7000 copies of each book).

These books feature a QR code linking families to the Early Childhood section of the SPAN Parent Advocacy Network website that links them to:

- LTSAE developmental milestone checklists
- Curated book recommendations from RoR
- Early Childhood Specialists who offer screening and follow-up support

Additionally, 5000 bilingual copies of *Clifford's Bedtime Story* have been purchased and distributed along with customized bookmarks (in English & Spanish). These bookmarks reinforce the importance of reading and engaging with children during everyday routines and include the same QR code for easy access to resources, particularly targeting families with one-year-old children.

All materials are being distributed across pediatric practices within the RoR network. Participating sites also receive bilingual posters for waiting and exam rooms, featuring consistent messaging and the QR code to increase accessibility and engagement.

Impact and Feedback

Initial feedback from participating practices, as well as the RoR Pediatrician Champion who also serves as the Early Childhood Champion at NJAAP, has been overwhelmingly positive. Providers highlight that:

- Bilingual materials improve accessibility for families
- The single, centralized QR code simplifies access to a wide range of trusted resources
- Families benefit from having milestone tracking, local resources, and literacy guidance in one place

The selected ESM monitors progress on increasing parent-completed early childhood developmental screening using an online Ages and Stages Questionnaire (ASQ) tool. It also monitors 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 of *Developmental Screening*. The NJ DCF, in collaboration with TVP at

the NJDOH, continues to implement the Early Childhood Comprehensive Systems Prenatal-through-three grant that focuses on enhancing the early childhood system. With the invaluable support of the Help Me Grow Physician Champion, the Early Childhood Champion at the NJ Chapter of the American Academy of Pediatrics, and other Health Care Provider Champions, this iteration has focused on health integration and promotion of the coordinating system of care of families of young children and creating greater awareness with health providers as they support families with young children. The previous iteration of ECCS (Impact) focused on five communities to test and scale up developmental health promotion and parent-completed early childhood developmental screenings in children under three years old.

The ASQ Enterprise software (Brookes Publishing) is being utilized to add a parent/family portal for easy access to developmental screening and links screening to Connecting NJ hubs. NJ's expanded data system links developmental screenings with all 21 Connecting NJ hubs to enhance the engagement of families not connected to early childhood services/programs. This expansion of the data system could potentially be engaged and linked for additional services and supports as identified, including developmental needs as determined by the completed ASQ. Families receive support and referrals to an array of services, for instance, pediatric primary care and/or other systems partners, including home visiting, HWHF, CHWs, and/or other service providers as determined by the family and their needs/interests. The referrals and connections provided through the CNJ Hubs extend to quality Child Care, Early Head Start/Head Start, and Preschool programs. In FY23 and FY24, the Connecting NJ hubs maintained developmental health promotion, screening, and linkage. There were 1808 screens completed in FY25 through the Connecting NJ hubs via the Brookes Publishing Family Access Portal for children two months to 60 months. Below is a chart outlining the percentage of children reached by age domain for FY20, 21, 22, 23 and 24 (Table 6). In FY25, the Ages and Stages Questionnaire Social Emotional - 2 (ASQ SE-2) was added statewide to the Family Access Portal throughout NJ in June of 2025. Families are now able to access the ASQ-3 and ASQ SE-2 development screens in each county in English and in Spanish.

Table 6. Percentage of Completed Screenings of children in NJ using the ASQ

ASQ - *Family Access Portal Screens completed*	FY 20	FY 21	FY 22	FY 23	FY 24	FY25
Total # of screens	1689	1107	1382	1084	1513	1808
Age of Child	%	%	%	%	%	%
2-12MO	35%	35%	25.9%	25.9%	27.8%	21.3%
13-24MO	18%	22%	26.9%	26.5%	25.4%	25.7%
25-38MO	16%	19%	21.8%	22.3%	22.0%	19.4%
39-50MO	20%	13%	14.9%	14.6%	13.6%	15.3%
51-66MO	11%	11%	10.5%	10.5%	10.9%	11.6%

Child Health Application Year

Plan for the Application Year - NPMs of Developmental Screening and Preventive Dental Visit, and SPNs of Improve Nutrition, Food Security & Increase Physical Activity and Promote Healthy Youth Development from Childhood Through Adolescence & Young Adulthood (AYA) and with the following ESMs & SPMs:

- ESM: *Percent of children in food sufficient households*
- ESM: *Number of parent completed early childhood developmental screening using an evidence-based tool*
- SPM: *Number of children who have a preventative dental visit*

The NJDOH will continue to participate as an active interdepartmental partner with the NJCYC, the Preschool Development Grant Birth to Five, CDC's NJ "Learn the Signs. Act Early." Ambassador and the NJCYC Infant-Child Health Committee. The Infant-Child Health Committee has prioritized improving system connections for children and families with health care providers, community services, Early Intervention, childcare, home visiting, health care, and early care and education settings to support overall child development and well-being. The NJ ECCS P-3 work informs potential improvements in early childhood systems, focusing on universal access to evidence-based developmental screening. The Connecting NJ system (Help Me Grow Central Access Point) supports linkages and access to programs and services for families within their community.

The CDC's NJ LTSAE Ambassador workplan is also focused on supporting health care providers and early care and education providers in their efforts to continue to engage families in developmental health monitoring using the LTSAE materials and for the sustainable integration of LTSAE into their policies and practices. The CDC's NJ LTSAE Ambassador has also been instrumental in supporting the statewide WIC agency staff and local WIC agencies with implementing the WIC Developmental Monitoring Project, a technical assistance grant from the CDC and the Association of State Public Health Nutritionists. SPAN will continue to collaborate with the NJ Chapter of the American Academy of Pediatrics on the HRSA-funded Transforming Pediatrics for Early Childhood grant also known as NJ SEEDlings Project to support family engagement activities to enhance engagement of families in early childhood development.

SPAN has been funded by the NJ DHS Division of Family Development for over 27 years to implement the NJ Inclusive Child Care Project. This provides the unique opportunity for SPAN to continue to support the Child Care Resource and Referral (CCR&R) Agencies to host Books, Balls, and Blocks developmental screening events. In addition, SPAN will support CCR&R Family Engagement Specialists by training them to serve as hosts for Be Strong Families Parent Cafés and as facilitators of *Positive Solutions for Families*, a seven-week, evidence-based series grounded in the Pyramid Model. The program equips parents and caregivers with practical

strategies to support the social-emotional development of young children. Through these trainings, Family Engagement Specialists will be better prepared to engage families in meaningful and ongoing ways.

Grow NJ Kids, a Quality Improvement Rating System developed for early learning programs, requires the use of a "state-approved" developmental screening at Level 2 of a 5-level rating. Through the ECCS P-3 grant, the parent/family portal for easy access to parent-completed early childhood developmental screenings in children two months to five years old continues to be universally accessible to all parents in NJ. The parent/family portal will permit monitoring of ESM *Promote parent-completed early childhood developmental screening* and promote improvement in NPM of *Developmental Screening*.

The NJDOH collaborated with Advocacy for Children NJ and their Pritzker Children's Initiative to advance a comprehensive system that supports families in the prenatal-to-three life stage. The Title V Director participates in NJ's Pritzker Children's initiative through leadership team meetings. Furthermore, the Advocacy for Children NJ participated in the needs assessment as stakeholders as well as other members of the Leadership Team.

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

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

Some highlights from NJ-EASEL work this year were:

- Build a secure File Transfer Protocol solution for data exchange between multiple agencies using existing Amazing Web Services Infrastructure
- Migration of the Mathtech NJ-EASEL SharePoint to the DOE NJ-EASEL SharePoint. The new link for current NJ-EASEL SharePoint users is: NJ-EASEL - Home

- Links within documents on the NJ-EASEL SharePoint will no longer work, however, all links in documents should be proceed by the Path. To open a link, follow the Path listed in the document

Lastly, the Health Promotion Division of the NJDOH is expanding services to address the NPM of *Preventive Dental Visit*. To address this significant gap in oral health services, specifically, for children in third grade (data from the *Basic Survey Screening Tool*), the Oral Health Services Unit (OHSU) will continue to focus and enhance the grant activities to expand the dental sealant programs as one of the most compelling evidence-based practices for low-income children. Additionally, the OHSU will provide nutritional counseling to this at-risk population to reduce the intake of sugary products that increase the incidence of tooth decay.

Adolescent Health Annual Report

Annual Report - NPMs Bullying and Adult Mentor

Decreasing and preventing Bullying is an important measure in the domain of Adolescent/Young Adult Health and is related to the SPN of *Promoting Youth Development*, and the SPN of *Preventing Teen Pregnancy and Sexually Transmitted Infection*s *(STIs)*. Bullying can impact both short and long-term physical and emotional health in adolescents and young adults. Bullying can also lead to physical injury, social problems, emotional problems, increased risk-taking behaviors, and death. Bullied teens often have problems adjusting to school, higher rates of absenteeism, long-term damage to self-esteem, and are at increased risk for mental health problems including suicidality (Agustiningsih et. al., 2024).

The 2023 National Youth Risk Behavioral Surveillance data show that 16% of all students are bullied online and 19% are bullied on school property. Within this data, girls report a higher incidence of bullying online (21%) and on school property (22%) compared to boys' incidence of bullying online (12%) and on school property (17%). The ten-year trend data shows that both online and on school property bullying incidence has remained stable with no significant decrease. Therefore, efforts to decrease bullying should remain a priority. Through the CAHP, multiple efforts are made to decrease bullying in schools and build the social-emotional learning competencies of both bullies and bullied youth. Building youth's capacity for self-awareness, social awareness, self-management, relationships, and decision-making helps build the core skills teens need to refrain from bullying others and bounce back when bullying occurs (Bollmer et. al., 2005).

According to Collaborative for Academic Social and Emotional Learning (CASEL), these social and emotional skills allow children, adolescents, young adults and adults to calm themselves when angry, initiate friendships, resolve relationship conflicts respectfully, and make ethical and safe choices throughout the lifespan (Program Guide - CASEL Program Guide, retrieved May 2026). To develop these capacities, children, adolescents, and young adults need to experience safe, nurturing, and well-managed environments where they feel valued and respected; have

meaningful interactions with others who are socially and emotionally competent; and receive positive and specific guidance.

Research also suggests strong peer connections are a key protective factor against bullying (Healy et. Al., 2024; Ajibewa et. Al., 2025). Supportive friendships and a sense of belonging at school reduce the risk of being bullied and lessen the negative mental health effects if bullying occurs. Peers can act as defenders, decreasing bullying behavior and promoting social, emotional, and academic resilience. Having even one supportive friend can buffer against anxiety, depression, and academic challenges, while positive school relationships create a safer environment and strengthen social skills (Wang et. al., 2013).

In 2025, 348 students completing the Teen Outreach Program (TOP®) had the following post survey outcomes regarding safety and belonging:

- 86% felt TOP® is a safe place for me to say what I think
- 92% felt physically safe
- 84% felt like they belonged
- 94% felt that their adult facilitators supported them and cared about them
- 92% were glad they joined TOP®

During the 2024–2025 school year, School Health NJ initiatives were implemented across NJ using the CDC Whole School Whole Community Whole Child framework. Benchmarks included:

- 126 students participated in at least one evidence-based social and emotional learning program including Teen Connection Project, Speak to the Potential, Ability, and Resilience inside every Kid Teen Mentoring, and Inner Explorer
- Students who participated in the Teen Connection Project demonstrated measurable gains, including:
    - help-seeking increased from 29% to 50%
    - peer trust increased from 14% to 40%
    - self-belief from 38% to 86%
    - decision-making improved by 62%
    - school engagement rose by 82.1%
    - emotional regulation difficulties decreased by 23%
    - 90% of Teen Connection participants would recommend the program
- Schoolwide social and emotional learning days, Wellness Fairs, prevention campaigns, and family engagement efforts reached 6,000+ students and families
- Youth Mental Health First Aid certification for 13 school-based professionals
- Professional development for 77 youth serving professionals
- Parent engagement events serving 360 parents and caregivers
- Nutrition education provided to104 students and 44 staff (administrators, teachers and school nurses)
- Physical activity programming including Kids360 and LifeCenter visits served 118 students

School Health NJ strengthened long-term infrastructure by supporting School Health Teams across NJ, expanding community partnerships, increasing trauma-informed and social and emotional learning centered practices, and integrating nutrition and physical activity into school wellness culture, resulting in measurable improvements in student connections, well-being and leadership development statewide.

Research shows that parent engagement reduces bullying involvement by promoting emotional regulation, social competence, and behavioral self-control (Healy et. Al., 2024; Ajibewa et. al., 2025). Warmth, supervision, and open communication are associated with lower rates of both bullying perpetration and victimization. Supportive parenting also buffers against the mental health effects of bullying, including anxiety and depression. Parent engagement helps parents and caregivers build confidence and better understand, support and communicate with their teens, which builds protective factors and reduces the impact and incidence of bullying. Teen Speak, the parent engagement program implemented via CAHP, offers skill-building workshops for parents and other supportive adults to help foster critical intergenerational connections and build protective factors in the home and community. Through short, multimedia workshops focused on improving adult-teen communication and/or in-person facilitated sessions where parents and caregivers can practice new techniques to engage their teens; Teen Speak seeks to reduce harmful behaviors and build strong family relationships. Teen Speak also collects data from participants via post-retrospective surveys and polls during lessons.

The Statewide Parent and Professional Engagement Program (S-PEP) has created a centralized website for parents and caregivers (PCGs), and professionals to access Teen Speak and request workshops and trainings. This site is set to launch early in 2026 and will expand and streamline access to PCG and professional education to better care for adolescents in NJ. In 2025, S-PEP served 720 parents, caregivers and 125 youth serving professionals.

In addition to engaging teens and parents directly, youth-serving professional capacity must be improved at the school and community-based level. There is a strong connection between bullying and mental health, and the National Institute of Child Health and Human Development (NICHD) research studies show that anyone involved with bullying, those who bully and are bullied, are at increased risk for depression. NICHD-funded research studies also found that, unlike traditional forms of bullying, youth who are bullied electronically, such as by computer or cell phone, are at higher risk for depression than those who bully them. The same studies also found that cyber victims were at higher risk for depression than were cyberbullies or bullying victims (i.e., those who both bully others and are bullied themselves), which was not found in any other form of bullying.[21,22] These findings are in the NICHD news release: *Depression High Among Youth Victims of School Cyberbullying, NIH Researchers Report.*

Through a comprehensive approach aimed at building the skills, competencies, and capacity of teens, parents/caregivers, and youth-serving professionals, the CAHP seeks to decrease bullying and increase resilient responses to bullying in NJ schools and communities. The most recent program added to the CAHP roster is the Teen Connection Project, an evidence-based group program for high school students that has demonstrated improvements in social connectedness, emotional well-being, and academic engagement by strengthening

communication skills, empathy, resilience, and positive peer relationships in a safe and supportive environment.

The new NPM for the Child and Adolescent Health Program focuses on *Adult Mentoring*. While mentoring has long been embedded in the CAHP, its designation as an NPM enables CAHP to build formal mechanisms to measure and strengthen its impact on youth interns, leaders, advisors, and contributors.

Adult mentoring plays a critical role in adolescent and young adult development by providing stable, supportive relationships during a formative period of life. Positive relationships with caring adults strengthen social-emotional skills such as emotional regulation, confidence, and healthy coping, while also supporting character development and a sense of purpose. Mentors model problem-solving, leadership, and goal setting, which contributes to improved academic engagement and clearer career pathways. Research also shows that strong connections with non-parental adults serve as protective factors, reducing the likelihood of risk behaviors and buffering against stress. Overall, adult mentoring promotes resilience, belonging, and the developmental assets necessary for long-term well-being (Lereya, et. al., 2013; Li et. al., 2025).

To collect the data needed to effectively measure this new NPM, youth leaders have begun developing a youth-led, youth-designed website to showcase advisory projects, accomplishments, and leader spotlights. The initial content will feature spotlight interviews conducted by a recent intern with youth leaders who have partnered with the NJDOH through youth engagement and leadership initiatives, providing opportunities for leaders to share and provide feedback. Additionally, CAHP has introduced structured mentoring opportunities for young adults and are working in collaboration with youth leaders to develop a survey tool to formally assess the impact of adult mentoring on teens and young adults.

SPN: Reducing Teen Pregnancy
Annual Report SPM: TOP program, Love Notes, Get Real, FLASH, and Teen PEP

Simultaneously, to satisfy the SPN of *Promoting Healthy Youth Development by Reducing Teen Pregnancy & Sexually Transmitted Infections (STIs)*, Title V staff has selected the ESM of *Number of females aged 10-19 who give birth*, which monitors progress in reducing teen pregnancy in NJ. The CAHP has adopted the TOP®, Love Notes, Get Real: Comprehensive Sex Education that Works (Get Real), FLASH High School, and Teen PEP, all evidence-based models proven to reduce teen pregnancy. These curricula utilize a strengths-based approach, which is a framework designed to help young people realize and leverage their strengths to facilitate growth and resiliency. Participants are equipped with the skills to make informed decisions, build confidence, improve communication and develop healthy relationships. Additionally, TOP®, and Get Real are evidence-based program models for social and emotional Learning. Not only do these curricula change behaviors associated with teen pregnancy and sexually transmitted infections, but they also help youth develop the skills necessary for healthy relationships and emotional well-being while building community engagement. In the past year, approximately 3,300 students have been actively engaged in the evidence-based models (EBMs) indicated.

In addition to experiencing EBMs, CAHP pregnancy and STI prevention programs offer additional positive youth development. Positive youth development is a purposeful and supportive approach that actively involves young people within their communities, schools, organizations, peer groups, and families in ways that are productive and constructive.[26] It too focuses on identifying, utilizing, and strengthening existing abilities while fostering positive outcomes through meaningful opportunities, nurturing relationships and essential support needed to develop their leadership potential. Positive youth development strategies further help teens develop the social and emotional skills necessary to reduce the risk of pregnancy and STIs. Therefore, each participant engaged in EBM also participates in positive youth development through community service learning, and youth engagement opportunities. Community service learning and youth for youth programming provide opportunities to promote self-efficacy, confidence, and practice life skills that are transferable in life situations such as communication and teamwork, while also influencing the interpersonal and community levels of prevention. Last year, 3036 youth enrolled in EBM also participated in community service-learning activities, reaching approximately 10,250 peers in youth-by-youth programming through workshops, conferences and special events.

Data are collected for all EBMs through pre-and post-surveys.
All participants complete measures related to SEL, and ask questions related to healthy relationships, emotion management, decision making, goal setting, and safety/belonging in the program. High school students complete additional measures related to sexual health behaviors, such as abstinence/delaying from sexual activities, preventing pregnancy and STIs, and using birth control and condoms. Of those youth completing a survey, data from 2024-2025 show:

- 87% felt that being in the program made them more likely to understand what makes a relationship healthy
- 88% felt respected as a person all the time or most of the time while they were in the program
- 86% felt the risks associated with getting a STI was an important factor in abstaining from sex

Improved social and emotional learning is also linked to improved decision-making and healthy relationships and contributes to reducing teen pregnancy. The CAH Programs link teens from various backgrounds and groupings within schools and facilitate dialogues that encourage teens to be introspective, connect with their peers, partner with adults, and participate in bettering their communities. Data are collected for all EBMs implemented via pre- and post-surveys delivered to participants that measure sexual health behaviors such as abstinence/delaying from sexual activities, using birth control, and condoms. In addition, social and emotional learning questions regarding bullying behaviors, teen connectedness, and resiliency are also measured.

Adolescent Health Application Year

Plan for the Application Year - NPM Bullying, NPM Adult Mentor, and SPN Promoting Healthy Youth Development by Reducing Teen Pregnancy & Sexually Transmitted Infections using the following ESMs:

- ESM: *Reduce the percentage of high school students who are bullied on school property.*
- ESM: *% of program participants reporting protective factors related to bullying, including speaking to a trusted adult and resiliency skills*
- ESM: *Number of students (male and female) who completed at least 75% of an evidence-based Teen Pregnancy Prevention Model (Teen Outreach Program, Reducing the Risk or Teen PEP)*
- ESM: *Require mentor training for professionals engaging youth in CAHP-supported programs. Require all CAHP sub awardees to include a survey question assessing mentorship support*
- ESM: *Promote Teen Speak workshops to parents and caregivers through TeenSpeakNJ.org and expand access to workshops by partnering with existing providers serving PGCs*

The CAHP will continue to implement in-person and virtual social and emotional learning and parent and caregiver engagement programs along with activities that provide youth with opportunities to lead and educate their peers. The CAHP will continue to promote the adoption of Evidence-based social and emotional learning programs, including TOP®, Love Notes, Teen PEP, Get Real, FLASH, Teen Connection Project® and the CDC Whole School Whole Community Whole Child framework. Whole School/Whole Community/Whole Child model in NJ schools, with the goal of reaching over 4,000 youth. In addition, the CAHP will be launching the Statewide Parent and Professional Engagement Program (S-PEP) website. Teen Speak currently serves approximately 750 parents statewide and, with the new website and partnership with other NJ based programs Teen Speak is expected to reach over 1,000 parents and caregivers in 2026.

CAHP will continue to host the NJDOH Voice of Youth Planning Committee (VoYPC) as they plan and implement youth-led virtual and in person programs for their peers. The committee has not chosen a focus for 2026 but is continuing to offer activities for youth who are adjusting to new environments such as middle to high school, high school to college and the job market. The

Committee selected to continue with the current topic of growth and change at the March, 2026 VoYPC meeting.

In 2026, to support the NPM Adult Mentor, the NJDOH interns will be developing a website for all youth participating in a NJDOH supported youth advisory structure. The space will be for youth by youth and showcase their successes as future leaders of NJ. Finally, the NJDOH will continue to provide training and technical assistance to the grantees and partner organizations that will aid youth-serving professionals to build their competencies to help provide youth opportunities to avoid bullying as a perpetrator or victim.

CSHCN Annual Report

The NJ CSHCN program has many strong areas of service including a robust NBS program, an FCC program that is county-based and offers services to all NJ residents, laws and regulations that support public surveillance efforts, an integrated data approach, and a strong relationship with the CDC to monitor emerging threats. The program has a strong, comprehensive staff in terms of career level, public health, nursing, and epidemiology expertise. In the last several years, staff have also been successful at obtaining competitive grants to further broaden the efforts such as CDC Sickle Cell Data Collection grant, a HRSA State NBS System Priorities Program, NBS Propel grant to establish long-term follow-up for children identified through NBS, and the CDC Surveillance for Emerging Threats to Mothers and Babies Network Pregnant Persons-Infant Linked Longitudinal Surveillance grant to support the efforts with emerging threats to newborns such as COVID-19, cCMV, and Syphilis.

The program has a record of working closely with Pediatric Specialty providers, 21 county and local health departments, many family-led advocacy agencies, and 47 birthing hospitals providing close to 100,000 births per year that support the health of children with special health care needs and their families. Moreover, the program has a long history of working towards decreasing gaps in health outcomes across populations given the state's large population. The CSHCN programs have been tailored to address the varied cultures and languages across urban, suburban, and rural communities.

Family Centered Care Services (FCCS)

At the center of the FCCS efforts is the county-based case management program and two NPMs: *Medical Home* and *Transition*. The Special Child Health Services Case Management (SCHSCM) Case Management Units (CMUs) are a mix of local county agencies and non-profit organizations. Once registered with the BDAR, children are automatically referred to their county's CMU. Given the many diagnoses and conditions that are included in the BDAR, the types of treatments, supports and services are individualized to meet each family's unique needs. Therefore, some families may only need a few resources, while others remain engaged with their CMs until they turn 22 years old.

The SCHSCM program is unique in its funding and each unit's population is distinct in many ways. While the state does have a large urban area in the north, it also has a robust agricultural and rural area in the south. Even neighboring counties can have very different characteristics. In fact, the counties with lowest and the highest state funding are neighboring counties with very different demographic and economic characteristics. All these differences are considered in the funding approach. Each county government provides a designated amount of funds to the grantees, in addition to the funds provided by the NJDOH. While the state program provides structure and policy for the units, each unit has a different formula of state to local funding. The average county receives 67.4% of their funds from the state, while the range is 45.6% to 86.1%.

Although most case managers are highly experienced, ongoing education and training is provided through quarterly meetings. These opportunities are part of the unit's continuous quality program improvement process. Additionally, analyzing the Case Management Referral System (CMRS) data to measure the overall effectiveness of the program has provided important insights into how the CMUs are reaching out and addressing the identified CSHCN population.

Annual NPM: Percent of children with and without special health care needs having a medical home.

Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with stable and continuous sources of health care are more likely to receive appropriate preventative care and immunizations. They are less likely to be hospitalized for preventable conditions and are more likely to be diagnosed early for chronic or disabling conditions. The AAP specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Ideally, medical home care is delivered within a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child, the family, and the child's health history. The Maternal Child Health Bureau uses the AAP definition of medical home. CMUs continue to link families to medical homes and document within CMRS all seven qualities essential to medical home care.

Updates continue to be made to CMRS to accommodate reporting, data collection, and tracking of medical home components. Having a primary care physician is the 'first step' in building the infrastructure of a medical home for CSHCN. The ESM of P*ercentage of CSHCN with a primary care physician* provides a baseline for programmatic needs to increase and identify the 'next steps' needed to establish medical homes for CSHCN. A medical home webpage on the Department's website includes a Shared Plan of Care (SPoC), and a medical home tool for families.

CSHCN with a medical home has been a priority for the SCHSCM program and continues to be supported by several partnerships and collaboratives. Having a primary care physician service identified in a child's Individualized Service Plan (ISP) developed with a case manager served as a medical home proxy beginning with 2014 reporting. As part of the Medical Home grant, SCHSCM and its partners developed the SPoC, a document meant to increase care coordination for CSHCN. This additional component was added to the medical home proxy in 2017 with reporting today for the relevant ESM. While a medical home is more comprehensive than just having a primary care physician, it is also imperative for a child to have consistent health insurance to increase access to the provider.

In SFY 2025, 27.4 % of the 15,526 children aged 0 to 18 years who received SCHSCM services had a primary care physician and/or SPoC documented (Table 7). This is slightly lower than the estimates for the National Survey of Children's Health of 31.6 for NJ and 40.1% for the US. The *percentage of CSHCN ages 0-18 years served by CMUs with a primary care physician and/or SPoC* has been selected as the related ESM. With the CMRS redesign, particularly the ISP modifications made in FY24 and FY25, as well as the roll out of the SCHSCM program policies for annual monitoring, these numbers should increase as the improvements strengthen consistency and measure reporting.

Table 7. NPM - *Percent of Children with Special Health Care Needs having a Medical Home*

	2021	2022	2023	2024	2025
Annual NPM #11 Indicator	46.6%	48.1%	41%	33.1%	27.4%
Numerator	4,865	5,543	5,221	4,885	4,249
Denominator	10,449	11,524	12,701	14,754	15,526

Data Provisional/Final	Final	Final	Final	Final	Final

*Note: Data above reflect CSHCN ages 0-18 years served by Special Child Health Services Case Management Units with a primary care physician and/or Shared Plan of Care.

Data Source - The NJ Special Child Health Services, Family Care Center Services

While SCHSCM data only include CSHCN who live in NJ and participate in the case management system, findings from state data show lower estimates than those of the NSCH. NSCH estimates the percentage of children (0-17) with special health care needs having a medical home is 31.6 (n=170) for the combined years of 2023 – 2024.

For many CSHCNs, a specialty provider often serves as the child's usual source of care, where care coordination becomes vital to ensure primary care services are not overlooked. Past chart reviews have shown that greater than 90% of CSHCN receiving services through SPSP grant-funded programs have a primary care physician listed. The Title V CMUs and pediatric specialty providers continue to provide a safety net for families of CSHCN.

Annual Report - NPM Transition to Adulthood

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

The NJ SCHS CMUs provide children and youth with special health care needs with transition to adulthood services up to their 22nd birthday. Data for these services provided by SFY are presented below. To measure the provision of transition services, children between the age of 12 to 17 who received transition to adulthood services at least once during their 12 to 17 years of age were included (Table 9). Among those who received transition services, 65% have an autism diagnosis. The data show that children with the most needs received the services multiple times. For 2023-2024, the NSCH estimates that 13.6 % (n=43) of adolescents with special health care needs, ages 12 through 17, received services necessary to make transitions to adult health

care in NJ. While CMUs provide no cost resources and referral services, many children may receive these services through their school; therefore, these two measures are not equivalent.

Table 9: Provision of Transition Service in NJ for Children with Special Health Care Needs Ages 12 to 17 years

	2021	2022	2023	2024	2025
Annual NPM #12 Indicator	85.0%	85.1%	85.9%	80.9%	78.6%
Numerator	1,468	1,413	1,408	1,491	1,517
Denominator	1,727	1,660	1,639	1,842	1,930
Data Provisional/Final	Final	Final	Final	Final	Final

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

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

Identification and monitoring of transition to adulthood for CSHCN and their families served through the CMUs statewide is ongoing. Transition packets continue to be updated, shared, and thoroughly reviewed with families, and linkage to community-based support is provided. SCHSCM state staff monitor the CMUs efforts to outreach CSHCN regarding transition to adulthood, including documentation of these goals on the ISP.

The CMUs will continue to facilitate the transition to adulthood for youth by ensuring that an appropriate transition goal is incorporated into the ISP. Additionally, CMUs will assess the needs of youth and their families related to insurance coverage, education, employment, and housing, and will coordinate linkages to relevant community-based partners to support a successful transition to adulthood.

Ongoing CMRS demonstrations stimulate active discussions about how SCHSCM documentation relates to continuous quality improvement (CQI) efforts and MCH Title V Block Grant reporting as the redesign continues. These demonstrations also inform SCHSCM and CMUs on areas for training to ensure consistent documentation methods, shifting from a lengthy narrative charting style to drop-down menus supported by brief entries that use shorter and more consistent terminology. Monthly meetings are held jointly with SCHSCM state staff and all 21 CMUs to provide additional CQI presentations highlighting progress, resources, and additional areas of improvement in documentation on the Core Outcomes.

CMUs and pediatric specialty providers will refer youth and/or their families to the NJ Council on Developmental Disabilities for participation in Partners in Policymaking self-advocacy training, as well as continuing to assist youth and their families in advocating for transitional support through their Individualized Education Plans and community-based supports. TVP will continue to participate in mock trials to facilitate the development of clients' self-advocacy skills.

CMUs largely noted documentation of transition to adulthood planning to occur on or about age 14. The discussion with families/youth about transition planning and the distribution of materials are documented in CMRS. An anecdotal observation by the case managers noted that families prefer to receive materials incrementally, rather than in one large packet filled with resources. That incremental method provides 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 (SSI), and/or health insurance, including Medicaid, Medicaid expansion, and/or private insurance or the Marketplace; education/job training supports; statewide systems of care including the Department of Human Services Division of Developmental Disabilities and/or the DCF's Children's System of Care Initiative, and others.

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

Furthermore, FCCS has begun to incorporate the NPM of *bullying* in the program. During SFY 2024, the FCCS program began setting the foundation of understanding bullying for the CSHCN population in NJ. During SFY25, FCCS staff surveyed the SCHSCM program Case Managers to understand how CSHCN bullying victim and perpetrator incidents are reported and documented in CMRS, as well as what resources and trainings were need for Case Managers to assist families in either situation. In March 2025, formal bullying training was provided to SCHSCM staff providing resources on CSHCN victims and perpetrators. With the completion of the CMRS redesign, during SFY26, the SCHSCM will work with CMUs in documenting bullying case management actions in the ISPs of families served.

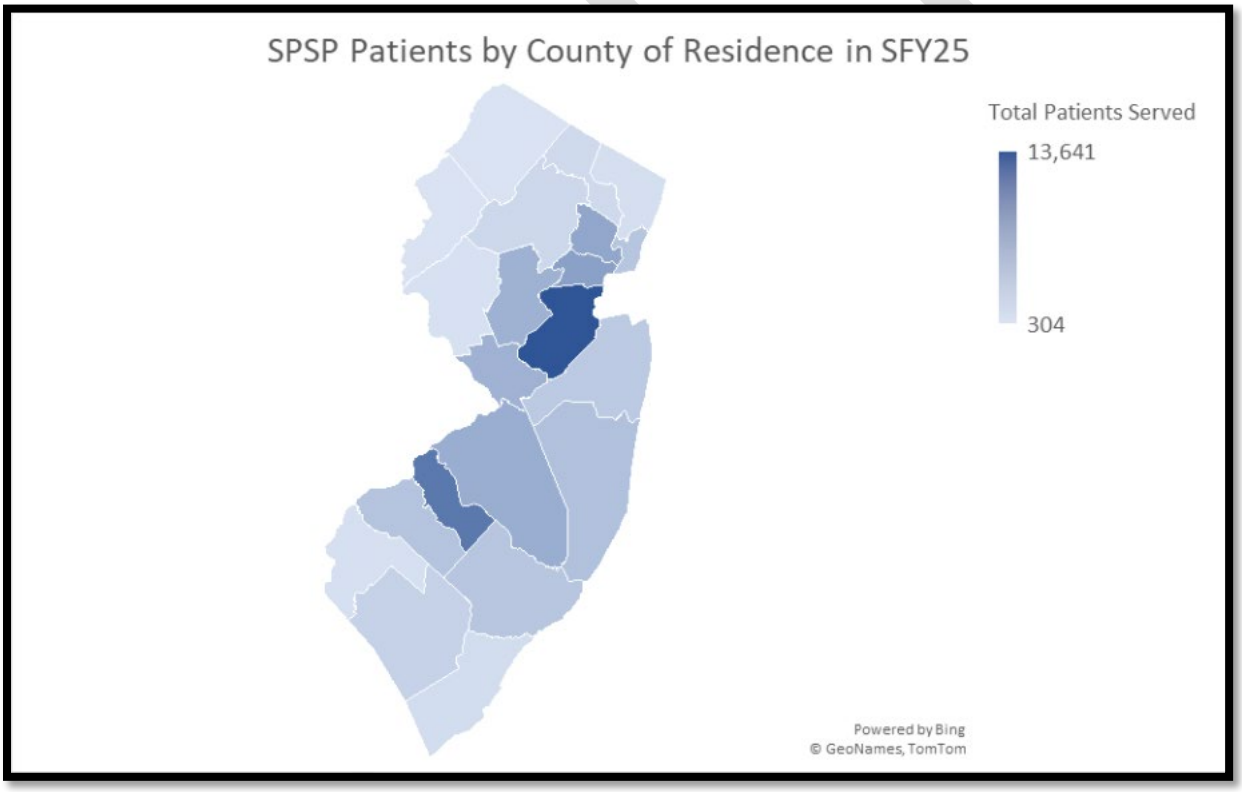
Through an agreement with SPAN, the Family WRAP (Wisdom, Resources, and Parent to Parent) project provides information, resources, and one-to-one family support that are directly helpful to clients active in SCHSCM. In FY25, the SPAN Family Resource Specialists spent over 705 hours engaging with families. The communication methods were phone calls, emails, or in-person Individualized Education Program (IEP) or education planning meetings.

SCHSCM maintains its partnership with AutismNJ to provide support to case managers for children active in SCHSCM who have a primary diagnosis of ASD. In SFY25, FCCS and AutismNJ partnered to launch the Emerging Challenging Behaviors (ECB) Program as a pilot initiative. This program is designed to offer an additional layer of support, with a focus on autism and behavior, to families of children in SCHSCM who are displaying challenging behaviors. The pilot began by identifying and referring children aged five and has since expanded to include children aged four through eight. The ECB program has received referrals from 18 of the 21 NJ counties. A short-term consultation model has been added to address the needs of families whose children fall outside the age criteria of the ECB program. A Board-Certified and Licensed Behavior Analyst was officially onboarded in FCCS in October 2024. There have been 62 referrals made through CMRS, and a total of 39 families enrolled in the ECB program as of February 2026, five of which are non-English speaking. In FY25, there were 147 family meetings. This program provides families with clinical expertise to address and mitigate emerging challenging behaviors before they become severely challenging and significantly impact on the child's and family's safety and quality of life.

The adolescent subset of CSHCN served through TVP remained relatively the same between SFY 2024 and SFY 2025. In SFY25, the most common diagnoses seen at the Child Evaluation Centers are Autism/ASD (18%), Attention Deficit/Hyperactivity Disorder (16%), and speech delay/disorders (12%). The top clinical services utilized by the Craniofacial patients are Plastic Surgery and Nursing (14% each), Speech/Language and Orthodontics (12% each) and Pediatrics (8%). The top clinical services utilized by Tertiary patients are General Pediatrics (13%), Orthopedics (12%) and Oncology (8%). The SPSP providers engage with adolescents and their families to facilitate transition to adult services. Transition to adult health

care primarily includes discussions about the importance of adult care, sharing resources regarding genetics, family medicine, adult care providers, support groups, and other medical and social-emotional related needs. The linkage of CSHCN to multidisciplinary team members, including social work and other community-based systems such as SCHSCM, SPAN, and disability-specific organizations, including the Arc of NJ, Tourette Association of America, and NJ Parents' Caucus, are resources utilized by the SPSP agencies. The SPSP collaborates with each grantee to ensure the definition of transition to adult care is established at each site, and that practice policies regarding transition to adult health care are created and implemented. Furthermore, Figure 17 represents the SPSP patients served in FY25 by county of residence across Child Evaluation, Cleft Lip/Palate Craniofacial, and Pediatric Tertiary Care Centers, demonstrating that all 21 counties are served by SPSP.

Figure 17. SPSP Patients by County of Residence in SFY25



Aligned with the TVP, programs and funded by Part D of the Ryan White Care Act, the NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to Women, Infants, Children and Youth (WICY) and families infected and affected by HIV disease in the State. There is ongoing collaboration across systems within the Division of FHS MCH and CSHCN'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, 177 were

living with HIV/AIDS, and of children 0-12 years, 23 were living with HIV/AIDS in 2024. Through diligent efforts to treat and educate HIV-infected pregnant women, the perinatal transmission rate in NJ remains very low. Intensive case management and appropriate antiretroviral therapy enable children with HIV to survive and successfully transition into adulthood.

Early Identification and Monitoring (EIM)

Within the EIM program, the EDHI program is responsible for SPM #3- *Newborn Hearing Screening*, the BDR ensures that children registered with Birth Defects are referred to Special Child Health Services Case Management, and the Autism Registry monitors the age of initial autism diagnosis (SPM #5).

Annual Report- SPM# 3 Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening, and have outpatient audiological follow-up documented Table 10.

The NJ EHDI program has processes in place to help ensure that all children who do not pass newborn hearing screening receive follow up screening in alignment with national EHDI guidelines. These diagnostic audiologic evaluations take place prior to three months of age for infants and ensure that any child who goes on to be diagnosed with hearing loss is enrolled in Early Intervention no later than six months of age.

Provisional data for SFY2025 indicates that 71.3% of infants who did not pass their initial newborn hearing screening prior to discharge from the birthing hospitals had a documented outpatient audiological follow-up visit. Since follow-up exams are still occurring on children born at the end of calendar year 2025, it is expected that the rate will increase when final data are available. We anticipate that the final rate will be level with prior years and exceed the target. The program also monitors the follow-up rates by certain populations to reduce any differences in outcomes.

Table 10. SPM: Percentage of Newborns who are Discharged from NJ Hospitals, Reside in NJ, Did not pass their newborn hearing screening, and had a Documented Outpatient Audiological Follow-Up Visit.

	2021	2022	2023	2024	2025*
Annual SPM#3 Indicator	81.0%	87.0%	85.3%	85.4%	71.3%
Numerator	1397	1726	1728	1767	1429
Denominator	1724	1984	2026	2069	2004
Data Provisional or Final	Final	Final	Final	Final	Provisional

*Note Final rate is expected to exceed this rate.

Birthing facilities are required to make at least one contact with families to remind them of the need for follow-up. Additionally, an Outreach Coordinator funded by the EHDI program contact families to ensure follow-up visits take place. Barriers to follow-up efforts include disconnected phone numbers, undeliverable returned mail, and unanswered voicemail messages. Other families do not have follow-up testing completed despite contacts made by the hospital or Outreach Coordinator. Barriers can include lack of insurance, transportation or childcare issues preventing travel to an outpatient audiology appointment, or parents not feeling follow-up testing is important because the child appears to respond to sounds around the home.

The program strives for 100% follow-up and to eliminate any difference across the groups. To reach as many groups as possible, and reduce lost to follow-up, the EHDI program *Newborn Hearing Screening* brochure is provided to birth facilities to distribute to all families. The brochure is in English and provides information on newborn hearing screening and follow up. A QR code is provided on the EHDI Newborn Hearing Screening brochure for access on the EHDI website to the brochure translated into ten languages. The brochure explains the importance of and the process of newborn hearing screening as well as the importance of follow up if a baby did not get a pass on the newborn hearing screening.

The EHDI program is responsible for assuring newborn hearing screening goals are met, including ensuring timely and ear-specific audiological follow-up for children that did not pass the initial screening. All outpatient audiologic reporting to the EHDI program continues to be submitted via an EHDI module in the NJIIS which had a complete system rebuild and modification to the EHDI module improve the information collected about follow-up contacts with parents.

In 2025, the NJ DOH used HRSA EHDI grant funding to support the NJ Deaf Mentor Program and for Family Based Organization Resource Parent services to conduct follow-up phone calls to parents, physicians, and birth facilities of children who need hearing follow-up.
The EHDI Monthly Reconciliation Report was distributed to individual birthing facilities detailing children still in need of additional audiological follow-up after not passing inpatient hearing screening. These reports serve as a notice to the hospitals of babies who still need follow-up. Additionally, the annual report includes statistics comparing the individual hospitals to statewide statistical average.

The annual EHDI Audiology Facility Report was provided to audiology facilities with feedback on their timeliness of follow-up for children who did not pass their inpatient hearing screening. The report also includes statistics on the timeliness and completeness of the documentation of their results.

The annual EHDI Midwife Report was provided to all midwives providing information about the requirement to advise parents about the mandated hearing screening and comparisons of the newborn hearing screening outcomes of their deliveries in 2024 with the statewide averages for home deliveries.

The Hearing Evaluation Council, a commissioner-appointed advisory board to the NJ EHDI program, held three meetings. The council is made up of physicians (a pediatrician and

otolaryngologist), an audiologist, a child of Deaf or Hard of Hearing adults, a member of the Deaf community, a Hard of Hearing individual, and NJ residents interested in the welfare of Deaf and Hard of Hearing Children (including a parent of Deaf and Hard of Hearing children and a teacher of the Deaf and Hard of Hearing).

The EHDI Advisory Committee met twice. Members represent health care professionals, parents/families of deaf or hard of hearing children, individuals that are deaf or hard of hearing, as well as various state programs. The meeting provides an opportunity for members to provide information, build partnerships, share concerns, and offer input to the EHDI Program.
The EHDI program provided 'next steps' letters to pediatricians and families who have a child with a newly diagnosed hearing loss. The next steps letter shares recommended follow up and encourages pediatricians to report those actions to the EHDI program. The family letter was edited to be more visually appealing, family-friendly and updated with current family support information.

The EHDI Coordinator participated as faculty for the AAP Extension for Community Healthcare Outcomes (ECHO) Program It Takes a Village: Provider Partnerships to support Deaf/Hard of Hearing Children and Their Families, and as a presenter for session 4 Every Step Counts: Reducing LTF/LTD Through Cross-Disciplinary Collaboration.

The EHDI Program hosted two interns, each bringing unique perspectives and expertise to the program. The first intern is a student pursuing a degree in public health, learning about community health initiatives and public policy. The second intern, who has a hearing loss, is studying to become a Teacher of the Deaf and Hard of Hearing. This intern offered a profound understanding of the challenges and needs of Deaf and Hard of Hearing individuals.

Annual Report- SPM Percent of 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.

The BDARS links registered children electronically via an interface with the CMRS system so that they are offered services through the county-based Special Child Health Services CMUs (Table 11). Case managers are electronically notified when a child has been registered and released for follow-up. Case managers use CMRS to create and modify ISPs, track services, create a record of each contact with the child's family, create standardized quarterly reports and register previously unregistered children.

The annual state performance indicator below has consistently exceeded the annual objective for all the reported years (see table below.) While multiple attempts are made to engage children who are referred from the BDR, not all children with a mandated reportable condition will need case management service. Specifically, children with conditions that are corrected at birth such as hypospadias and would not need ongoing supports.

Table 11. SPM - 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 who are Receiving Services

State Provided Data	2021	2022	2023	2024	2025
Annual objective	66%	67%	68%	69%	70%
Annual Indicator	63.0%	68.5%	72.8%	68.6%	58.6%
Numerator	4277	5314	5830	6759	5387
Denominator	6788	7760	8007	9857	9196
Provisional or Final	Final	Final	Final	Final	Final

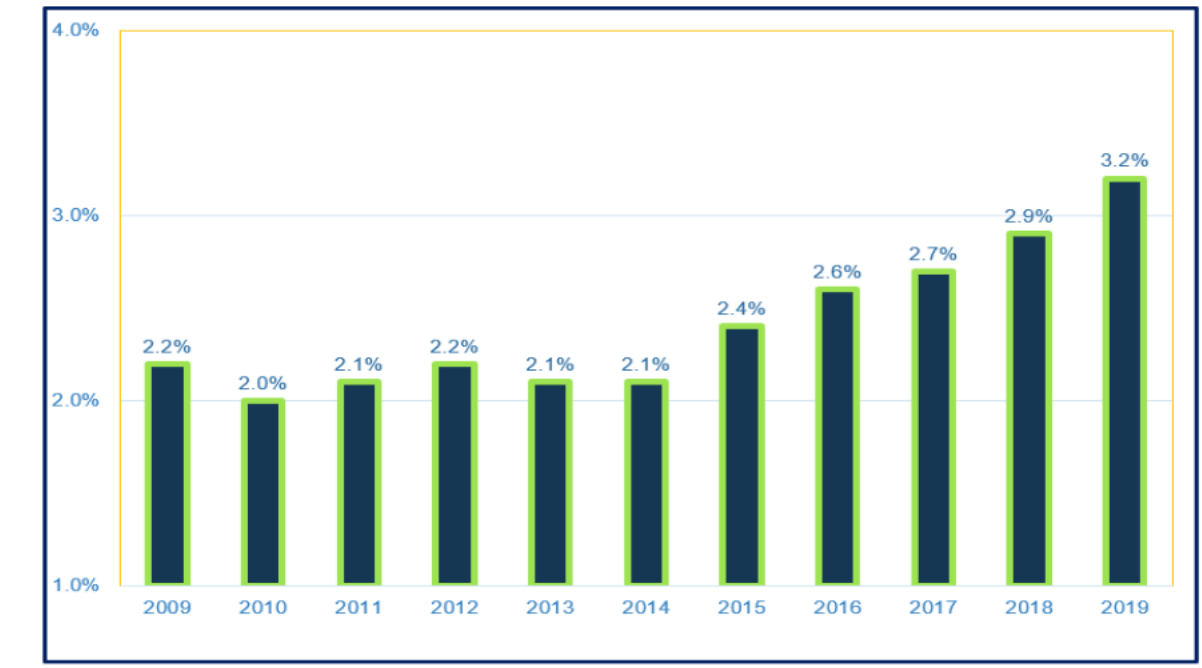
*Data Source- The NJ Special Child Health Services, Family Care Center Services
Note: The numerator reflects all children who received case management services while the denominator represents all children released to case management.

BDAR and SCHSCM staff collaborate to improve the system's functionality, ease of use, and efficiency. CMRS allows CMUs to receive registrations in real time, enables faster family contact, and more rapidly assists a registered child gaining access to appropriate health, education and other resources and services. SCHSCM staff perform annual reviews of electronic records in CMRS to assess key functions and expectations of the CMUs and evaluate Individual Service Plans to assess linkage to services. SCHSCM 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.

NJ Autism Registry

The Autism Registry monitors prevalence of ASD in all 21 NJ counties. Health care providers who diagnose or provide routine health care (such as pediatricians) for children with autism up to age 22 are required to register or ensure those children have been registered. The Registry collects information via the BDARS which provides secure online access to health care providers. In addition to demographic information such as the child's age, race/ethnicity and county of residence, the Autism Registry collects data related to risk factors such as the child's birthweight, gestational age, and the age of the parents. Additional data fields request information related to autism severity such as the child's verbal abilities, behavioral symptoms, the presence of intellectual disabilities and mood disorders, sensory disorders, and other signs and symptoms associated with autism. Figure 18 shows changes over time in the overall autism prevalence rates for children born between 2009 and 2019. For the birth cohorts after 2014, there was a steady rise in prevalence. Registry staff have been examining this divergence. Registry staff are examining this rise which could be associated with increased screening and diagnostic efforts and/or an increased number of children with autism, and/or an expansion of who are included in the spectrum.

Figure 18. Autism Spectrum Disorder Prevalence Rates by Birth Year



The Autism Registry can provide reliable information for autism for children born between 2003 through 2021. Since some children are diagnosed later than others, looking at the entire overall prevalence of children with autism is helpful for policy planning, service providers, and others who support families with children on the spectrum. The overall average prevalence of autism for all children was 2.4%.

In 2024, Autism Registry staff performed analytics on total autism rates and other metrics for each NJ county as compared to the state overall. Staff used this data to create a snapshot or profile of registry data for each county, which was posted to the Registry website and disseminated to stakeholders. Some counties show a higher prevalence rate than the State overall, while some are lower. The range across counties varies from 1.6% in Bergen County to 3.3% for Atlantic County. These variations may shift over time and families with children with autism might also move to location and school districts that have more robust services. Certainly, this supports the need to analyze by subgroups.

Other metrics examined include presence of known perinatal risk factors (low birth weight, multiple birth, and maternal age >35) for children with and without autism in each county compared to children with and without autism in the State overall. The profiles include the average age at which a child is diagnosed in a county compared to the State and examine the percentage of children who were able to receive a diagnosis in the county where they reside or if they had to travel elsewhere (compared to the State overall). The profiles were developed to help families learn more about autism in their communities and the resources available to them, and to help public and private agencies plan for programs and services for people with autism.

Annual Report- SPM Average age (in years) of initial diagnosis for children with an Autism Spectrum Disorder was chosen to measure the timeliness of diagnosing autism in children (Table 12). Early diagnosis is important for initiation of services, as children who receive services at an early age have better functional outcomes. While the causes of autism are not known, receiving intensive services early in a child's life can improve development in speech, cognitive, and motor skills. Appropriate diagnosis at an early age is an important precursor to ensuring that families gain access to early and intensive intervention.

In 2025, there were over 4,900 children diagnosed with autism. The average age of initial autism diagnosis is 5.5 years old. The current average age of 5.5 indicates an increase from last year, also higher than the previous three years (2021-2024). While the average age of initial symptoms being noticed is consistent at 2.3 yrs across the population of children with autism, there were differences in age at diagnosis. Black children are less likely to get diagnosed before 36 months (35.9%) versus White (39.9%), Hispanic (42.5%), and Asian (38.2%) children.

Table 12. SPM Average age (in years) of Initial Diagnosis for Children with an Autism Spectrum Disorder

	2021	2022	2023	2024	2025
Annual Indicator SPM #5	4.7	4.6	5.1	5.1	5.5

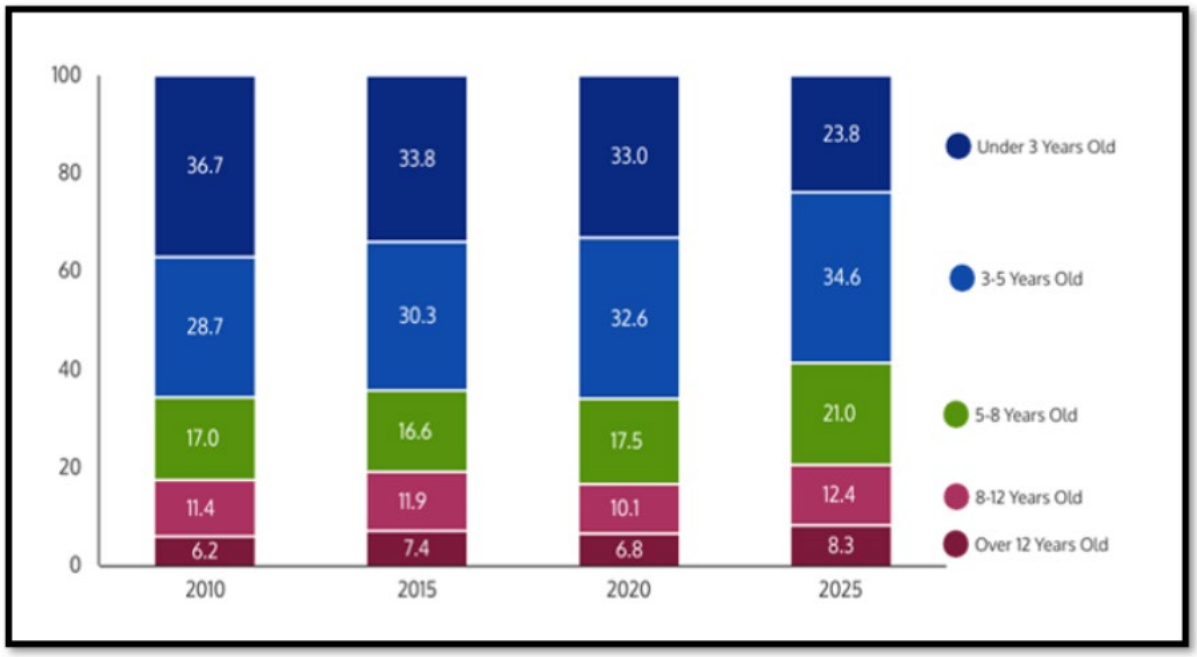
Many factors influence the age at which a child is first diagnosed with autism. The age at which signs are first exhibited or noticed by the family can vary and can be influenced by the family's experience with other children, knowledge about typical developmental milestones, or the types of delays or behavioral differences the child is experiencing. Children with more severe symptoms,such as no speech, extreme tantrums, stereotypical behavior such as hand flapping, or being unresponsive to social interaction, are likely to be evaluated and diagnosed earlier than those with milder or more nuanced symptoms. Cultural differences and expectations of child behavior can also play a role. Other family members and even PCPs may advise parents of very young children to take a "wait and see" approach when they raise concerns about atypical development. Even when providers do promptly advise families to seek an evaluation with a specialist, there can be long waiting times for appointments.

Additionally, screening efforts, identified risk factors, recognition of symptoms, availability of timely diagnostic evaluations, and concerns about labeling all contribute to variability in diagnosis timing. Children born during the early 2000s when the CDC began their prevalence studies were born during a time of heightened autism awareness programs, when early screening was becoming well established within primary care.

In Figure 19, we see 36.7% of children diagnosed in 2010 were under the age of three. However, over time we see more children being diagnosed later relative to younger children. This accounts for the rise in the average age of autism. There are several potential explanations. One is that earlier efforts to get children screened and diagnosed earlier are waning possibly due to autism

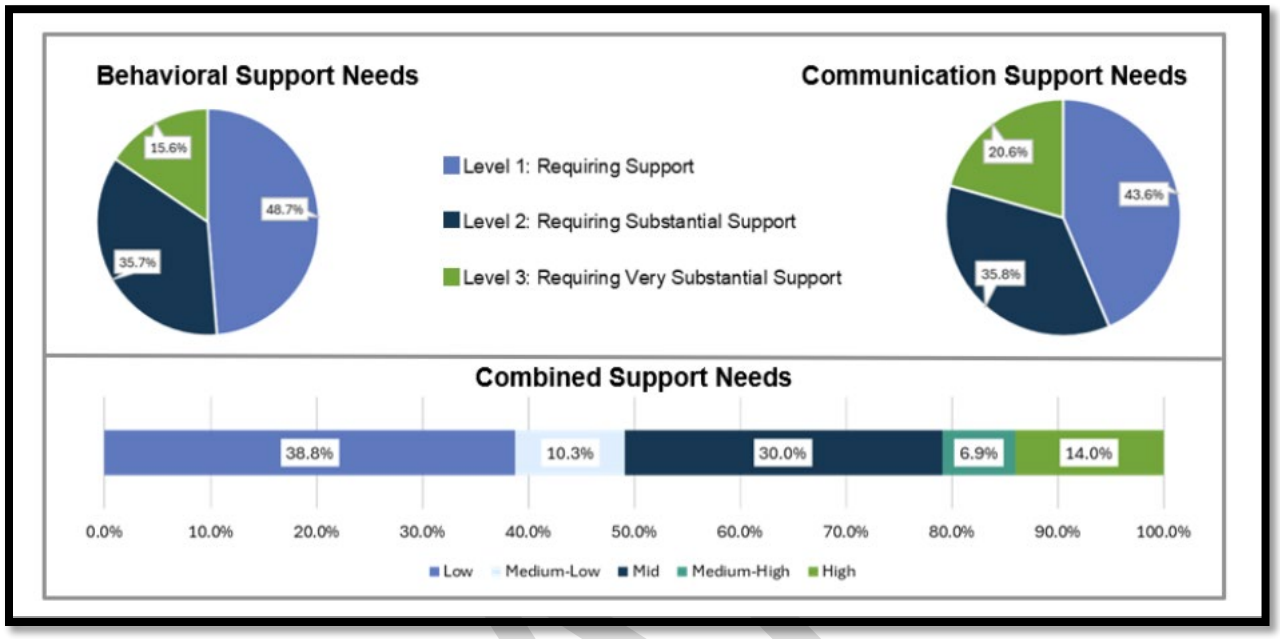
becoming more prevalent in the community. Secondly, the increasing number of children with autism continues to strain the availability of diagnostic opportunities. Third, more parents of older children are seeking a diagnosis as milder forms of autism and acceptance of neurodiversity are expanding the recognition of who has autism.

Figure 19. Age of Initial Autism Diagnosis for Children Diagnosed from 2010 to 2025



Autism Registry staff examined perinatal risk factors and identified that age of diagnosis was related to preterm delivery, plurality, and other conditions such as birth defects. Additionally, we looked at the DSM criteria for autism (see Figure 20.) The two support criteria provide a deeper understanding of the severity of autism. About 40% of children scored a Level 1 for Behavioral and Communication Support Needs criteria. When combined, the criteria show a continuum of support needs with about 40% at Level 1 on both criteria to 14% of children Requiring Very Substantial Support. These varying support needs could also impact on the age of diagnosis as children with higher needs being noticed and evaluated earlier than children with not nuanced symptoms who require less support.

Figure 20. Analysis of DSM-5 Defined Support Needs



To ensure the quality of the data, BDARS staff have conducted outreach to educate and inform physicians and health facilities about the Registry, how they can register children with autism living in NJ, and the rules regarding the Registry. Registry staff 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 also trained several psychiatric/behavioral departments located within hospitals. Another area of outreach was identifying telehealth providers who are licensed in NJ and provide diagnostic services. Staff notified the provider of the state mandate and provided instructions on how to register children.

Staff from the Registry presented information concerning the Autism Registry to state and county case managers as part of training on the case management electronic component of the BDARS. They continue to retrain new staff within health facilities as needed. Staff has also created materials for both providers and families about autism, and these materials have been translated into multiple languages, including Spanish, Korean, Polish, Hindi, and Arabic. There is also information about the Autism Registry on the NJDOH website, and staff continue to make conference presentations and exhibits.

The program will continue to address this performance measure by working with the NJ Chapter of the American Academy of Pediatrics and the Elizabeth M. Boggs Center on Developmental Disabilities, NJ's University Centers for Excellence in Developmental Disabilities, in reaching out to various health care providers and distributing information and trainings on the Learn the Signs, Act Early campaign that educates providers on childhood development, including early

warning signs of autism and other developmental disorders, as well as to encourage developmental screenings and intervention.

One of the most important BDARS changes this year was to include an MPI number. Basically, a unique identifier is created by an algorithm of the child's personal identification information. Many data systems such as the VERI system also include MPI numbers. This makes matching the data sets easier and more reliable. In addition, BDARS implemented a VERI ID (birth certificate number) association which adds the number to the child's registration (if born in NJ), and a newborn screening ID number if the child receives a diagnosis as part of newborn bloodspot screening.

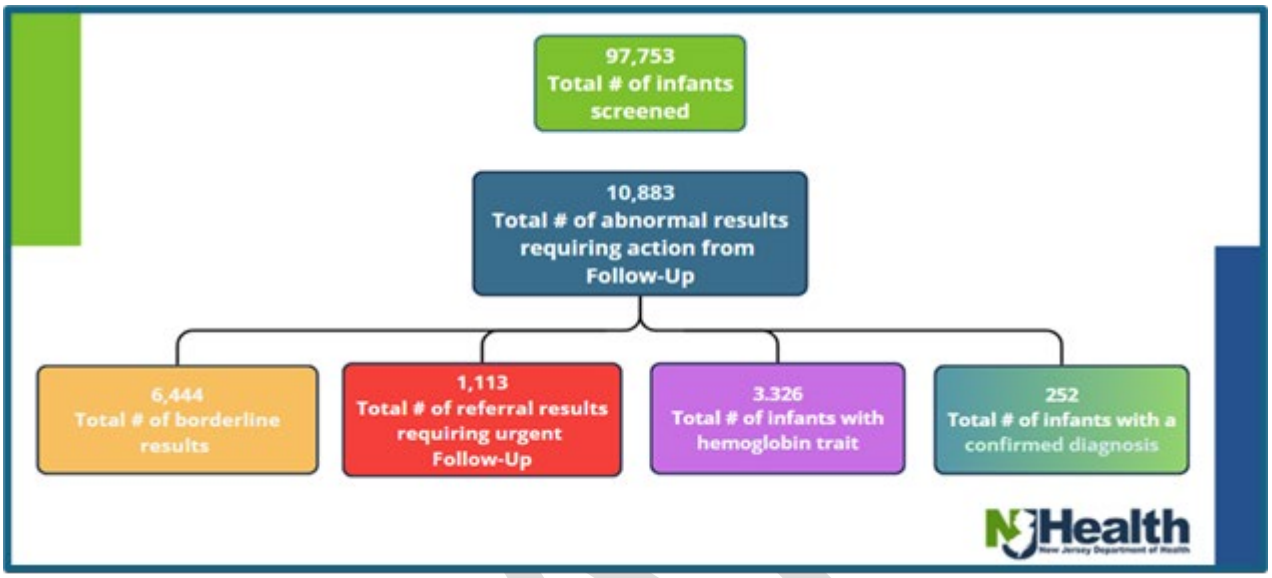
The BDR has successfully initiated a batch import process of diagnoses from the NBS program. Staff export an Excel file from the NBS program data system and BDR staff import the file data into the BDARS. The fields auto-populate, reducing data entry time. Staff nurses review the data for completeness, enter the ICD-10 codes for the diagnoses, and complete the registrations.

The BDR is currently piloting batch importing with several birth facilities, with plans to add more facilities through 2026. Hospital staff send a list of VERI ID (birth certificate) numbers to BDR staff, who then create new registrations with information imported directly from VERI, and reduce manual data entry. The system runs validation checks to prevent duplicate registration before creating a new one. The new registrations are then placed in a queue for review by the hospital staff, who enter any additional information and the birth defect diagnoses. Staff nurses then review each case and enter diagnostic codes before completing the registration.

Newborn Screening and Genetic Services

The NBS Program is in its 61st year and going strong. Calendar year 2025 was similar to past years. Over 97,000 babies were screened and close to 11,000 abnormal results were received by the short-term follow-up group (See Figure 21.) From this work, close to 250 children were confirmed to have a disorder from the NJ NBS panel. Children with confirmed diagnoses require continued care, and in line with State requirements, these children are registered in the BDAR that includes referral to the County Case Management services. Additionally, there were approximately 3,500 children identified as likely to be carriers of disease. These children are not registered in the BDR, but their families do receive a letter making them aware of their potential carrier status with recommendations for follow-up testing.

Figure 21. Newborn Screening Follow-Up in Numbers (2025)



NBS continued its commitment to program enhancement and team development through the ongoing "Rep Refreshers". These biweekly meetings, held with Public Health Representatives (Reps) as staffing and operational demands allow, provide a structured forum for case review, procedural updates, and collaborative problem-solving. During these sessions, staff discuss complex or challenging follow-up cases, review changes to policies and workflows, and ensure consistent application of program protocols. The meetings also serve as an opportunity to strengthen teamwork by coordinating coverage for vacations and staffing gaps, addressing workload challenges, and sharing practical strategies for locating hard-to-reach families and facilitating timely diagnostic follow-up. Reps regularly exchange tips and tricks that enhance efficiency and reinforce best practices across the team. Rep Refreshers have become an integral component of the program's ongoing performance strengthening efforts, fostering communication, consistency, and shared accountability in the unit's mission to ensure every newborn receives appropriate and timely follow-up care.

The program continues to focus on regular data analysis and review to identify trends and inform process updates that will reduce the strain on health care providers and the number of families impacted by false positive results. Due to this program, there has been a reduction in the number of urgent results reported through correlation of demographic information with confirmed case data. A review of condition specific NBS values and their outcomes have informed recommendations for cutoff updates, improved confirmed case profiles to better assess urgency for reporting, and demonstrated the need for better data collection practices, where a project to decrease the number of cases without a final disposition was launched. On the recommendation of the greater NBS community, the program has focused on improving

communication of abnormal NBS results with primary care providers by redesigning the referral report for significantly out of range results. The new report is integrated into the current workflow software and is meant to clearly communicate the urgency of results and the specific next steps using a consistent format that reduces transcription errors and time in creating the report.

In an effort to establish a system of LTFU for children identified through NBS, progress continued to be made in Year 3 of the NBS Propel grant. Active LTFU began in March of 2025. Outreach to families is done using a survey distribution tool through a public facing REDCap application, while data collection and analysis is conducted within a secure NJDOH REDCap environment. The current Laboratory Information Management System was configured to include a dedicated LTFU module which is used for record organization and workflow documentation. To date, the Long-term Follow up program has sent out 336 welcome letters, called 215 families, distributed 22 surveys, and received 8 completed surveys.

Stakeholder engagement is a strength of the NBS Program. In SFY2025, the program provided 12 health services grants to support the efforts of Follow Up, to help ensure access to services. These health services grants provide funds to 32 individual specialty programs to support their clinical services for the children identified through NBS and those who need ongoing services. The grants fund clinical programs for cystic fibrosis, sickle cell and other hemoglobinopathies, endocrine, genetic, immunologic, metabolic, and lysosomal disorders. While there is not yet funding for cardiac care, the NSARC subcommittees have grown to include a subcommittee for CCHD, bringing the total number of subcommittees to seven. The CCHD subcommittee is established and focused on implementing the newly adopted AAP pulse oximetry screening for CCHD algorithm. NSARC and all seven subcommittees meet at least twice a year in the spring and fall. The grantees and specialty committees help to strengthen the overall quality and capacity of services available in NJ.

Data Systems and Emerging Threats (DSET)

The DSET unit works to improve the collection and use of data to meet SCHS program needs and to improve interoperability. In 2024, the staff worked with internal and external partners to implement the use of a MPI with the BDAR and EHDI records. The MPI project began with other NJDOH units and the NJ Institute of Technology (NJIT) establishing a process to create a unique patient identifier for health encounters in NJ. The project has previously used data from hospital admissions, hospital billing, birth certificates, and the immunization registry to identify unique individuals as assign a common key, the MPI, that can be used to link cases across data sets. The BDAR records now receive an MPI assignment, and the identifier is maintained in the BDAR data system. The EHDI program's outpatient audiology testing results are reported in a module in the state's immunization registry and DSET staff worked to get the MPI already assigned to all immunization records included in the EHDI data extracts for use in matching with birth certificate and BDARS records.

During 2024, DSET staff have also begun a process to integrate electronic Case Report (eCR) data into BDARS. Meetings with staff from CDC and APHL have identified the opportunity to use data files currently being received by the NJDOH CDS program to obtain reports of birth defects from several NJ hospitals that are currently including that data in submissions to APHL. Project staff are currently working with CDS and IT staff to secure an additional data server so that files can be split for different programs to use.

DSET also manages the CDC-funded Surveillance for Emerging Threats to Pregnant Persons and Infants (SET-NET) grant. During 2024, the program finalized data submission to CDC on 338 cases of syphilis during pregnancy from 2018-2021, tracking children through their age two well child visits. The project then identified additional 160 cases of affected pregnancies from 2022 and began the record review on those cases. Congenital CMV is the other SET-NET monitored exposure. During 2024, 197 charts were reviewed to identify 68 cases meeting the criteria. Those cases are being tracked through the child's third birthday for CDC data submission. The project is also beginning additional efforts to conduct outreach to those families through the child's sixth birthday to document additional family outcomes and needs.

The program has remained alert for other potential exposures of concern, staying abreast of increasing rates of parvovirus in the United State and awareness of travel-associated viruses such as oropouche, mpox, and dengue. The program stays in contact with staff from CDS, who will alert SCHS if pregnancy cases of emerging disease are identified.

CSHCN Application Year

While the NJ CSHCN program has many strong areas of service, there will be an enhanced focus on efforts to address population differences such urban, suburban, and rural communities and economic differences, and a robust new commerce. While for many years, the NJDOH has been an important partner with the state universities' clinical training programs, county and local health departments, and foundations that support the health of New Jerseyans, and countless community organizations such as Family Voices, SPAN, Autism NJ, there continues to be more work to be done.

In the coming year, the CSHCNs program plans to increase efforts with Medicaid to ensure better financing of services which will improve the quality of life for the state's children and their families and ensure access to care. Programs plan to expand their efforts to engage families and people with lived experience. The long-term follow-up efforts will be expanding. The registries will also be launching new audit processes to ensure that data are complete, and no child is delayed or not connected to services due to providers not registering appropriately. Lastly, there is a plan to provide more public facing information so that providers, families, policymakers, and other stakeholders learn more about programs and services, more about the

populations that serviced, and more about the potential epidemiological information provided about the conditions which we monitor.

Early Hearing Detection and Intervention

Selected during the last Five-Year Needs Assessment, 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* remains an important measure to assess. While initial newborn hearing screening rates are extremely high, for those newborns who fail this screening, it's vital to ensure that they receive follow-up testing. There continues to be much room for improvement.

The EHDI program will continue with a continuation of current efforts such as follow-up phone calls to parents and physicians of children needing hearing follow-ups, sending hospital-level surveillance data to NJ birthing hospitals and distributing the audiology facility reports to highlight the timeliness of follow-up and identify children with incomplete follow-up testing.

The EHDI program plans to continue working with medical homes to ensure that children receive timely and appropriate follow-up after a referred hearing screening or inconclusive follow-up testing. An extract available in the NJIIS allows the EHDI program to identify the name, address, and fax number of the medical home provider that has most recently provided immunization data for a child and will provide this information to the NJ American Association of Pediatricians Chapter Champion so she can contact provider offices to remind them to refer children for additional follow-up as needed and obtain hearing screening results when possible.

The program will also continue to collaborate with the EI (Early Intervention) Hearing Consultants, currently funded by NJEIS, by coordinating outreach regarding timely referrals of children with hearing loss to Early Intervention. The Hearing Consultants created a presentation for Early Intervention providers to increase collaboration between hearing consultants and service coordinators, ensuring timely and appropriate services for infants and toddlers. The three NJ Hearing Consultants will be presenting this information to groups of EI providers over the next year.

Since 2018, the HRSA EHDI grant-supported Deaf Mentor Program has engaged Deaf or Hard of Hearing Adults to provide support to families of children newly identified with hearing loss. The program will be planning a family event in the upcoming grant year to celebrate the growth of the program. The EHDI Coordinator will continue to enhance family support, as the parent of two adult sons who are deafblind, by contacting families to assess their specific needs, identify existing support systems, and determine any additional services required.

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 decreasing the number of children lost to follow-up. The EHDI program frequently uses online meeting platforms to make educational outreach efforts more accessible to the target audiences, reduce staff travel time, and improve efficiency while decreasing costs. The EHDI Coordinator will be meeting with successful birth facilities to develop instructional materials on ensuring hearing screenings are completed by one month of age for statewide dissemination.

Utilizing enhanced EHDI grant funds from HRSA, the program is currently developing an "EHDI Innovations Project" to further enhance its "0-3 Expansion Plan." The program will partner with three early childhood programs for Deaf/Hard of Hearing children to collect and evaluate language acquisition outcomes using multiple standardized tests that are norm-referenced for young children. Additionally, the program is partnering with the University of Colorado Early Language Outcomes Lab to data analysis.

Regarding CMV/pediatric hearing loss awareness/prevention, NJ EHDI has updated its brochure with public service information in multiple languages geared toward women of childbearing age. In 2021, NJ law (P.L. 2021, c.413) requires all infants born in NJ to be screened for cCMV. This legislation also requires the establishment of a public awareness campaign to educate New Jerseyans on the value of early detection, intervention, and treatment options for children diagnosed with this condition. cCMV is the most common congenital infection in the United States, with approximately 1 in 200 children born with this condition or approximately 30,000 children born yearly. According to the CDC, 10–20% of children born with cCMV will go on to have neurodevelopmental disabilities, including sensorineural hearing loss. The unit's CMV staff are working with the Communications office to provide them with materials and to connect them to the national organization.

Representatives from NSARC and the Hearing Evaluation Council for the NJ EHDI Program are currently developing condition readiness criteria for NJ's NBS Panel to be presented at the May 2024 meeting of NSARC. In addition to surveying State birthing facilities regarding cCMV screening practices, the NJDOH is also participating in a national survey from the CDC regarding cCMV surveillance activities in the state.

The screening of cCMV through the state newborn blood spot screening program has been on hold for several reasons. The laboratory is waiting for cCMV to be added to the RUSP, and the filter paper used to collect the blood spot needs to be changed to collect an additional spot to support the test process. In the interim, a few hospitals are testing for cCMV if there are indications at birth that suggest the condition. An ad hoc committee that includes different groups of health care professionals and NJDOH staff who share an interest in this topic has been

meeting regularly to investigate evidence-based universal cCMV screening protocols and formulate follow-up guidelines for those children in NJ who have tested positive for this diagnosis.

The EHDI program recently recommended four new members to the Hearing Evaluation Council for appointment by the Commissioner. They will begin their tenure by attending the first 2025 Hearing Evaluation Council meeting. The new members, in accordance with the statute, represent individuals and parents in the deaf and hard-of-hearing community. They will offer their unique perspective on the needs of families with children who have hearing loss and include an adult with hearing loss and three parents who have a deaf or hard of hearing child representing different communication choices and use of hearing technology.

The EHDI program also convenes the EHDI Advisory Council annually. The council is composed of stakeholders in the EHDI system that includes health care professionals, parents of deaf and hard of hearing children, individuals who are Deaf/Hard of Hearing, and various state program representatives. The council met in May 2025 to finalize the EHDI infrastructure report for submission to the HRSA. The objective of the report is to highlight the EHDI system's key strengths and challenges, and to propose strategies for building and sustaining an infrastructure that supports the national 1-3-6 benchmarks (screening, identification, and enrollment in Early Intervention) and improving language outcomes for Deaf/Hard of Hearing children.

Birth Defects Registry

SPM - *Percent of live children registered with the Birth Defects and Autism Reporting System who have been referred to NJ's Special Child Health Services Case Management Unit and are receiving services* was chosen to improve the timeliness and effectiveness of the BDARS. The system has been an invaluable tool for surveillance, needs assessment, service planning, research, and linking families to services. Through CDC funding, the BDARS continues to be upgraded and improved. BDARS staff has developed a training schedule to ensure that staff at birthing facilities, autism centers, audiologists, and other agencies who use the revised electronic BDARS and its modules are trained on how to properly complete the data fields that are specific to birth defects and autism registrations. Staff will continue to assist reporting agencies with individual inquiries and concerns and provide training to new users if needed in between regularly scheduled training sessions. In addition, BDARS staff will continue to review the quality of the data in the BDARS and its modules and ensure completeness through data matching with other DOH sources such as the electronic birth certificate system.

Another initiative of the BDR is an agreement with the Children's Hospital of Philadelphia to ensure that NJ children who are transferred to or born at the hospital are included in the BDR if they are diagnosed with a birth defect. The children receiving care are usually those with the

most complex birth defects and otherwise may not be referred to case management or be identified in NJ's surveillance activities. BDR staff nurses undergo security clearance checks and a series of training courses prior to being provided with access to the Children's Hospital electronic medical records. They conduct chart abstractions on cases identified by the hospital and enter them into the BDARS. We studied the impact of including this group of children in the birth defects surveillance program and presented this at 2025 National Birth Defects Prevention Network Conference. To date, Birth Defects Registry staff nurses reviewed 3,207 charts and added 1,363 new registrations for children born between 2021 and 2024. Each of these new cases was referred to Case Management, offering more families the opportunity to benefit from this service. Staff nurses are currently reviewing charts for 378 potential new registrations and potential updates for 117 existing cases for children born in 2025.

In the coming year, BDR staff will be launching a new audit process that capitalizes on the ability to request access to electronic medical records remotely to review charts that have been selected for review in the audit. Reasons for chart review would include failure to register a child with a registerable condition, or discrepancies between the audit data sent by the facility and the information entered in the BDARS. During the audit cycle, staff first notify key hospital staff and administrators in writing that an audit will take place and explain the phases and associated dates. Instructions include a request for a data file containing names, medical record numbers and other demographic information to be sent in a secure file for all children whose medical records contain specific ICD-10 codes for specific time frames during a multi-year period. Staff then match the list to the BDARS to check for agreement between them (both the names of the children and the diagnoses). Additional quality assurance measures include completeness of the records' data fields. After accessing charts for additional reviews, staff provide verbal and written feedback to the facilities on their compliance during a summation session and will discuss further action/remediation plans if needed.

Autism Registry

As we report on SPM # 5 *Average age [in years] of initial diagnosis for children with Autism Spectrum Disorder*, we rely on the quality of the data from the diagnosticians and medical home providers to ensure that the statistics are correct. The Autism Registry is actively auditing diagnostic facilities to ensure that all children are being registered and to improve the quality of the information about the diagnosis. The audit cycle is similar to that of the BDR. A particular focus will be on the completeness of details of the diagnosis. The Autism Registry staff are planning a series of training courses for facilities that will focus on navigating the BDARS system and completing registrations to ensure data quality. Training materials will be available to participants. Staff are in the planning phase of adding batch import capability to autism providers, similar to the process currently being rolled out to hospitals for the Birth Defects Registry.

The primary purpose of our work in this realm has been to decrease the average age of diagnosis, but that has been a difficult task for several reasons. While we support early screening efforts, we also recognized the nuances and complexity of the presentation of autism. Getting improved data on the DSM5 criteria scores, symptoms, and co-occurring conditions will provide a better understanding of the needs of children with ASD and prevalence across the state.

With over 60,000 autism registrations, this robust data source can be used to examine epidemiological factors that might be related to autism, identify new risk factors, and better describe the need and diagnostic experiences of children with autism. This year, three research projects are underway. The first is to examine factors that influence the age of diagnosis. There are many factors such as the scarcity of diagnosticians, cultural reasons that influence health seeking behaviors, and perinatal risk factors which impact the age of diagnosis. The level of support needed as a way to measure severity of autism will be considered. While small datasets often have mixed findings because of the breadth of phenotypic types of autism presentation, a large population-based data set would be able to control differences. The second study is in collaboration with a Rutgers University professor and focuses on the concordance rates among twins. The impact of chorionicity and amnionicity will be examined. The teams expect the concordance rates to be ~10-30% in the dizygotic twins and ~60-90% in the monozygotic twins. An additional project is to study the prevalence of autism among children who were born to mothers who tested positive for COVID-19 during pregnancy. Since the DSET program was funded by the CDC to surveil over 9,000 maternal COVID cases and their infants developmental follow-up to through the six months well-baby visits, the autism rate of children born to mothers who had COVD during pregnancy compared to children born during the same time to mothers who did not have a positive PCR test will be determined.

Family Centered Care Services & Redesign of Case Management Referral System

FCCS received CDC-Enhancing Laboratory Capacity funding to redesign the CMRS system to improve performance on the Six Core Outcomes for CSHCN and promote targeted improvement to the documentation for all performance measures. The system redesign has developed numerous new features to help minimize the loss to follow up opportunities, improve intersystem communication, and streamline statewide documentation and services provided. The follow-up process used by CMs was enhanced to ensure that every eligible child registered in CMRS is assigned a Monitoring Date. Previously, follow-up dates were not mandatory for all eligible children, creating the risk that some children could be unintentionally missed in ongoing monitoring efforts. The new intercommunication feature provides units with a functional and efficient method for CMs to communicate both within and between units, as well as with other

CMRS users, including the Emerging Challenging Behaviors Case Manager and FCCS staff. By facilitating direct and immediate communication within CMRS, this enhancement streamlines information exchange and ensures successful collaboration.

The Individual Service Plan has been updated to reflect the services most frequently utilized, removing options that were rarely or never selected and consolidating and/or renaming others to improve clarity, efficiency, and overall workflow. These changes support clearer documentation and make it easier to access specific data points within ISP service categories. Building on this redesign, FCCS staff will continue to survey the population they serve and establish quality improvement and quality assurance measures to promote a more uniform and effective case management practice. The primary goals of this redesign are to improve the quality of data reporting and user experience and implement an acuity measurement tool. These improvements will allow for more robust reporting related to medical homes for the CSHCN population and improved data quality for adolescents served by SCHSCM. FCCS will use a weighted acuity scale that uses key information from CMRS, such as diagnosis, linkage to services, insurance information, medical home, and other critical indicators, to determine each child's acuity level in a clear, user-friendly format. The data will also allow FCCS staff to evaluate staffing of CMUs, identify communities of greater need, and determine each child's real-time level of need at-a-glance.

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

Improvement of Program Monitoring

On-site visits will be conducted at each CMU, as needed, to ensure proper usage of CMRS, adherence to program guidelines, and strengthen the relations with FCCS staff. This will allow more consistent use of the system linking referred families to services and refine tracking of Performance Measures. FCCS staff will continue providing ongoing statewide and individual feedback and technical assistance. Formal manuals and guides will be developed and shared at the conclusion of the redesign.

During FY26, FCCS staff completed the revision of program policies that will establish a more uniform standard of practice for SCHSCM to ensure consistent documentation in a child's electronic record across the state. The policies are in the process of review and approval in the state workflow management system. Uniform standards of practice across the state

will enhance statewide monitoring, service delivery, and aid the CMUs in providing comprehensive care in every county. Because some of the policies require legal review and approval, the policies will be implemented in FY27. The CMU staff currently follow timelines and guidelines outlined in their grant contract.

Emerging Challenging Behaviors

In FY27, FCCS will continue its collaboration with Autism NJ to address the clinical needs of families with children between four and eight years old diagnosed with ASD who are at risk for severe challenging behaviors. Following a successful pilot year in which a Board-Certified and Licensed Behavior Analyst served as the ECB Case Manager in collaboration with SCHS Case Managers, FCCS and Autism NJ plan to expand the ECB program by adding a second ECB Case Manager to support the program's continued growth and increasing impact. Autism NJ and FCCS staff developed the criteria and trained Case Managers in their use. Children are identified by their SCHS Case Manager via review of clinical criteria and electronic referral to the ECB Case Manager. Following identification, the ECB Case Manager engages with the family and determines next steps which include a comprehensive service review and identification of priorities to create an individualized plan. The goal of the project is to provide families with best practice information, evidence-based strategies, resources, and referrals to decrease the likelihood of severe challenging behaviors.

As of the beginning of 2026, there are 39 families enrolled in the ECB program. During FY25, there were a total of 147 family meetings led by the ECB Case Manager, some of which included the SCHS Case Manager, in addition to the family. Of these children enrolled, 27% received a diagnosis of Autism before age two, 31% received a diagnosis before age three, and 42% over age three. The ECB Case Manager has created a library of resources specific to the needs of the enrolled families. The most common topics in resources include, but are not limited to, school discipline in students with autism, effective homeschool collaboration, and understanding Applied Behavior Analysis (ABA) services. One of the families with a child who received a new diagnosis has reported:

"Thank you for the call and the articles and resources you shared, I already feel like I know more about how to help my son!"

In addition, the ECB Case Manager has assisted families in feeling more empowered and confident in advocating for their child in new ways. For example:

- Family #1: After a 63-minute intake call in which parents shared concerns about their child being treated fairly at school and looking for ways to effectively collaborate,

parents said, "*Thank you so much for your time and for this program. We feel validated and heard and are more hopeful after speaking with you.*"

- Family #2: A consultation call was conducted with the ECB Case Manager, SCHS Case Manager and parents to provide target support for a family with two young children, both with autism. The parents shared concerns about the younger child's increased aggressive behavior and expressed feeling overwhelmed while managing the needs of both children. The ECB Case Manager provided several resources for the family, including guidance on pursuing ABA services and what to expect from them, and a referral to Autism NJ's Health and Wellness connection sessions for support for the parents. The mother expressed appreciation for the support and reassurance of available resources, stating, "*Thank you so much. It can be very overwhelming and it's nice to know there is support available*." The SCHS Case Manager also noted the value of the consultation, sharing, "*That was phenomenal… I learned a lot just listening to you*."

Moving forward, we are planning to add an additional ECB Case Manager to assist more families. We will be expanding the ages eligible and working with Case Managers to identify the families who could benefit from this specialized service. As we monitor the number of children in case management with challenging behaviors or behavioral health diagnoses, we will provide more education to the case managers, identify additional services, and adjust the services to adapt to the needs of the children we serve.

CSHCN and Bullying

In SFY27, FCCS will implement its family survey to all SCHSCM families to understand the impact of bullying on their families. This will be a new NPM for the CSHCNs moving forward. According to the National Child Health Survey (2023-2024), 52.1% of all CSHCN ages 12-17 years old experienced bullying. The NJ estimate was similar at 46.1%. Additionally, of the same population nationwide, 18.7% of all CSHCN ages 12-17 bullied others, while in NJ the estimate of CSHCN who bullied others was 11.9%. During SFY25, FCCS surveyed SCHS Case Managers to establish the baseline of services currently available to assist families with children who are victims or perpetrators of bullying. Additionally, FCCS provided training to Case Managers on how to specifically assist CSHCN families. From the initial survey of SCHS Case Managers:

- 81% reported that children on their caseload have experienced bullying from other children. Parent/guardian reported mostly physical and verbal abuse.
- 27% reported that children on their caseload have bullied others. This bullying was either in-school or at home with sibling(s) or parent/guardian.

In SFY26, Bullying was added as a category in CMRS to identify CSHCN who are victims or perpetrators of bullying. This new addition will allow Case Managers to better identify, monitor, and refer families to the appropriate resources for further assistance.

Specialized Pediatric Services Program Clinics

In response to the national shortage of Developmental Behavioral Pediatricians, centers have implemented unique strategies to decrease the amount of wait times and the burden on existing Developmental Behavioral Pediatricians and Neurologists. Examples of these efforts include piloting a decision-making tree for schedulers, opening additional weekend office hours, increased Autism Diagnostic Observation Schedule (ADOS) training for eligible staff, partnering with internal and external stakeholders to address wait-time concerns, and limiting evaluations for second opinions.

NBS and Genetic Services

The NBS program continues to collaborate with internal and external stakeholders. Together with the lab, the Program will continue to provide in-service offerings for midwives and community birth providers, participate in Quality Improvement activities with the Association of Public Health Laboratories (APHL), and host bi-annual NSARC and Subcommittee meetings Staff will also continue to follow up on all newborns with out-of-range screening results and conduct long-term follow-up to better understand the experience of families engaged in the NBS community and to help ensure access to services and family and child well-being. The Follow up program will work on ways to improve LTFU for children identified through NBS. The program will focus on exploring additional methods of survey distribution such as text messaging and QR codes, to increase survey availability. The survey will also be translated into additional languages to expand accessibility. Alongside these efforts, the program has ambitions of enhancing family engagement and participation through attendance at community events.

Data Systems and Emerging Threats

The DSET team will continue to enhance data systems through increasing interoperability, including using electronic case report data. A new Data Use Agreement (DUA) with NJEIS services will be completed to include additional language acquisition measures needed for EHDI grants and will be reviewing other NJEIS Battelle data related to autism. The DSET staff will continue to work through the CDC grant on their emerging threats program to prevent fetal exposures to viruses such as syphilis and CMV and ensure appropriate services for families affected by those conditions.

Cross-Cutting Systems Annual Report

Oral Health

Children and Pregnant Women

This section addresses oral health as a cross-cutting domain because it includes two population domains - children and pregnant women. Specifically, this domain tracks the percent of women who had a dental visit during pregnancy, while related state-level monitoring supports broader system integration and access to care for children under the age of 17 through the Children Oral Health Program. Data for the measure on pregnant women is primarily derived from the Pregnancy Risk Assessment Monitoring System (PRAMS), a statewide surveillance system that captures maternal experiences before, during, and after pregnancy. According to recent PRAMS data, fewer than half of women in NJ receive dental care during pregnancy, with estimates generally in the 40–45% range. These findings highlight persistent gaps in oral health utilization during pregnancy, particularly among lower-income populations, including Medicaid enrollees, who are less likely to access dental services despite having coverage.

Children Ages 1–17

Within the same Life Course framework, NPM of Preventative Dental Visit which focuses on the *Percent of children ages 1–17 who had a preventive dental visit in the past year*, with an ESM specifically tracking preventive dental services among children enrolled in Medicaid or Children's Health Insurance Program using CMS-416 (Early and Periodic Screening, Diagnostic, and Treatment) data. This measure reflects federal reporting requirements for oral health utilization and serves as a key indicator of access to preventive care for publicly insured children. In NJ, the most recent available data indicate that only about 40–55% of Medicaid-enrolled children receive at least one preventive dental visit annually. Despite comprehensive dental coverage under Medicaid, these rates remain below recommended levels, suggesting ongoing barriers such as limited provider participation, access challenges, and gaps in care utilization.

To address persistent gaps in oral health access and utilization, the Children’s Oral Health Program has played a longstanding role in prevention and education across NJ. Established in the 1980s, this program focuses on increasing awareness of the importance of preventive dental care, primarily targeting school-aged children. Through a combination of community outreach, education, and the direct provision of preventive services, the program works to improve oral health outcomes and reduce disparities statewide. Program activities are implemented through key regional partners, including Zufall Health, which serves northern and central NJ, and South Jersey Family Medical Centers, which serve southern NJ. Together, these efforts increase access to care and advance statewide goals for improving oral health among vulnerable populations.

Some of the key achievements of The Oral Health Services Unit (OHSU) during this reporting period include:

- **Fluoride Varnish Applications:** Provided fluoride varnish to 5,220 children, helping prevent tooth decay.

- **Oral Health Education and Promotion:** Delivered oral health literacy and education programs to over 48,633 school-aged children, including their parents and school staff. Additionally, provided oral health presentations and dental referrals to 489 pregnant women.

- **Nutritional Counseling and Dental Sealants:** Reached 6,530 families of low-income children and adolescents (ages 5–18) with oral health–focused nutritional counseling, promoting healthy food choices to support oral health and overall well-being. This initiative also resulted in the placement of 5,825 dental sealants in school-aged children to prevent tooth decay.

- **Basic Screening Survey (BSS):** Completed NJ's third BSS targeting adolescents in grades 7–8, making the state the first in the nation to conduct the survey for this population. Results showed that 17% of adolescents screened had at least one permanent tooth with untreated decay. Due to a low school participation rate, these findings cannot be considered fully representative of all NJ adolescents, highlighting the need for further BSS efforts.

- **PRAMS Oral Health Section:** The NJ PRAMS, a collaboration between the NJDOH and the CDC, collects weighted survey data from mothers 2–6 months postpartum to inform maternal and infant health programs. The dataset includes over 30,300 respondents (2002–2023) with a 69% response rate. The Oral Health Services Unit assisted with co-authoring the oral health section of this report.

- **Professional Presentations:** The OHSU team conducted presentations at two national oral health conferences: the National Oral Health Conference in April 2025 and the Association of Dental Safety Annual Conference in May 2025, both held in Orlando, Florida. Additionally, OHSU developed a dedicated oral health presentation for school nurses, covering topics such as early signs of dental disease, dental screening, and referral processes. This presentation was created in close collaboration with the NJDOH and the NJ Department of Education and is now available to all school nurses across NJ.

- **Inaugural State Oral Health Conference:** The NJDOH hosted its first Oral Health Conference in Princeton, with over 200 in-person and 150 virtual attendees, bringing together medical, dental, public health, and school nursing professionals. This landmark hybrid event united oral health care advocates, policymakers, and public health officials to advance oral health initiatives statewide. Several sessions focused on children,

including Head Start and Early Childhood Education, as well as Dental Emergencies training for school nurses.

Cross-Cutting Systems Application Report

To continue to address NPM *Preventive Dental Visit* through the following ESMs:

- *Percent of Medicaid-enrolled pregnant women who received a preventive dental visit during pregnancy*
- *Percent of Medicaid-enrolled children ages 1–17 who received a preventive dental visit in the past year*

In NJ, funding toward Oral Health programming has helped to educate the public on the importance of preventive oral health services, with programs primarily targeting school-aged children and pregnant women. The oral health program will continue to provide outreach, education, and preventive oral health services to children and adolescents throughout NJ.

Historically, oral health activities have been carried out through two main grantees: Zufall Health, covering northern and central NJ, and South Jersey Family Medical Centers, covering southern NJ.

In this grant cycle, we expanded outreach to four grantees and focused on three main goals.

Goal 1- Promote and monitor oral disease preventative measures by applying fluoride varnish to the teeth of elementary school students and children enrolled in Head Start (HS), Early Head Start and elementary school students. The program will also provide oral health education and dental referrals to students, families and staff to promote preventive care and facilitate access to dental services.

- Importance of Fluoride Varnish Application, Education, and Referrals

Fluoride varnish is a safe, effective, and evidence-based preventive intervention that strengthens tooth enamel and helps prevent or slow the progression of tooth decay in children. School- and community-based fluoride varnish programs are especially important for underserved populations who may have limited access to dental care. In addition to fluoride applications, oral health education helps children, families, and school staff understand the importance of good oral hygiene, healthy nutrition, and regular dental visits. Referrals ensure that children identified with dental needs receive appropriate follow-up care.

Goal 2-Collect Oral Health Data Implemented through Basic Screening Survey

- **Importance of BSS**

The **BSS** is a standardized oral health surveillance tool developed by the Association of State and Territorial Dental Directors to help states collect consistent data on oral health status and treatment needs in community settings such as schools and Head Start programs. Using a simple visual screening method, the dental professionals collect information on tooth decay, untreated dental disease, dental sealant use, and treatment needs. This data helps public health programs monitor trends, identify disparities, and guide policies and interventions that improve access to oral health care. The BSS survey is conducted every three years to monitor oral health trends and measure progress.

NJ BSS Findings

NJ's **2022–2023 Third Grade Oral Health Survey** found that **36% of third-grade children have untreated tooth decay**, significantly higher than the national average of **20%**. In addition, **29%** of children had dental sealants (national average **42%**), **15%** required urgent dental care, and an estimated **13,200 third grade students** were experiencing active tooth decay and pain.

The **2023–2024 Head Start Oral Health Survey** identified similar concerns among young children. **Thirty-two percent (32%)** of Head Start children had experienced tooth decay, and **24%** had untreated decay, **double the national average for children ages 3–5 (12%)**. About **4%** require urgent dental care due to pain or infection, which translates to more than **5,000 young children (3-5 years old) enrolled in Medicaid in NJ** experiencing dental pain or infection on any given day.

In **2024–2025**, NJ conducted the **Adolescent Oral Health Survey** among **7th and 8th grade students** and found that **17% of adolescents screened had at least one permanent tooth with untreated decay**. Due to low participation rates, these findings may not be fully representative of NJ's middle school population.

In September 2025, NJ launched a new BSS focusing on older adult residents in nursing homes and assisted living facilities. Because participation in this oral health survey is voluntary, enrollment from facilities has been slower than anticipated. This is an ongoing process, and results will be shared upon completion.

This grant cycle, we are pleased to report the launch of a new BSS cycle focusing on pregnant women. Screening this population is critical because untreated tooth decay and periodontal disease during pregnancy are linked to adverse pregnancy outcomes and can affect infants' early oral health. Data collected will guide targeted maternal oral health programs and improve access to preventive and dental care services.

Limited state-level data from other U.S. programs indicate that many pregnant women have untreated dental disease. For example, perinatal BSS initiatives in North Carolina and Virginia

revealed high levels of untreated decay, underscoring the need for systematic screening and follow-up.

Implementing a BSS for pregnant women in NJ will:

- Identify the prevalence of oral health issues
- Highlight disparities in access to care
- Inform targeted interventions and policy decisions to improve maternal and infant oral health

Given the oral health risks during pregnancy and the lack of current surveillance in NJ, this BSS is both timely and essential. The survey began in November 2025 and is expected to conclude by September 2026.

Goal 3- Strengthen medical–dental integration to identify, refer, and manage chronic disease risk factors among underserved populations. Health screenings and referrals are offered to all at-risk patients, with a special focus on pregnant women and women of childbearing age.

- **Importance of Medical-Dental Integration**

  Medical–dental integration is a promising public health approach that recognizes the connection between oral health and chronic diseases such as diabetes and cardiovascular disease. Organizations such as the HRSA and the CDC support integrated care models to improve early detection of health conditions, expand preventive services, and enhance care coordination for underserved communities

Additionally, NJ will host its second annual Oral Health Conference on July 8, 2026. The event is expected to attract over 300 in-person and 200 virtual attendees, featuring renowned local and national speakers on oral and integrated health. Participants will include oral health professionals, school nurses, pediatricians, and public health practitioners, with many presentations focusing on improving health outcomes for children and expectant mothers.

IV. Appendix

A. Acronyms

Acronym	*Full Name*
ACOG	*American College of Obstetricians*
AMCHP	*Association for Maternal and Child Health Programs*
APHL	*Association of Public Health Laboratories*
ASD	*Autism Spectrum Disorders*
ASQ	*Ages and Stages Questionnaire*
BDARS	*Birth Defects and Autism Reporting System*
BDR	*Birth Defects Registry*
BIM	*Black Infant Mortality*
BSP	*Breastfeeding Strategic Plan*
BSS	*Basic Screening Survey*
CAHP	*Child and Adolescent Health Program*
CASEL	*Collaborative for Academic Social and Emotional Learning*
CCHD	*Critical Congenital Heart Defects*
cCMV	*congenital Cytomegalovirus*
CDC	*Centers for Disease Control and Prevention*
CDS	*Communicable Disease Services*
CHF	*Community Health Factors*
CHW	*Community Health Worker*
CLG-CHWI	*Colette Lamothe-Galette Community Health Worker Institute*
CMRS	*Case Management Referral System*
CMUs	*Case Management Units*
CNJ	*Connecting NJ*
COOP	*Continuity of Operations Plan*
CSHCN	*Children with Special Health Care Needs*
DCF	*Department of Children and Families*
DHS	*Department of Human Services*
DOE	*Department of Education*
DSET	*Data Systems and Emerging Threat Response*
DUA	*Data Use Agreement*
EBMs	*Evidence-based Models*
ECB	*Emerging Behavioral Challenges*
ECCS	*Early Childhood Comprehensive System*

EHDI	***Early Hearing Detection and Intervention***
EIM	***Early Identification and Monitoring***
ESMs	***Evidence-Based Informed Strategy Measures***
FASD	***Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder***
FCCS	***Family Centered Care Services***
FHS	***Family Health Services***
FIMR	***Fetal Infant Mortality Review***
FQHCs	***Federally Qualified Health Centers***
HNJ	***Healthy New Jersey Initiative***
HRSA	***Health Resources Service Administration***
HWHF	***Healthy Women Healthy Families***
IBCLC	***International Board-Certified Lactation Consultants***
ISP	***Individual Service Plan***
LTFU	***Long-Term Follow-Up***
LTSAE	***Learn the Signs Act Early***
MCH	***Maternal and Child Health***
MCH EPI	***Maternal and Child Health Epidemiology***
MCHB	***Maternal Child Health Bureau***
MCHBG	***Maternal and Child Health Block Grant***
MCHC	***Maternal and Child Health Consortia***
MHI	***Maternal Health Innovations***
MIECHV	***Maternal, Infant, and Early Childhood Home Visiting***
MOA	***Memorandum of Agreement***
MPI	***Master Index Person***
mPINC	***Maternity Practices in Infant Nutrition and Care***
NBS	***Newborn Screening Follow-up and Genetic Services***
NFR-CRS	***National Fatality Review Case Reporting System***
NICHD	***National Institute of Health and Human Development***
NJ	***New Jersey***
NJAAP	***NJ Chapter of the American Academy of Pediatrics***
NJCYC	***NJ Council for Young Children***
NJDLC	***New Jersey Doula Learning Collaborative***
NJDOH	***New Jersey Department of Health***
NJEIS	***New Jersey Early Intervention Services***
NJIIS	***New Jersey Immunization Information System***
NJMCQC	***New Jersey Maternal Care Quality Collaborative***
NJMIHIA	***New Jersey Maternal and Infant Health Innovation Authority***

NJMMRC	***New Jersey Maternal Mortality Review Committee***
NJPCA	***NJ Primary Case Association (NJPCA)***
NJPRSN	***New Jersey Postpartum Resources and Support Network Program***
NJSHAD	***NJ State Health Assessment Data***
NPMs	***National Performance Measures***
NSCH	***National Survey of Children's Health***
OHSU	***Oral Health Services Unit***
PAHS	***Postpartum Assessment of Health Survey***
PCPs	***Primary Care Providers***
PDQ	***Psychological Development Questionnaire***
PEP	***(Teen) Prevention Education Program***
PMAD	***Perinatal Mood and Anxiety Disorder***
PPOR	***Perinatal Periods of Risk (PPOR)***
PRA	***Perinatal Risk Assessment***
PRAMS	***New Jersey Pregnancy Risk Assessment Monitoring System***
RFA	***Request for Application***
RFP	***Request For Proposals***
SCHS	***Special Child Health Services***
SCHSCM	***Special Child Health Services Case Management***
SCNJ	***Sudden Infant Death Syndrome Center of New Jersey***
SET-NET	***Surveillance for Emerging Threats to Pregnant Persons and Infants***
SIDS	***Sudden Infant Death Syndrome***
S-PEP	***Statewide Parent and Professional Engagement Program***
SPNs	***State Priority Needs***
SPoC	***Shared Plan of Care***
SPSP	***Specialized Pediatric Services Program***
SRAE	***Sexual Risk Avoidance Education***
SRAE-PAS	***SRAE -Performance Analysis Study***
SSDI	***State Systems Development Initiative***
STIs	***Sexually Transmitted Infections***
SUID	***Sudden Unexpected Infant Death***
SUID-CR	***Sudden Unexpected Infant Death Case Review***
TOP	***Teen Outreach Program***
TVP	***Title V Program***
VERI	***Vital Events Registration & Information System***

WIC	***Women Infants and Children***
WICY	***Women, Infants, Children, Youth***

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