The August meeting was cancelled so it's been a while since we met.

We also cancelled this September meeting because none of the Advisory Council members had logged on by 1:20pm.

The following slides were prepared for the meeting and will include the notes for self-review.

The agenda items were as follows:

- Welcome and Recap of activities since the July Advisory Council meeting
- Heathy NJ Action Team Membership
- Updated Calendar of Healthy NJ meetings
- SHIP Progress Update
    - Updated Action Plans
- Next Steps and Adjourn

A lot has happened since the July Advisory Council meeting

- At that meeting, we discussed the 2025 SHIP Strategies and Actions that were shared with New Jersey Department of Health (NJDOH) senior staff. Senior staff asked for additional information, such as details regarding responsible parties, indicators with data sources, and linkages to the NJDOH Strategic Plan. The revised SHIP Strategies & Actions document was shared with you via email.
- I also spoke with NJDOH staff and community partners to document the progress made towards each of the 2020 SHIP objectives.

Other topics included in the last meeting were:

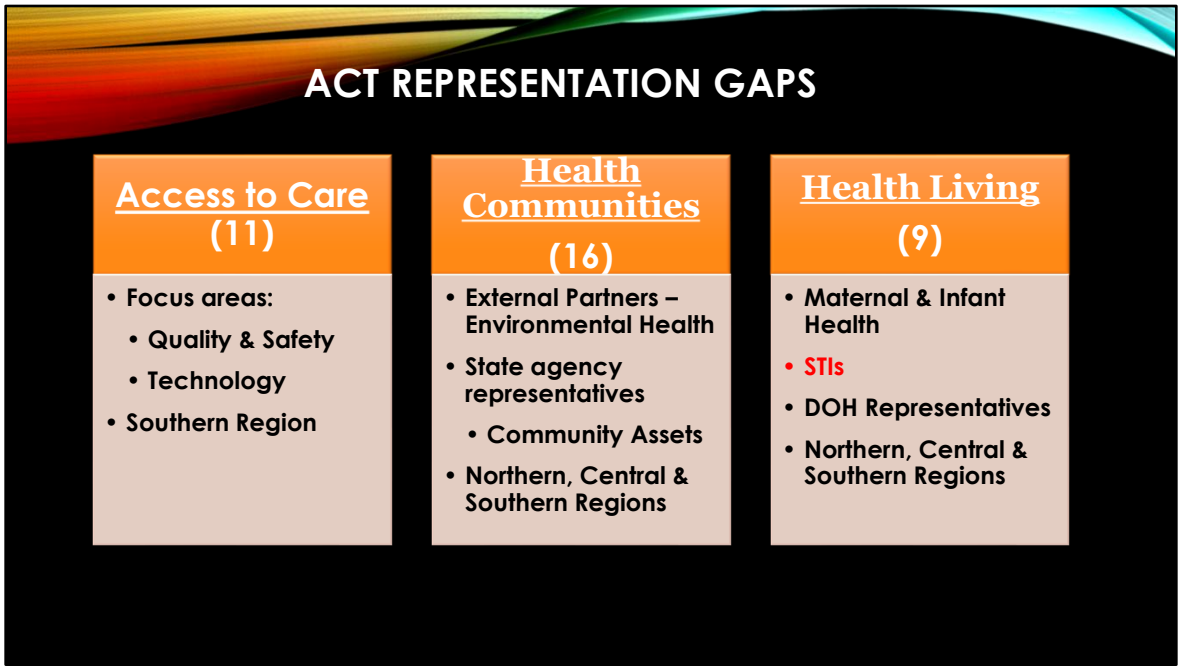
- Healthy NJ Membership Manual
    - I am still missing the signed agreement from a few members. I will attach another copy to the email for those who could not open the link or simply forgot to send it back. Please send back the signed agreement if you are still interested in participating on the Advisory Council and have not already done so.
- Action Team Recruitment Process
    - This will be covered in the next few slides.

Action Team Recruitment Process

Since our last discussion, I have emailed former Action Team members; identified and removed inactive members; and assessed the interest of members in continued participation.

We invited those former members, and newly recruited members, to a Kickoff meeting, scheduled for **Thursday, October 2nd** to inform them of the process and progress made towards Healthy NJ since the Action Teams last met in 2023.

I also reviewed the list of interested Action Team members to identify gaps in geographic and expertise representation to assist with our recruitment.



Access to Care has **11** members with good representation from the DOH and external community partners. The Action team is lacking representation from other state agencies and representatives focused on: Access to Quality Care related to **Quality & Safety, Technology**, especially those who provide services statewide. The Action Team is also lacking representation from the **Southern Region** overall.

The **Health Communities** Action Team focuses on environmental health and coordination of community assets that support healthy eating and active living. With **16** confirmed members, this Action Team has good representation of **External Partners,** except in the area of **Environmental Health.** The action team is also lacking representation from **State agencies** (both DOH and other state agencies), especially those that support healthy food access and active living. There is also need for more regional representation in the **Northern, Central, & Southern Regions.**

The **Health Living** Action Team focuses on maternal, infant, & family health; clinical preventive services; sexually transmitted infections; and behavioral health. Currently, there are only **9** confirmed members, and this Action Team is lacking representation from DOH staff in all areas and those with expertise in **Maternal & Infant Health** and **STIs**, which has no members. This action team is lacking representation from **Northern, Central, & Southern Regions**

We are asking DOH staff and HNJ Advisory Council members to identify potential members to fill the gaps. I will follow up with an email to include the list of current Action Team members and the list of gaps.

We also planned to go over the meeting schedule for the remainder of 2025 and 2026.

Since attendance at the Advisory Council meetings has not been optimal, we will conduct another poll to determine if the 4th Thursday of the month at 1pm is still good for most members.

For the remainder of 2025,

- State recognized holidays are in red.
- Advisory Council meetings are in the darker blue.
- There are no Advisory Council meetings in **October** or **December.**
- The next meeting is scheduled for **Thursday, November 13th from 1-2:30pm.** The meeting was not scheduled on the 4th Thursday of the month due to the **Thanksgiving** holiday.

The first meeting of the reconvened **Action Teams** is **October 2nd.**
Each Action team will then meet in November and December to plan for implementation of the finalized strategies and actions starting in 2026.
Advisory Council members are welcome to join this meeting to hear the update.

The plan was to have the HNJ Advisory Council meet quarterly in 2026 with the meetings to remain on the 4th Thursday of the month: January 22nd, April 23rd, July 23rd, and October 22nd. Indicated in **blue**
As previously mentioned, we will conduct a poll to see if this still works.

The **quarterly Action Team** meetings will be staggered and scheduled on **Wednesdays** or **Thursdays** based on the members' availability.

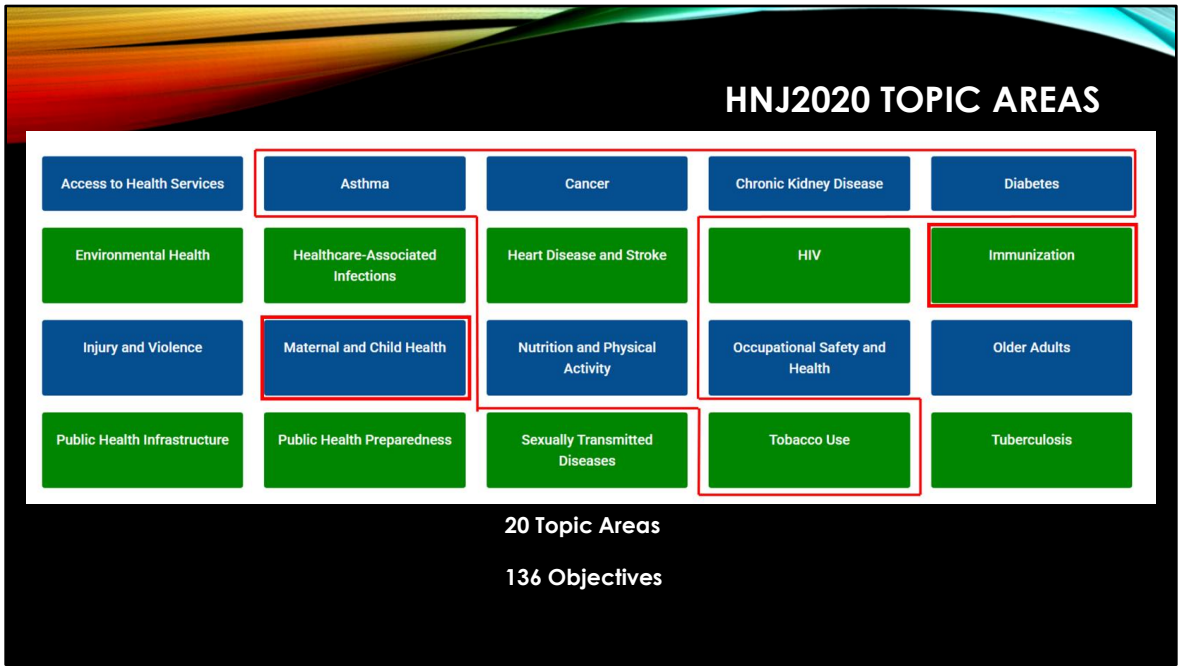
- The **Access to Quality Care Action Team** will meet the **first month** of each quarter; January, April, July, and October.
- The **Healthy Communities Action Team** will meet the **2nd month** of each quarter; February, May, August, and November.
- The **Healthy Living Action Team** will meet the **last month** of each quarter; March, June, September, and December.

The meeting schedule will be finalized based on a poll of the members.

Since the Advisory Council will only meet quarterly and your knowledge and expertise is needed on the Action Teams, we are asking each Advisory Council members to chose at least one Action Team to join based on your interest and expertise.

I will send out a poll to capture your selections.

Next, we will take a look at the Action Plans that have been revised based on DOH Senior Staff feedback.



As a reminder, there were 20 topic areas with 136 objectives for HNJ2020.

As you can image, there were too many objectives to address effectively.

Ultimately, the 2020 SHIP contained only 6 chapters focused on the highest priority areas. All chronic diseases were a priority along with nutrition, physical activity, and tobacco use.

The priorities are highlighted in red and will also be included in the 2025-30 SHIP.

The overall mission was revised from HNJ2020 to HNJ2030, with more of a focus on health equity and well-being.

- There are **10** topic areas across into **3 d**omains, **Access to Quality Care**, **Healthy Communities**, and **Healthy Living**.
- There are **20** objectives within **Access to Quality Care: 13** within the **Equitable and Sustainable Access** topic area, **2** focused on the **Quality & Safety** topic area, and **5** in the **Data and Technology** topic area.
- Within the **Healthy Communities**, there are **3** topic areas with a total of **14** objectives: **2 Environmental Health** objectives, **5** objectives for **Injury & Violence**, and **7** objectives for **Community Assets** for healthy living.
- Within **Healthy Living**, there are **4** topic areas with a total of **22** objectives. There are **5** proposed objectives within **Maternal, Infant & Family Health**, **3** for **Clinical Preventive Health**, **4** for **Sexually Transmitted Infections**, and **10** within **Behavioral Health**.

Equity, Policy, and Resilience are the cross-cutting considerations incorporated into the objectives.

Overall, there are **56** proposed objectives (which is a lot tackle so we would like to limit the number of objectives to no more than **35).**

Our goal was to discuss and decide at this meeting.

We made recommendations of which objectives to keep (highlighted with green stars).

The first set of objectives that we will review are within the **Access to Quality Care** domain.

These objectives focus on addressing the top Barriers to Accessing Healthcare such as…

- **Healthcare staffing shortages,** specifically **Primary Care**
- Insufficient **insurance coverage / Cost of Care**
- **Quality & Safety**
- **Data & Technology** related to Patient barriers (communication and language, Transportation / location-related barriers; Time / work-related barriers) and **health care system barriers** (Stigma and bias)

Let's take a look at the **20** objectives for **Access to Quality Care.**

HNJ2030
ACCESS TO QUALITY CARE
PRIMARY CARE

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 1. Increase equitable and sustainable access

Key Performance Indicators

- **1A. Decrease the Health Professional Shortage Area (HPSA) Scores in Primary Care Shortage Areas (or Decrease the HPSA FTE number in Shortage Areas / lower the population-to-provider ratio)**
  - **Indicator: HPSA Scores / HPSA FTE # / % Met Need**
  - **Baseline (XX; YEAR): Target: Increase to XX by 6/30/2030**
  - **Data Source: KFF**
  - **Lead: NJ DOH**

Location	Total Primary Care HPSA Designations	Population of Designated HPSAs	Percent of Need Met	Practitioners Needed to Remove HPSA Designation
New Jersey	37	163,027	69.24%	19

The first objective under Access to Quality Care looks at **Healthcare staffing shortages.** The nation is facing a shortage of primary care, dental, or mental health providers and about a third of the shortage is specific to **primary care**. These shortages affect everyone, but particularly patients already in "healthcare shortage areas".

This indicator has a **green star** because it is recommended for the SHIP.

A **Health Professional Shortage Area** (HPSA) is defined as an area with a shortage of health providers. These can be shortages based on a **geographic area** (city, county), a **high-risk population** (higher than average group of low-income, homeless, or migrant farmworker populations), or a **facility** (public medical facility that serves a population or geography -- correctional facility or youth detention facility). Some facilities are automatically designated as HPSAs by definition (FQHC, FQHC Look-A-Likes (LALs), Indian Health Facilities and Tribal Hospitals, and CMS-Certified Rural Health Clinics (RHCs).

Several factors are considered in Health Professional Shortage Area designations (see images in the slide).

For **Primary Care**, HPSAs can receive a score between **0-25** based on:

- **Population-to-Provider Ratio** [10 points max].
- **Percent of population below 100% Federal Poverty Level** (FPL) [5 points max]

- **Infant Health Index** (Infant Mortality Rate or Low Birth Weight Rate) [5 points max]
- **Travel time to Nearest Source of Care** (outside the HPSA designation area) [5 points max]

The higher the score, the greater the priority.

In NJ, there are currently **37** areas/facilities that have a HPSA Primary Care designation, and **163,027** individuals living within those designated areas.
The current number of health professionals that work in those areas only met **69.24%** of the populations' needs and **19** practitioners are needed to meet the needs of the entire population in those HPSA designated areas.

Federal workforce programs use these designations and scores to focus limited resources on communities that need it the most.
These programs connect skilled health care providers to communities in need, they offer scholarships, loans, and loan repayment programs to providers who work in HPSAs, and they award grants to organizations (i.e. schools, hospitals, health departments) to help strengthen the health workforce and improve access to care.

There are several ways to measure success in HPSAs, decrease the number of practitioners needed, increase the % of needs met, or decrease the number of HPSA designations (because the needs have been met and there is no longer a health professional shortage in the area).

We will determine the appropriate measure with the **Action Team** and subject matter experts.

HNJ2030
ACCESS TO QUALITY CARE
PRIMARY CARE

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

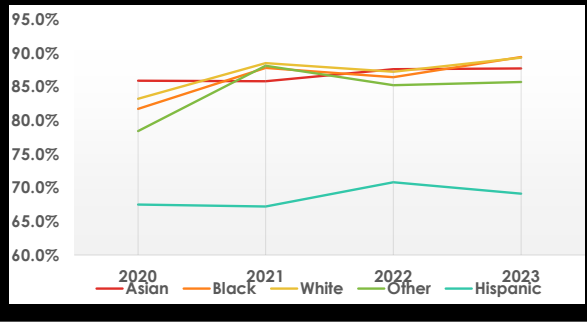
Strategic Objective: 1. Increase equitable and sustainable access

Key Performance Indicators

Key Performance Indicators

- **1B. Increase the proportion of adults with a dedicated Primary Care provider**
  - **Indicator:** % of adults with a dedicated Primary Care provider

- **1C. Eliminate disparities relative to those with a dedicated Primary Care provider**
  - **Indicator:** % of adults with a dedicated Primary Care provider
  - **Baseline** (0.8 Hispanic:White; 2020):
  - **Target**: 1.0 by 6/30/2030
  - **Data Source: BRFSS**
  - **Lead: NJDOH**



Even when you do not live in a Health Professional Service Area, finding a dedicated source of primary care can be a barrier.

Increasing the proportion of adults with a dedicated Primary Care provider is important and the proportion has a slight upward trend, except among the Hispanic population. However, disparities still exist between racial/ethnic groups.

We are proposing to **eliminate the disparities** instead of simply increasing the proportion of adults with a dedicated primary care provider (as indicated by the green star).

HNJ2030
ACCESS TO QUALITY CARE
PRIMARY CARE

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 1. Increase equitable and sustainable access

Key Performance Indicators

- **1D. Increase % of healthcare providers who received CLAS / Implicit Bias Training**
  - **Indicator:** % of healthcare providers who receive CLAS / Implicit Bias Training
  - **Baseline:** Data Not Available **Target:** Increase to XX by 6/30/2030
  - **Data Source:** Data Not Available
  - **Lead: NJ DOH**

RESEARCH?

Stigma and bias within the health care system are also barriers to quality care.
It was therefore proposed that we include an objective related to Culturally and Linguistically Appropriate Services (CLAS) / bias training.

However, we have be unable to find reliable data to quantify how many providers have received bias training or taken advantage of related medical education resources.

We could drop this indicator or use the Healthy People category of "Research" to include strategies to investigate this further.

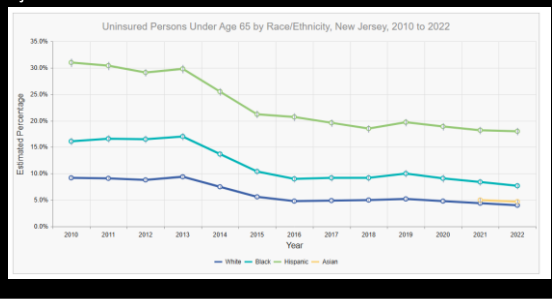
HNJ2030
ACCESS TO QUALITY CARE
COST OF CARE

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 2. Eliminate cost-associated barriers to care

Key Performance Indicators

- **2A. Increase the proportion of youth under aged 19 that have health insurance**
  - **Indicator:** % of youth under age 19 who are insured
  - **Baseline** (**XX; YEAR**): **Target**: Increase to **XX** by **6/30/2030**
  - **Data Source: NJHA**
  - **Lead: NJHA**
- ★ **2B. Eliminate the disparity in the proportion of adults aged 18-64 that have health insurance**
  - **Indicator:** % of adults aged 18-64who are insured, age adjusted
  - **Baseline** (**XX**; **2020**):
  - **Target**: **1.0** by **6/30/2030**
  - **Data Source: BRFSS**
  - **Lead: NJHA**



These 2 objectives apply to health insurance coverage.

2A refers to the proportion of youth under the age of 19. As of January 1, 2023, all children under 19 are eligible for NJ FamilyCare, regardless of their immigration status and the proportion of **youth under aged 19** that have health insurance has held steady around **96.1%** over the years. Additionally, data are not available by race/ethnicity so there is little room for improvement and no way to assess for racial/ethnic disparities.

On the other hand, data for adults aged **18-64** is available from BRFSS by race/ethnicity and is worth including in the SHIP (green star). The slide was updated to 'Eliminate the disparity" instead of 'increase the proportion of adults with health insurance'.

HNJ2030
ACCESS TO QUALITY CARE
COST OF CARE

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 2. Eliminate cost-associated barriers to care

Key Performance Indicators

- **2C. Increase the proportion of uninsured adults who access care at FQHCs or LHDs**
  - **Indicator:** % of uninsured adults who access care at FQHCs or LHDs
  - **Baseline** (XX; YEAR): **Target:** Increase to XX by 6/30/2030
  - **Data Source:** Data no available
  - **Lead:** ???

FQHCs and LHDs provide high quality health care to people regardless of their ability to pay and are a good resource for the uninsured who do not have a dedicated primary care provider.

It was therefore proposed that we include an objective to increase the proportion of uninsured adults who access care at FQHCs or LHDs.

However, we have be unable to find reliable data on the proportion of uninsured adults who access care at FQHCs or LHDs instead of emergency departments and therefore cannot include this measure.

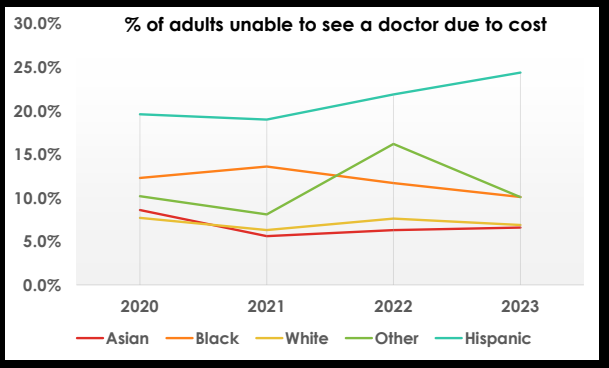
HNJ2030
ACCESS TO QUALITY CARE
COST OF CARE

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 2. Eliminate cost-associated barriers to care

Key Performance Indicators

- **2D. Reduce proportion of those who avoided care due to costs**
  - **Indicator:** % of adults that avoided care due to costs, age-adjusted
  - **Baseline** (11.1; 2020): **Target**: XX by 6/30/2030
  - **Data Source: OHCAT**
  - **Lead: NJHA**
- ★ **2E. Eliminate disparities among those who avoided care due to costs**
  - **Indicator:** % that avoided care due to costs
  - **Baseline** (2.5 Hispanic:White ratio; 2020)
  - **Target**: 1.0 by 6/30/2030
  - **Data Source: BRFSS**
  - **Lead: NJHA**



In 2020, the proportion of adults who avoided care due to costs was **11.1** overall.

As you can see in the graph, the proportion decreased for some populations but there are clear racial/ethnic disparities

To focus on health equity and the elimination of disparities, the proposed objective is to **eliminate disparities among those who avoided care due to costs (2E)**

HNJ2030
ACCESS TO QUALITY CARE
SUPPORTIVE SERVICES

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 3. Increase access to existing medical and social service programs and resources

Key Performance Indicators

- **3A. Increase access to services for Health-Related Social Needs (HRSN)**
  - **Indicator:** % of adults screened and referred for HRSN/SDoH
- **3B. Increase the proportion of agencies using referral platforms**
  - **Indicator:** % of agencies using county or state-level, closed loop referral systems
- **3C. Increase the proportion of provider that offer alternative health care delivery models**
  - **Indicator:** % of providers that offer alternative health care delivery models
- **3D. Increase access to transportation for non-emergency health care**
  - **Indicator:** % of adults who access transportation options for non-emergency health care

  - **Baseline:** Data not available
  - **Data Source:** Data not available
  - **Lead:** ???

While Health-Related Social Needs (HRSN) and Social Determinants of Health (SDoH) are important barriers to care, we could not find data to document and track any of these indicators related to assessing and addressing social needs.

Therefore, none of these indicators will be included in the SHIP.

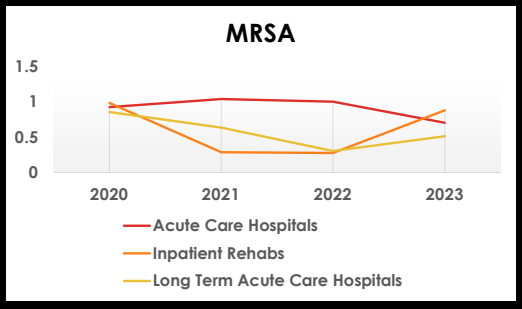
HNJ2030
ACCESS TO QUALITY CARE
QUALITY & SAFETY

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 4. Improve quality and safety in healthcare facilities.

Key Performance Indicators

- **4A. Reduce Healthcare Associated Infections in all settings (specifically the MRSA standardized infection ratio)**
  - **Indicator:** MRSA standardized infection ratio in all care settings
  - **Baseline** (XX; 2020): **Target**: Decrease to XX by 6/30/2030
  - **Data Source: CDC**
  - **Lead: NJ DOH**



This next set of objectives are related to **Quality & Safety** in care. In the original action plans, a focus on **Healthcare Associated Infections (HAI)** was proposed, with a focus on **MRSA**, the most prevalent Healthcare Associated Infections .

In addition to Healthcare Associated Infections, there are other measures that the NJDOH Health Care Quality and Assessment unit uses to document quality. They are outlined on the next slide.

HNJ2030
ACCESS TO QUALITY CARE
QUALITY & SAFETY

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 4. Improve quality and safety in healthcare facilities.

Key Performance Indicators

- **4B. Eliminate disparities in Overall PQI rates**
  - **Indicator:** PQI rates

- **Prevention Quality Indicators (PQIs)**
  – potentially avoidable hospital admissions (diabetes, hypertension)
- **Inpatient Quality Indicators (IQIs)**
  – inpatient mortality (stroke, heart failure)
- **Patient Safety Indicators (PSIs)**
  – complications/adverse events in hospital

Table 13. Comparing New Jersey's Statewide PQI Rates with National Rates (per 100,000 population)

Preventiona Quality Indicators (PQIs)	National	New Jersey	
	2018	2018	2020
Diabetes with Short Term Complications (PQI.01)	82.2	78.4	66.5
Diabetes with Long Term Complication (PQI.03)	108.9	138.4	105.5
COPD or Asthma in Older Adults (PQI.05)	381.1	486.2	218.7
Hypertension (PQI.07)	60.8	72.9	51.1
Heart Failure (PQI.08)	429.6	463.7	339.7
Community-Acquired Pneumonia (PQI.11)	183.6	182.8	112.1
Urinary Tract Infection (PQI.12)	134.8	162.3	106.7
Uncontrolled Diabetes (PQI.14)	42.1	55.7	38.6
Asthma in Younger Adults (PQI.15)	29.2	49.0	27.0
Lower Extremity Amputation (PQI.16)	32.3	34.0	28.8
Overall PQIs - Composite (PQI.90)	1,301.4	1,444.5	960.5

County	Overall (PQI.90) Volume	Rate
Statewide	**71,539**	**960.5**
Atlantic	3,136	1,328.2 **
Bergen	4,492	547.0 *
Burlington	4,591	1,172.2 **
Camden	6,334	1,534.9 **
Cape May	1,083	1,025.9
Cumberland	3,338	2,803.3 **
Essex	7,316	1,224.1 **
Gloucester	1,901	792.3 *
Hudson	4,628	1,012.8 **
Hunterdon	805	675.6 *
Mercer	3,333	1,118.3 **
Middlesex	5,596	853.8 *
Monmouth	5,341	948.7
Morris	2,419	553.0 *
Ocean	6,192	1,005.7 **
Passaic	3,473	901.0 *
Salem	609	1,071.3 **
Somerset	1,481	526.8 *
Sussex	965	773.1 *
Union	3,591	831.4 *
Warren	915	926.7

The NJDOH Health Care Quality and Assessment unit uses these indicators to document quality**:**

- **Prevention Quality Indicators (PQIs)** or "ambulatory care sensitive conditions", which are conditions that can be effectively treated in an outpatient setting, potentially preventing the need for inpatient hospital admissions. PQIs include conditions such as diabetes and hypertension that could be managed by a primary care provider to avoid hospitalization.
- **Inpatient Quality Indicators (IQIs)** provide information on inpatient mortality for certain procedures and medical conditions. This data can be used to compare performance outcomes and mortality rates for various hospitals.
- **Patient Safety Indicators (PSIs)** which provide information on potential complications and adverse events that occur in the hospital following surgeries, procedures, and childbirth. PSIs are mostly used to help hospitals identify and assess potential adverse events in the hospital for quality improvement.

Table 13 shows the National and NJ PQI rates. As you can see in the red box, in 2018 many of the NJ indicators were below the national average (**1,301.4**) although the overall combined PQI was slightly higher (**1,444.5**). By 2020, the overall PQIs rate decreased (to **960.5**).

However, looking at the other chart, the **Overall PQI rates for 2020** in NJ by county, we see several counties with rates higher than the State average as indicated by ** (such as Atlantic, Burlington,, Camden). This suggests higher rates of preventable/avoidable hospitalizations in those NJ counties. The objective would be to eliminate disparities in Overall PQI rates by county.

Since the focus for HNJ2030 is on health equity and upstream prevention strategies and actions, an objective to Eliminate the disparities in Overall PQI rates (**4B)** is proposed instead of **4A -** Reducing Healthcare Associated Infections (MRSA) in all settings.

HNJ2030
ACCESS TO QUALITY CARE
DATA & TECHNOLOGY

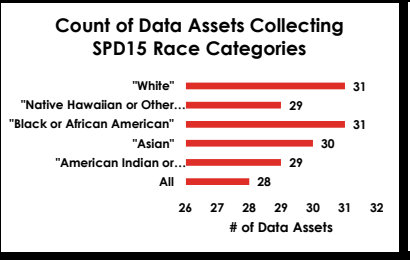
Goal: A comprehensive, quality health system that people can access, afford, and navigate.

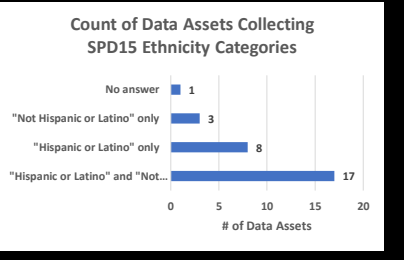
Strategic Objective: 5. Collect and analyze outcome data across key demographics that will address health disparities.

Key Performance Indicators

- **5A. Analyze outcome data across NJDOH datasets that collect at least the minimum 5 races plus Hispanic ethnicity, language spoken at home, and sexual orientation, gender identify (SOGI).**
  - **Indicator:** % of NJDOH datasets that collect at least the minimum 5 races plus Hispanic ethnicity, language spoken at home, and SOGI.
  - **Baseline** (XX; YEAR): **Target**: Increase to XX by 6/30/2030
  - **Data Source: NJDOH**
  - **Lead: NJDOH**

- **5B. Increase the use of data across NJDOH datasets that collect at least the minimum 5 races plus Hispanic ethnicity, language spoken at home, and SOGI.**





This next set of indicators look at **Data & Technology**. In order to eliminate disparities, it is important to have data available to properly document differences. Therefore, it was proposed that we "Analyze outcome data across NJDOH datasets that collect at least the minimum 5 races plus Hispanic ethnicity, language spoken at home, and sexual orientation, gender identify (SOGI)."

In January 2024, NJDOH data stewards and topic area experts who manage varying datasets across the NJDOH's many divisions, offices, and programs were surveyed. Thirty-one responses were analyzed to assess whether NJDOH population health datasets collected race and ethnicity data in line with the **1997 "*Statistical Policy Directive No. 15, Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*" (SPD15),** which establishes a minimum set of race and ethnicity categories that federal agencies must use when collecting data and best practices.

- Among the **31** datasets, all included standard White and Black racial categories. **29** of the 31 also include the Native American, Asian, and Native Hawaiian categories but only **28** datasets included ALL of the race categories.
- In terms of ethnicity, only **17** datasets **(~55%)** collect both **"Hispanic or Latino" AND "Not Hispanic or Latino"** as recommended by the SPD15 standards. It is recommend that surveys collect both to avoid missing data for those who do not respond but fit in one of the categories.
- For language, only **three (~9%)** reported that they collect data on **language spoken at home,** and **13 (~42%)** collect data on **preferred language.**
- There were no questions in the survey to capture the data related to **sexual orientation or gender identify (SOGI).**

HNJ2030
ACCESS TO QUALITY CARE
DATA & TECHNOLOGY

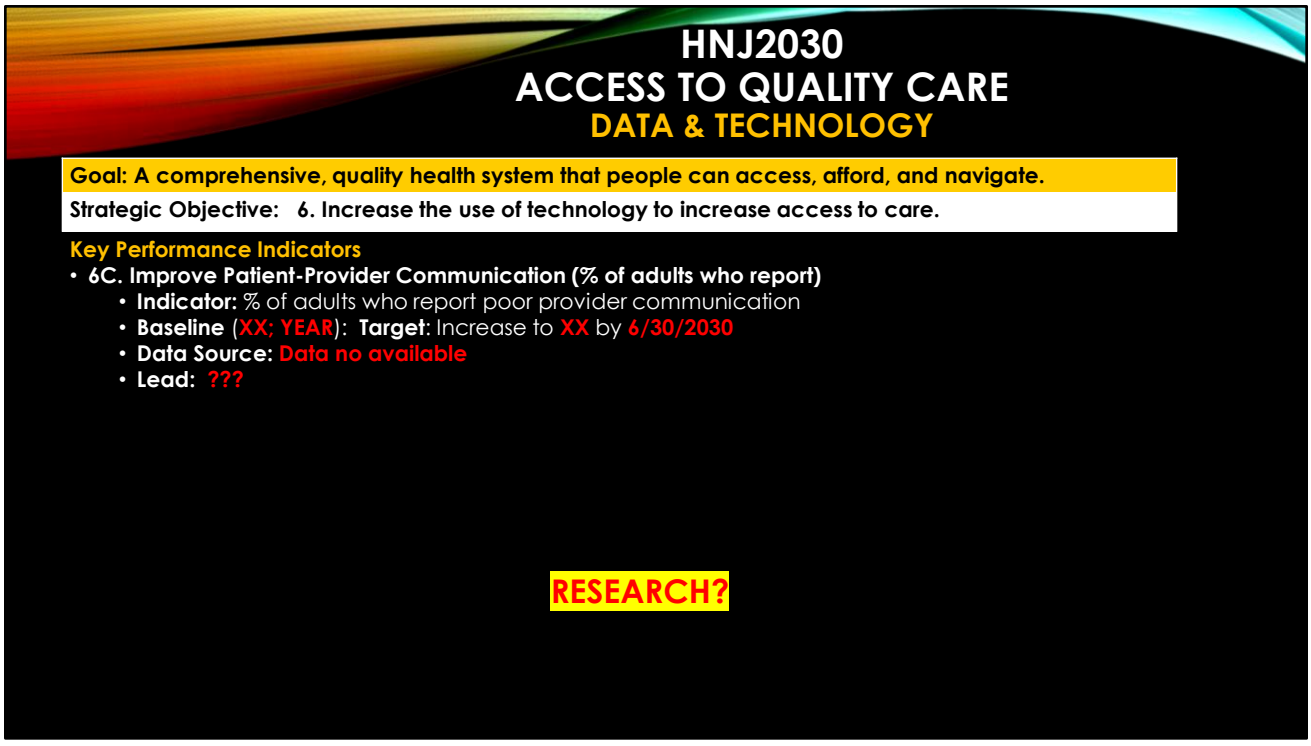
Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 6. Increase the use of technology to increase access to care.

Key Performance Indicators

- **6A. Increase the availability of patient portals to increase access to care.**
  - **Indicator:** % of adults who have access to a patient portal
  - **Baseline** (XX; YEAR): **Target:** Increase to XX by 6/30/2030
  - **Data Source:** Data no available
  - **Lead:** ???
- **6B. Increase the use of patient portals to increase access to care.**
  - **Indicator:** % of adults who use patient portals to access care, communicate with providers and monitor health information
  - **Baseline** (XX; YEAR): **Target:** Increase to XX by 6/30/2030
  - **Data Source:** Data no available
  - **Lead:** ???

As previously noted, it is important to address barriers to care, including access to technology. However, we could not find data on the **availability and use of technology** (portals and telehealth). Therefore, we would not be able to track and show progress in this area.



Studies have shown that effective patient-provider communication is important for physical and psychological health outcomes and the patients' adherence to treatment.

The **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** is a patient satisfaction survey that a random sample of adult inpatients receive after the leave the hospital. The survey is required by the Centers for Medicare and Medicaid Services for hospitals in the US and includes measures of patient-provider communication. While HCAHPS scores are publicly reported on the CMS website under Hospital Compare, we could not find specific provider data and the % of adults who report poor provider communication in order to document changes.

Therefore, this indicator will not be included in the SHIP.

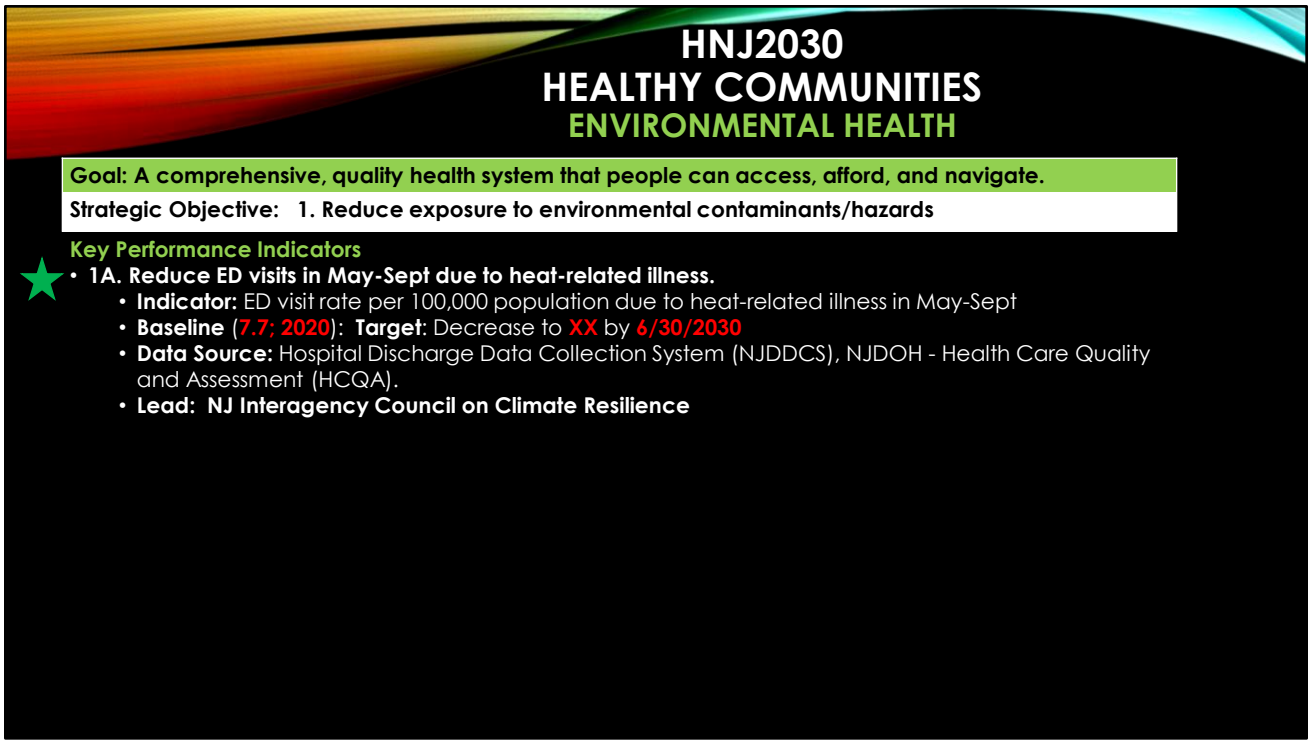
We could drop this indicator or use the Healthy People category of "Research" to include strategies to investigate this further.

Access to Quality Care	
Increase Health Access	
1A	Increase Needs Met in Primary Care Shortage Area (% Needs Met)
1C	Eliminate Dedicated Primary Care Disparities (% of adults)
1D	Increase the % of health care providers who have received Culturally and Linguistically Appropriate Services (CLAS) / Bias Training **RESEARCH**
Access – Cost of Care	
2B	Increase Insured adults (% of adults 18-65)
2E	Eliminate Disparities – those who avoided care due to cost (% of adults)
Quality & Safety	
4B	Eliminate disparities in the Overall Preventive Quality Indicator (PQI) rates
Data & Technology Patient Portals	
5A	Analyze Inclusive Demographic Data Collection (% of relevant NJDOH datasets that include at least the minimum 5 races plus Hispanic ethnicity, language spoken at home, and SOGI)
6C	Poor Provider Communication (% of adults who report) **RESEARCH**

In summary, there were **20** indicators for **Access to Quality Care** and based on our recommendations, there are now **6,** with **2** additional to be **RESEARCHED or dropped.**

The next set of objectives are within the Health Communities domain.

These objectives focus on environmental health, injury & violence, and community assets that support healthy eating and active living.



Looking at **Environmental Health,** heat-related illness is on the rise.

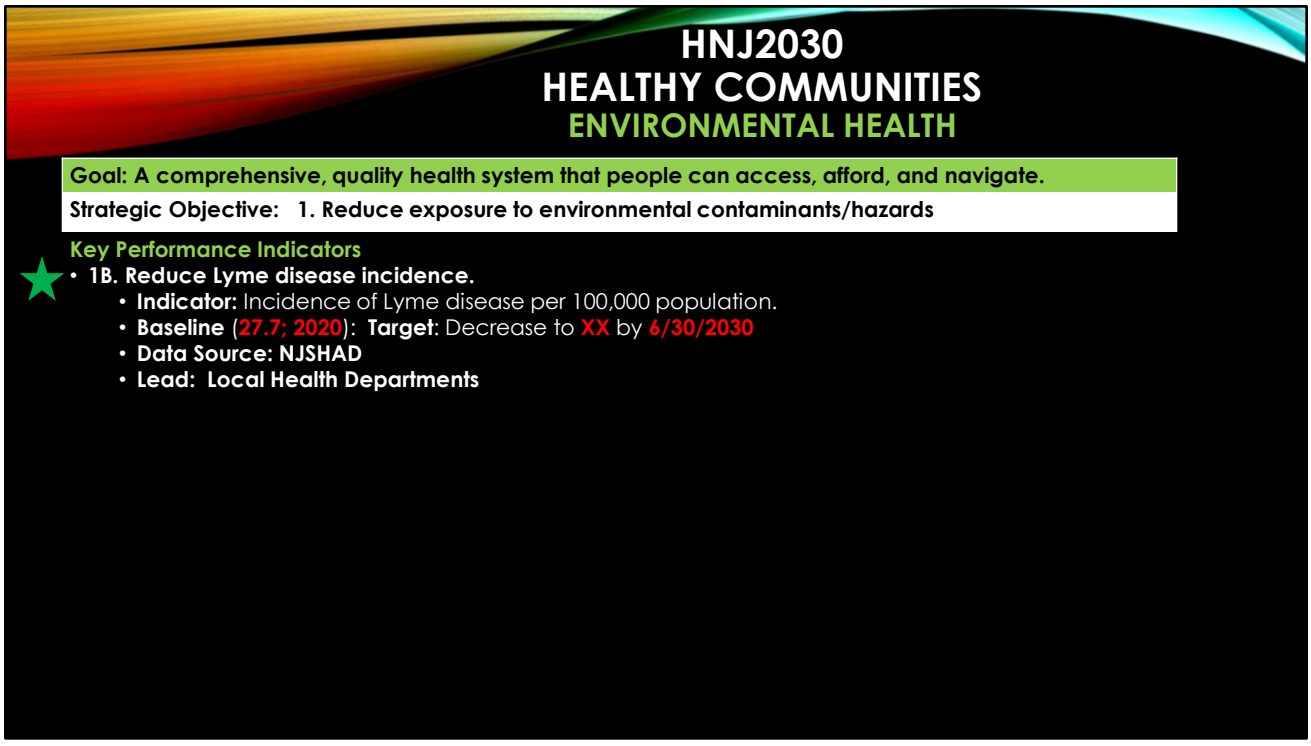
According to the **DOH Environmental Public Health Tracking Program**, the total number of days over 90 degrees F in NJ has increased by roughly **40%** since 1949. Throughout the state, the number of days over 90 degrees F have increased from about **17 to 23 per year,** and in 2024, there were **56** days where the temperature exceeded 90 degrees F.

A heat wave is generally defined as temperatures exceeding 90 F lasting about four days. There were **6** heatwaves recorded in 2024. These typically occur between May and September.

The NJ DOH has resources to track health related illnesses for targeted response. These include a Heat Hub NJ to track temperatures and the NJDOH Heat-related Illness Dashboard.

It is proposed to **reduce ED visits in May-Sept due to heat-related illness (green star).**

- NJDOH Climate Change Resources
- NJDOH Heat-related Illness Dashboard



The NJDOH also has a vector-borne disease data dashboard to display **vector-borne disease case data** (counts and incidence rates), **emergency department visits for tick-related illness,** and **vector-borne pathogen (germ) data** in mosquitoes and ticks.

Of the vector-borne diseases tracked, Lyme disease is the most prevalent in NJ. Lyme disease is an illness caused by bacteria that are carried by ticks and is spread to people by the bite of an infected tick; it is not spread from person to person. Lyme disease can cause a variety of symptoms and if left untreated can be severe.

It is proposed that we reduce Lyme disease incidence (green star).

HNJ2030
HEALTHY COMMUNITIES
INJURY & VIOLENCE

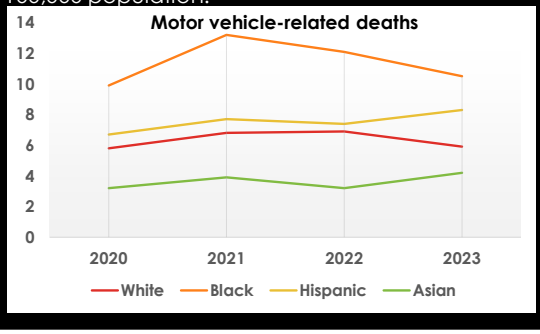
Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 2. Reduce fatality, serious injury, and exposure to violence and traumatic experiences.

Key Performance Indicators

- **2A. Reduce motor vehicle-related deaths.**
  - **Indicator:** Motor vehicle-related death rate per 100,000 population, age-adjusted.
  - **Baseline** (6.4; 2020): **Target**: Decrease to XX by 6/30/2030

- **2B. Eliminate the disparities in motor vehicle-related deaths.**
  - **Indicator:** ratio of motor vehicle-related death rate per 100,000 population.
  - **Baseline** (1.71 **Black:White; 3.09 Black:Asian; 2020**):
  - **Target**: Decrease to 1.0 by 6/30/2030
  - **Data Source:** Death certificate database
  - **Lead: DOT– Highway Safety**



The next set of indicators are related to **Injury & Violence**

As of 2023, **unintentional injury** was the leading cause of death among persons aged 15-44 years in NJ and the 3rd leading cause of death among all ages combined in NJ.

Motor vehicle crashes were the **3rd** leading cause of **unintentional injury death** in NJ; behind overdose deaths and falls.

Unintentional injuries are, for the most part, preventable.

While there has been some progress in this area, disparities still exist. It is proposed that we **Eliminate the disparities in motor vehicle-related deaths (2B)** as opposed to just reducing the rate overall **(2A).**

HNJ2030
HEALTHY COMMUNITIES
INJURY & VIOLENCE

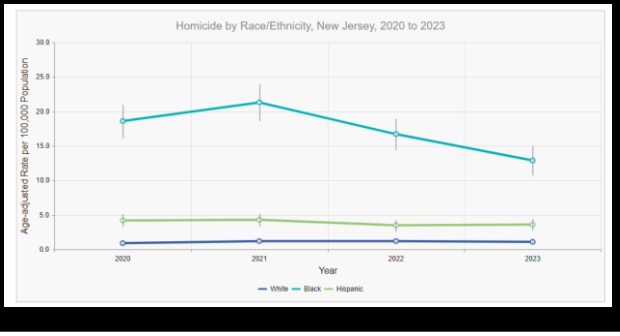
Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 2. Reduce fatality, serious injury, and exposure to violence and traumatic experiences.

Key Performance Indicators

- **2C. Reduce the proportion of homicides committed by youth and young adults.**
  - **Indicator:** % of homicides committed by individuals age XX and under.
  - **Baseline** (XX; 2020): **Target**: Decrease to XX by 6/30/2030
  - **Data Source:** NJSHAD
  - **Lead:** NJ Office of the Attorney General

- **2D. Eliminate disparities in homicides.**
  - **Indicator:** % of homicides, by race/ethnicity, age and gender of perpetrator and victim.
  - **Baseline** (20.66 **Black:White; 2020; age disparities**)
  - **Target**: Decrease to 1.0 by 6/30/2030
  - **Data Source:** Violence Crimes Report
  - **Lead:** NJ Office of the Attorney General



There are also racial/ethnic disparities in Homicides and **Elimination of those disparities** is also proposed **(2D).**

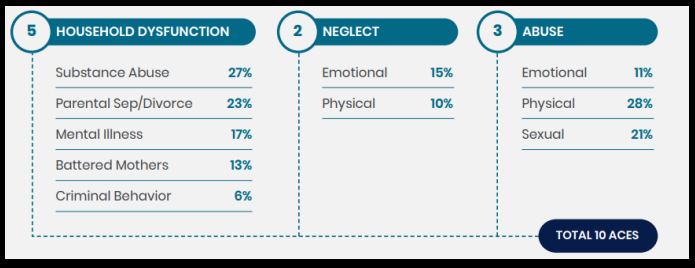
HNJ2030
HEALTHY COMMUNITIES
INJURY & VIOLENCE

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 2. Reduce fatality, serious injury, and exposure to violence and traumatic experiences.

Key Performance Indicators

- **2E. Eliminate Adverse Childhood Experiences.**
  - **Indicator:** % of children aged 0-17 who have ever experienced 2 or more ACEs.
  - **Baseline** (9.6; 2022): **Target**: Decrease to 1.0 by 6/30/2030
  - **Data Source: America's Health Rankings**
  - **Lead: NJ DCF, NJ Resiliency Coalition**



Adverse Childhood Experiences (ACEs) are stressful or traumatic events that occur before the age of 18. Examples of ACEs include household dysfunction, childhood neglect, or child abuse.

Researchers have found:

- Experiencing one or more ACEs, as well as environmental or historical traumas, such as community violence, can cause an individual to experience toxic stress.
- ACEs are common across all socioeconomic, racial, and ethnic groups.
- There are significant subgroup disparities by race and socioeconomic status.
- There is a strong relationship between exposure to abuse, neglect, or household dysfunction during childhood and risk factors for several of the leading causes of death in adults.

NJ ACES STATEWIDE ACTION PLAN

It is therefore proposed that we include Elimination of Adverse Childhood Experiences (green star).

HNJ2030
HEALTHY COMMUNITIES
COMMUNITY ASSETS

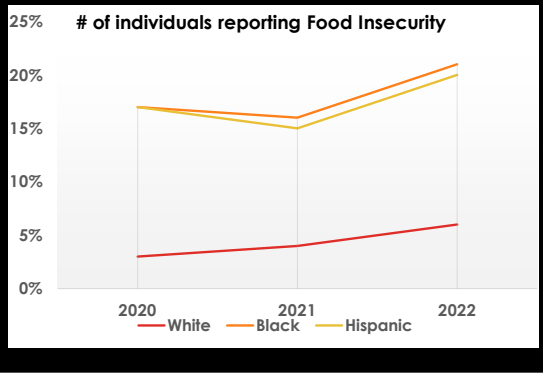
Goal: A comprehensive, quality health system that people can access, afford, and navigate.

Strategic Objective: 3. Increase community assets to support healthy living (i.e. nutritious food, and opportunities to engage in active living)

Key Performance Indicators

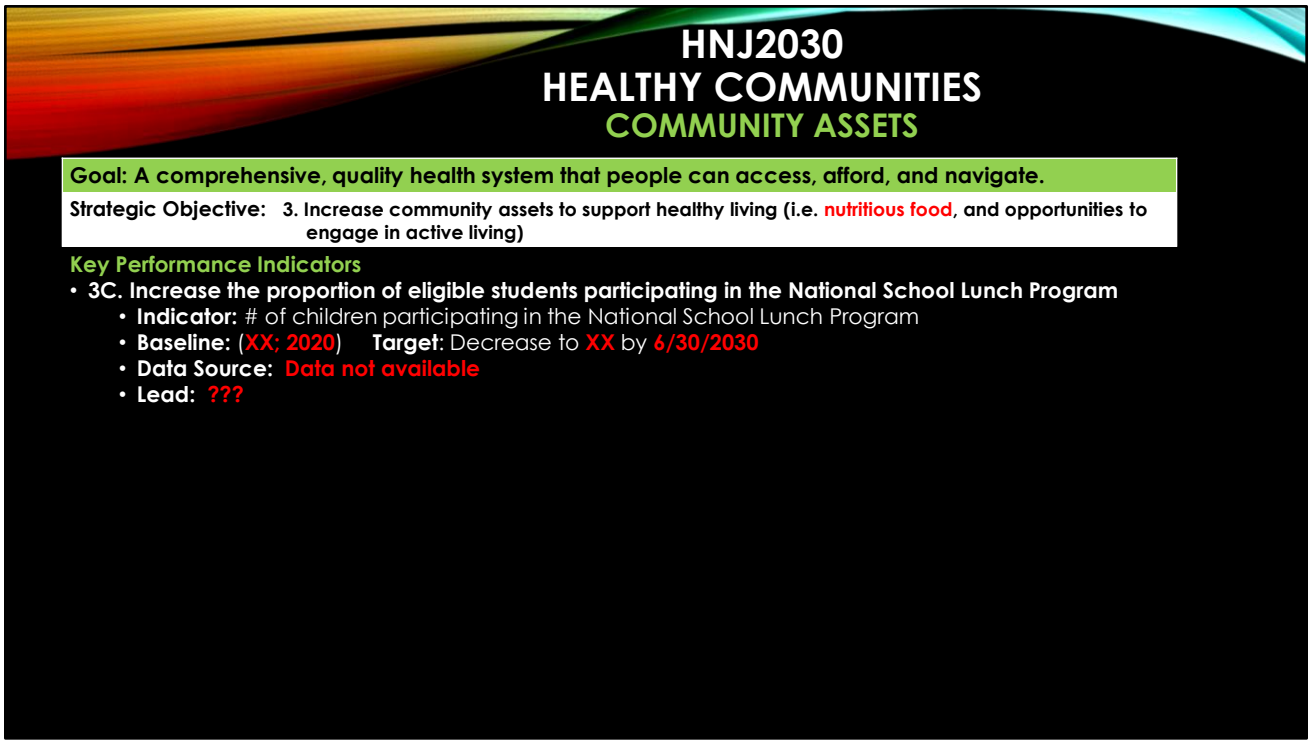
- **3A. Eliminate Food Insecurity.**
  - **Indicator:** # of individuals per 100,000 reporting food insecurity.
  - **Baseline:** (7.4; 2020)
  - **Target**: Decrease to XX by 6/30/2030

- **3B. Eliminate the disparity in food insecurity.**
  - **Indicator:** # of individuals reporting food insecurity.
  - **Baseline:** (5.67; 2020)
  - **Target**: Decrease to 1.0 by 6/30/2030
  - **Data Source:** NJSHAD
  - **Lead:** NJ Office of the Food Security Advocate



The next set of indicators are related to community assets that support healthy living such as access to nutritious food and opportunities to engage in active living.

Food security is important because proper nutrition promotes the optimal growth and development of children and helps reduce the risks for many health conditions. This graph shows the proportion of individuals reporting food insecurity (a lack of access to food) and the racial/ethnic disparity that exists. It is proposed that we eliminate the disparity **(3B).**



Many food-insecure children supplement their daily food intake with school meals.

However, we could not find reliable data to document the proportion of eligible students participating in the National School Lunch Program and the Kids Count Data Center states "due to changes in eligibility, it is advised not to compare the year-to-year data because of differing eligibility levels"

Therefore, we will not include this as a measure in the SHIP.

HNJ2030
HEALTHY COMMUNITIES
COMMUNITY ASSETS

Goal: A comprehensive, quality health system that people can access, afford, and navigate.

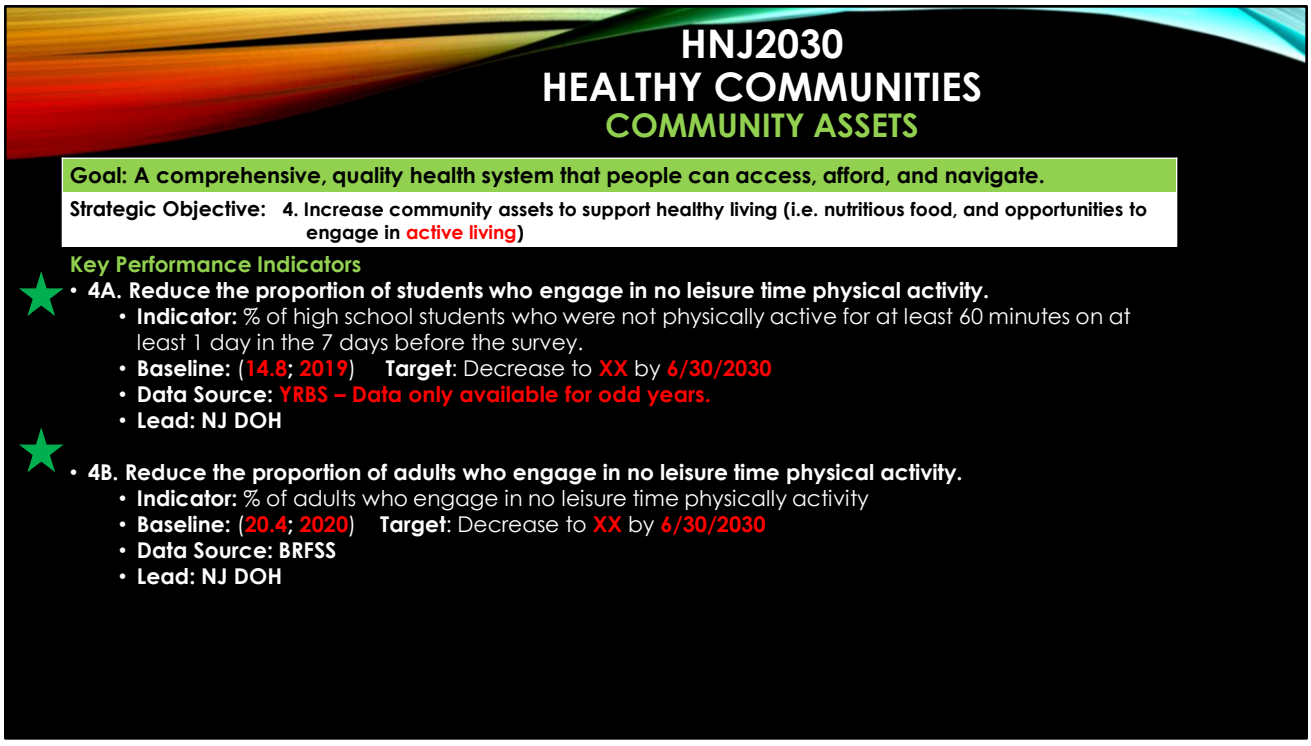
Strategic Objective: 3. Increase community assets to support healthy living (i.e. nutritious food, and opportunities to engage in active living)

Key Performance Indicators

- **3D. Reduce the proportion of children with obesity.**
  - **Indicator:** % of children aged 6-17 with obesity
  - **Baseline:** (30; 2020-21) **Target**: Decrease to XX by 6/30/2030
  - **Data Source: childhealthdata.org**
  - **Lead: NJ DOH**

- **3E. Eliminate the disparity in obesity among adults.**
  - **Indicator:** % of adults with obesity
  - **Baseline** (0.34 Black:Asian; 2020)
  - **Target**: 1.0 by 6/30/2030
  - **Data Source: NJSHAD**
  - **Lead: NJ DOH**

In terms of obesity, rates of overweight and obesity among adults and adolescents increased since 2020. The data for childhood obesity is not available by race/ethnicity.
The 2030 SHIP will include obesity indicators for children and adults.



Like overweight and obesity in the 2020 SHIP, there was little to no improvement in physical activity among adolescents and adults.

Regular physical activity helps improve a person's overall health and fitness and reduces the risk for many chronic diseases. These indicators are proposed for the 2030 targets.

Healthy Communities	
Environmental Health	
1A	Reduce ED visits due to heat-related illness in May-Sept.
1B	Reduce Lyme disease incidence.
Injury & Violence	
2B	Eliminate the disparity in motor vehicle-related deaths.
2D	Eliminate disparities in homicides.
2E	Eliminate Adverse Childhood Experiences.
Community Assets (Healthy Eating & Active Living)	
3B	Eliminate the disparity in the food insecurity rate.
3D	Reduce the proportion of children ages 6-17 years with obesity
3E	Reduce the proportion of adults with obesity.
4A	Reduce the proportion of high school students who were not physically active for at least 60 minutes on at least 1 day in the 7 days before the survey.
4B	Reduce the proportion of adults who engage in no leisure time physical activity

In summary, there were **14 Healthy Communities** indicators, and we reduced them down to **10.**

The last set of objectives are within the Health Living domain.

These objectives focus on healthy living and well-being throughout the lifespan starting with 1) maternal, infant & family health; 2) prevention and early detection through clinical preventive services; 3) including STIs rates (which has been getting worse of the years); and 4) behavioral health.

HNJ2030
HEALTHY LIVING
MATERNAL, INFANT & FAMILY HEALTH

Goal: Healthy living and well-being throughout the lifespan.

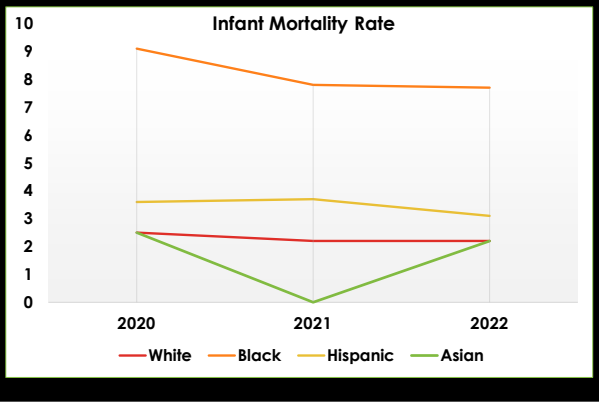
Strategic Objective: 1. Reduce infant and maternal mortality rates and eliminate disparities in birth-related outcomes.

Key Performance Indicators

- **1A. Reduce infant mortality**
  - **Indicator: %** per 1,000 live births
  - **Baseline:** (4.1; 2020) **Target:** Decrease to **XX** by **6/30/2030**
  - **Data Source:** Infant death-birth match database
  - **Lead: NJ DOH**

★

- **1B. Eliminate infant mortality rate disparities**
  - **Indicator:** ratio per 1,000 live births, Black:White ratio
  - **Baseline:** (3.64; 2020) **Target:** 1.0 by **6/30/2030**
  - **Data Source:** Infant death-birth match database
  - **Lead**: **NJ DOH**



With regards to **Maternal, Infant, and Family Health**, the commitment of Nurture NJ and the Maternal Infant Health Innovation Authority (MIHIA) has made progress since the 2020 SHIP but disparities still exist in both infant mortality and maternal mortality.

It is therefore proposed to **Eliminate disparities in infant mortality rates (1B)** AND …

HNJ2030
HEALTHY LIVING
MATERNAL, INFANT & FAMILY HEALTH

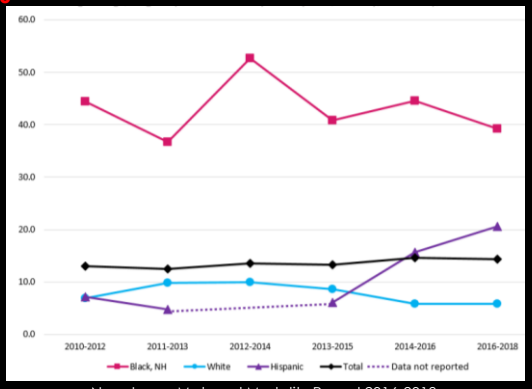
Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 1. Reduce infant and maternal mortality rates and eliminate disparities in birth-related outcomes.

Key Performance Indicators

- **1C. Reduce maternal mortality**
  - **Indicator:**
  - **Baseline:** (XX; 2020) **Target:** Decrease to XX by 6/30/2030
  - **Data Source: Maternal Mortality Review**
  - **Lead: NJ DOH**

- **1D. Eliminate maternal mortality rate disparities**
  - **Indicator:**
  - **Baseline:** (XX; 2018) **Target:** 1.0 by 6/30/2030
  - **Data Source: Maternal Mortality Review**
    Data not available after 2018
  - **Lead: NJ DOH**



New Jersey Maternal Mortality Report 2016-2018

Eliminate disparities in maternal mortality rates (1D). The data from the Maternal Mortality Review has not been regularly available since 2018 but we will continue to track this as data become available.

HNJ2030
HEALTHY LIVING
MATERNAL, INFANT & FAMILY HEALTH

Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 1. Reduce infant and maternal mortality rates and eliminate disparities in birth-related outcomes.

Key Performance Indicators

- **1E. Increase the proportion of infants who are breastfed at 12 months**
  - **Indicator:** % of infants breastfed at 12 months
  - **Baseline:** (33.8%; 2019) **Target**: Increase to XX by 6/30/2030
  - **Data Source: CDC Breastfeeding Report --- Reliable data source not available**
  - **Lead: CJFHC**

	Initiation of breastfeeding	Exclusive at 3 months	Any at 6 months	Any at 12 months
CDC NJ, Births 2019[1]	82.5%	41.2%	55.4%	33.8%
CDC NJ, Births 2022[1]	88.5%	47.1%	68.3%	48.0%

Recent New Jersey Breastfeeding Statistics - New Jersey Breastfeeding Coalition

In support of the 2022-2027 NJ Breastfeeding Strategic Plan to promote breastfeeding initiation and continuation, several measures were proposed.
Of those, measuring the proportion of infants who are still breastfed at 12 months is a good indicator of a successful start and continuation.

Data from 2019 and 2022 indicates that there has been progress towards i**ncreasing the proportion of infants who are breastfed at 12 months** .

However, the CDC Breastfeeding data is not available each year and data hasn't been released since 2022. Going forward, we may not have data to track progress.

Also, data are not available by race/ethnicity, so eliminating disparity isn't an option.

HNJ2030
HEALTHY LIVING
CLINICAL PREVENTIVE SERVICES

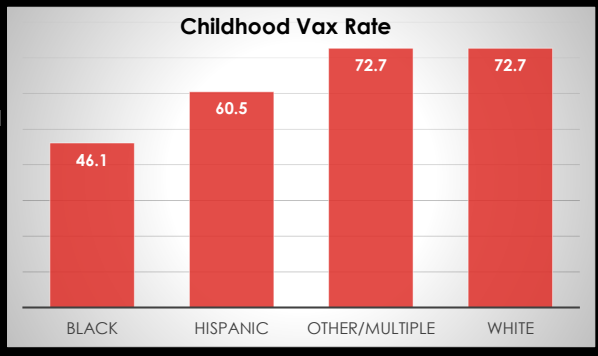
Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 2. Increase preventive care and reduce disparities among children, adolescents, and adults.

Key Performance Indicators

- **2A. Increase the proportion of children who receive the Combined 7 Series by age 24 months**
  - **Indicator:** % of children who receive the Combined 7 Series by age 24 months
  - **Baseline:** (XX; 2016-19)
  - **Target**: Increase to XX by 6/30/2030
  - **Data Source: Child Vax View**
  - **Lead: NJ DOH - VPDP**

- **2B. Eliminate the disparity in the proportion of…**
  - **Indicator:** % of children who receive the Combined
  - **Baseline:** (1.58; 2016-19)
  - **Target**: 1.0 by 6/30/2030
  - **Data Source: Child Vax View**
  - **Lead: NJ DOH - VPDP**



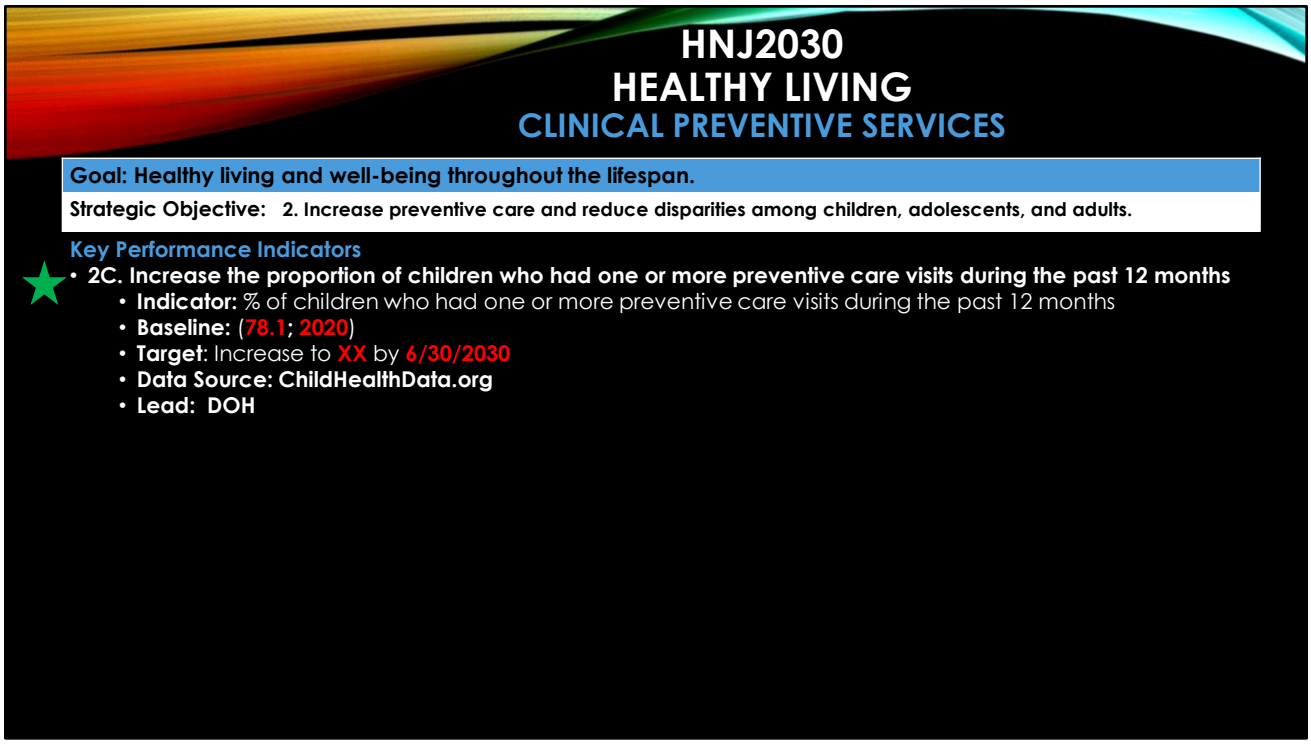
The next set of indicators are related to Clinical Preventive Health Services, specifically vaccinations.

Vaccines play an important role in keeping us healthy. They protect us from serious diseases.

Early childhood immunization has been proven to be a safe and cost-effective means of controlling vaccine-preventable diseases.

Unfortunately, there has been little to no improvement in the proportion of children receiving the recommended vaccines since the 2020 SHIP was published.

While both of the indicators have a green star, the availability of the data will determine whether we are able to track disparities or simply the proportion of children who receive the Combined 7 Series by age 24 months.



Looking at the proportion of children who had one or more preventive care visits during the past 12 months is also important but the data from ChildHealthData.org may not be available for race/ethnicity going forward so we may not be available to document racial/ethnic disparities.

Therefore, we will focus on increasing the rate overall.

HNJ2030
HEALTHY LIVING
CLINICAL PREVENTIVE SERVICES

Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 2. Increase preventive care and reduce disparities among children, adolescents, and adults.

Key Performance Indicators

- **2D. Increase the proportion of adult who visited a doctor for a routine checkup in the past year.**
  - **Indicator:** % of adults who visited a doctor for a routine checkup in the past year, age adjusted.
  - **Baseline:** (75.6; 2020)
  - **Target**: Increase to XX by 6/30/2030
  - **Data Source: BRFSS**
  - **Lead: NJDOH**

Data are available from BRFSS on the proportion of adults who visited a doctor for a routine checkup in the past year, so we will track that as well (green star).

HNJ2030
HEALTHY LIVING
SEXUALLY TRANSMITTED INFECTIONS

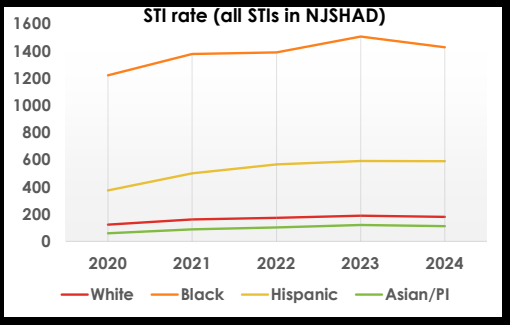
Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 3. Reduce the rate of Sexually Transmitted Infections (STIs) and their complications

Key Performance Indicators

- **3A. Reduce the STI rate (chlamydia, gonorrhea, and syphilis)**
  - **Indicator:** STI rate per 100,000 population
  - **Baseline:** (472; 2020) **Target**: Decrease to XX by 6/30/2030
- **3B. Eliminate the disparities in STI rates (chlamydia, gonorrhea, and syphilis)**
  - **Indicator:** Ratio Black:White
  - **Baseline:** (9.9; 2020) **Target**: 1.0 by 6/30/2030
- **3C. Reduce the congenital syphilis incidence rate**
  - **Indicator:** rate per 100,000 live births
  - **Baseline:** (25.7; 2020) **Target**: Decrease to 0 by 6/30/2030
- **3D. Eliminate the disparity in congenital syphilis incidence**
  - **Indicator:** Ratio Black:White
  - **Baseline:** (8.3; 2020) **Target**: 1.0 by 6/30/2030

- **Data Source: NJSHAD - CDRSS**
- **Lead: NJDOH - STIs**



This section is related to Sexually Transmitted Infections (STIs)

The rate of all STIs has increased among all populations since 2020. There is also a large disparity between racial/ethnic groups. This is a trend that needs to be reversed overall so reducing the rate may be the better choice. We will defer to subject matter experts to advise and update the SHIP accordingly.

Congenital syphilis cases are relatively low, eliminating congenital syphilis (altogether) may be the way to go.

Again, we will defer to subject matter experts to advise and update the SHIP accordingly.

HNJ2030
HEALTHY LIVING
BEHAVIORAL HEALTH

Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 4. Improve mental health, and reduce alcohol, nicotine, and substance use.

Key Performance Indicators

- **4A. Increase the proportion of individuals with depression (or other mental health condition) that receive treatment**
  - **Indicator:** % of individuals with depression that receive treatment
  - **Baseline:** Data unavailable **Target**: Increase to XX by 6/30/2030
  - **Data Source:** Data unavailable
  - **Lead:**

The next set of indicators are related to behavioral health (mental health and substance use).

In reference to the proportion of individuals who have been screened and diagnosed with depression, we have been unable to find data on the proportion screened and referred for treatment.

Therefore, we will not include this indicator.

HNJ2030
HEALTHY LIVING
BEHAVIORAL HEALTH

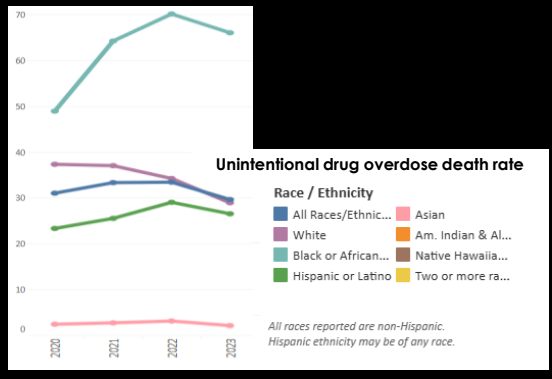
Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 4. Improve mental health, and reduce alcohol, nicotine, and substance use.

Key Performance Indicators

- **4B. Decrease the unintentional drug overdose death rate**
  - **Indicator:** overdose death rate
  - **Baseline:** (31.0; 2020) **Target**: Increase to XX by 6/30/2030
  - **Data Source: SUDORS**
  - **Lead: DHS & DOH**

- **4C. Eliminate disparities in unintentional drug overdose deaths**
  - **Indicator:** overdose death rate
  - **Baseline:** (2.1 Black:Hispanic; 2020)
  - **Target**: 1.0 by 6/30/2030
  - **Data Source: SUDORS**
  - **Lead: DHS & DOH**



We do however have data on unintentional drug overdose deaths.

As previously mentioned, unintentional drug overdose deaths are the leading cause of injury-related death in NJ. While a lot of progress has been made since 2020, there is still work to be done.

DOH and the Department of Human Services (DHS) have collaborated to reduce overdose deaths through harm reduction centers and medication assisted treatment.

We will consult with subject matter experts to advise on which indicator to use and update the SHIP accordingly.

HNJ2030
HEALTHY LIVING
BEHAVIORAL HEALTH

Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 4. Improve mental health, and reduce alcohol, nicotine, and substance use.

Key Performance Indicators

- **4D. Increase the availability of existing harm reduction strategies (naloxone, fentanyl test strips, and referral to substance use disorder treatment).**
  - **Indicator:**
  - **Baseline: XX** **Target**: Increase to **XX** by **6/30/2030**
  - **Data Source: ???**
  - **Lead: DMHAS**

- **4E. Increase the availability of Medication Assisted Treatment options for mental health and substance use recovery services**
  - **Indicator:**
  - **Baseline: XX** **Target**: Increase to **XX** by **6/30/2030**
  - **Data Source: ???**
  - **Lead: DMHAS**

While DOH and DHS have collaborated to reduce overdose deaths through harm reduction strategies and medication assisted treatment, data are not available to quantify the availability of existing harm reduction strategies and Medication Assisted Treatment options used by providers for mental health and substance use recovery.

Therefore, these indicators will not be included in the SHIP.

HNJ2030
HEALTHY LIVING
BEHAVIORAL HEALTH

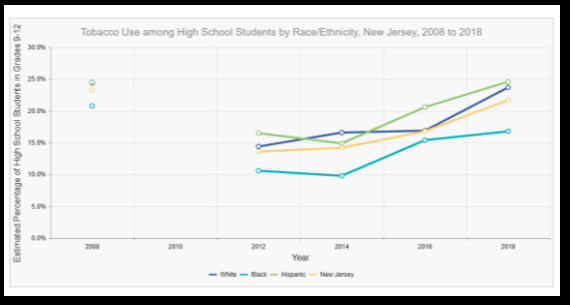
Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 4. Improve mental health, and reduce alcohol, nicotine, and substance use.

Key Performance Indicators

- **4F. Reduce the proportion of high school students who currently use tobacco and nicotine products**
  - **Indicator:** % of high school students who currently use tobacco / nicotine products
  - **Baseline:** 21.7%; 2018 **Target**: Increase to XX by 6/30/2030
  - **Data Source: Youth Tobacco Survey**
  - **Lead: NJDOH**

- **4G. Reduce the proportion of adults who are current cigarette smokers.**
  - **Indicator:** % of adults who are current cigarette smokers.
  - **Baseline:** (11.3; 2020)
  - **Target**: Decrease to XX by 6/30/2030
  - **Data Source: BRFSS**
  - **Lead: NJDOH**



Tobacco use is also a key contributor to adverse health conditions. Key intervention strategies include preventing youth from initiating use of tobacco and nicotine products and assisting adults to quit.

The graph shows an increase in tobacco use among NJ high school students between 2008 and 2018 by race/ethnicity.

The proposed indicators include reducing the proportion of high school students who currently use tobacco and nicotine products AND reducing the proportion of adults who are current cigarette smokers.

HNJ2030
HEALTHY LIVING
BEHAVIORAL HEALTH

Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 4. Improve mental health, and reduce alcohol, nicotine, and substance use.

Key Performance Indicators

- **4H. Decrease the Health Professional Shortage Area (HPSA) Scores in Mental Health Shortage Areas (or Decrease the HPSA FTE number in Shortage Areas / lower the population-to-provider ratio)**
  - **Indicator: HPSA Scores / HPSA FTE # / % Met Need**
  - **Baseline:** (XX; YEAR) **Target**: Increase to XX by 6/30/2030
  - **Data Source: KFF**
  - **Lead: NJ DOH**

Location	Total Mental Health Care HPSA Designations	Population of Designated HPSAs	Percent of Need Met	Practitioners Needed to Remove HPSA Designation
New Jersey	39	404,126	52.8%	28

Similar to the **Health Professional Shortage Areas** (HPSAs) in Primary Care, data suggests that there is more of a shortage in mental health providers.

In NJ, there are currently **39** areas/facilities that have a HPSA designation for Mental Health, and **404,126** individuals living within those designated areas.

The current number of mental health professionals that work in those areas only met **52.8%** of the populations' needs and **28 mental health** practitioners are needed to fill the gap.

Like the previously mentioned Primary Care HPSA data, we will consult with subject matter experts to determine the best way to document progress in these mental health shortage areas and include appropriate measures.

HNJ2030
HEALTHY LIVING
BEHAVIORAL HEALTH

Goal: Healthy living and well-being throughout the lifespan.

Strategic Objective: 4. Improve mental health, and reduce alcohol, nicotine, and substance use.

Key Performance Indicators

- **4I. Increase the proportion of community-based programs and school-based programs that offer mental health services**
  - **Indicator:** % of CBOs and school-based programs that offer mental health services
  - **Baseline:** Data unavailable **Target**: Increase to XX by 6/30/2030
  - **Data Source:** Data unavailable
  - **Lead:** ???

- **4J. Increase the proportion of FQHCs that have an integrated license for behavioral health services.**
  - **Indicator:** % of FQHCs that have an integrated license for behavioral health services.
  - **Baseline:** (XX: 2020) **Target**: Increase to XX by 6/30/2030
  - **Data Source:** NJDOH
  - **Lead:** ??? Office of Administrative Law

While community-based and school-based programs (including FQHCs) that offer mental health services can help alleviate shortage areas and increase access, we have been unable to find data to quantify available programs.

Therefore, these indicators will not be included in the SHIP.

Healthy Living	
Maternal, Infant & Family Health	
1B	Eliminate the disparity in the infant mortality rate
1C	Eliminate the disparity in maternal mortality rate
1E	Increase the proportion of infants who are breastfed at 12 months
Clinical Preventive Health Services	
2B	Eliminate the disparity in the proportion of children who receive the Combined 7 Series by age 24 months
2C	Increase the proportion of children who had one or more preventive care visits during past 12 months
2D	Increase the proportion of adults who visited a doctor for a routine checkup in the past year
Sexually Transmitted Infections	
3A	Reduce the STI rate (chlamydia, gonorrhea, and syphilis
3B	Eliminate the disparity in STI rates
3C	Reduce the congenital syphilis incidence rate
3D	Eliminate the disparity in congenital syphilis incidence
Behavioral Health (Mental Health & Substance Use)	
4B	Reduce the unintentional drug overdose death rate
4C	Eliminate the disparity in unintentional drug overdose deaths.
4F	Reduce the proportion of high school students who currently use tobacco and nicotine products
4G	Reduce the proportion of adults who are current cigarette smokers.
4H	Increase Needs Met in Mental Health Shortage Area (% Needs Met)

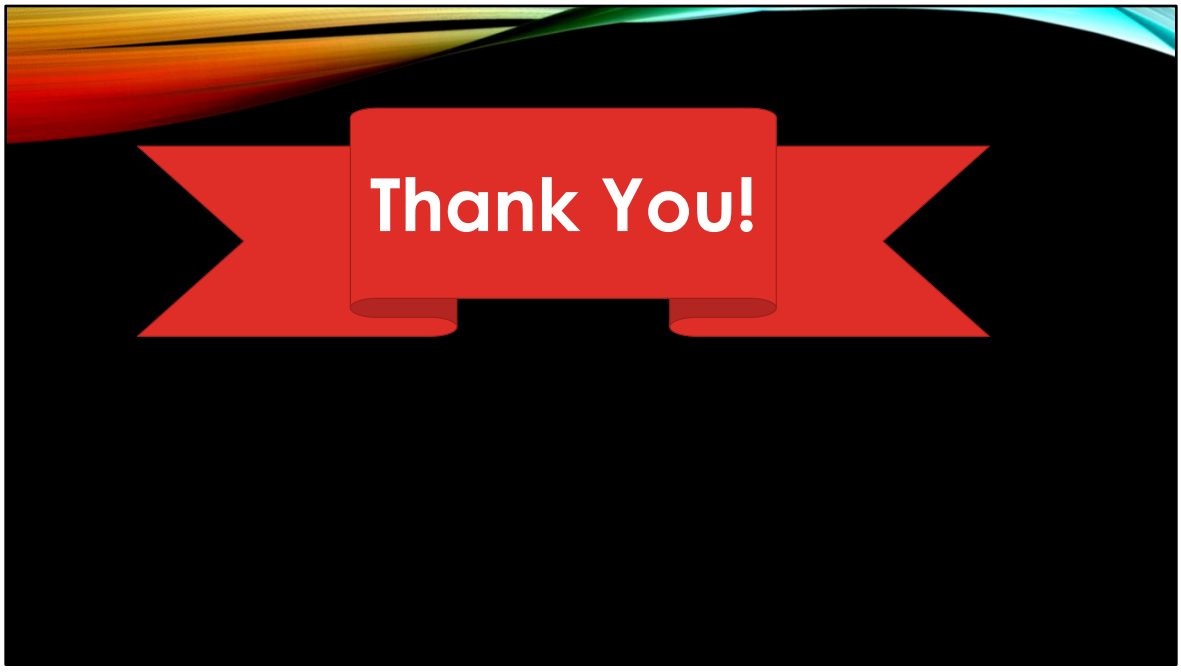
In summary, there were **22 Healthy Living** indicators, and we reduced them down to **15.**

There may be further reductions as we consult with subject matter experts regarding the indicators for STIs**.**

To recap, I will follow up with an email listing the current members for the Action Teams and the gaps. Please send recommendations of potential members to fill the gaps.

We also encourage the **Advisory Council** members to join at least one Action Team based on your area of interest. I will send a poll for you to select your preferred Action Team.

And lastly, after your review of these revised objectives and indicators to be included in the SHIP, please send data sources or other information that may assist with the final selections. I will send a link in the email for you to approve the final list.



Thank you for taking the time to review these slides.

Please respond to the email and provide your input. We will see you in November for the next meeting.

Take care.