Program Name: New Jersey Behavioral Risk Factor Survey

Healthy People 2030 Objective:

AHS-08Increase the proportion of adults who get recommended evidence-based preventive health care

Summary of the proposed project/intervention:

The NJBRFS is an annual health survey administered by telephone/cell phone to a random sample of New Jersey residents. The initiative is partially sponsored by the CDC; consistent with the terms of the cooperative agreement, the survey is designed to collect information on health status, chronic health conditions, access to health services, use of preventive health services and health risk behavior. Participating states are encouraged to add other CDC health modules or develop local questions that are particularly relevant to their jurisdiction. In 2025, in addition to the required elements of the core survey, which include: access to healthcare, health status, chronic health conditions, cholesterol awareness, hypertension, arthritis, prostate cancer screening, diabetes, disability, sleep, nutrition, exercise, tobacco use, alcohol consumption, and immunization, New Jersey will field optional questions that focus on cancer survivorship, asthma, other tobacco (heated tobacco, e-cigarettes), traumatic brain injury, Bethell's Positive Childhood Experiences, and the prevalence of screening for breast, cervical, colorectal and lung cancer.

Justification: The survey tool will be administered to a minimum of 7,500 NJ residents; approximately 1,700 of the surveys will be facilitated by the PHHSBG. The additional funding PHHSBG ensures a sample size that is sufficient to provide reliable data from which we can derive state and county level statistics by demographic status and county of residence.

SMART Objectives:

(1) Between October 2025 and September 2026, increase the quantity of completed New Jersey Behavioral Risk Factor Survey(s) from 6,000 to a minimum of 7,500 using a randomly selected sample of New Jersey landline and cell phone users to characterize the health status of the population.

(2) Between October 2025 and September 2026, clean, analyze, and disseminate data collected during the 2024 annual cycle of the BRFS project and post the information to NJSHAD (NJSHAD - (state.nj.us), an online source for data and health indicator reports.

Evidence/Promising Practice: NJBRFS provides data for health-focused programs to plan and/or evaluate program objectives.

Evaluation: Assessment of the number of interviews completed over the course of the data collection period and the ability to generate useful state and county level statistics by demographic characteristics from the collected data.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 200,000.00	$ 250,000.00

Program Name: NJ Heart Disease & Stroke Prevention Program

Healthy People 2030 Objective:

HDS-02 - Reduce coronary heart disease deaths

Summary of the proposed project/intervention:

NJDOH will partner with the Office of Emergency Medical Services to track CARES (The Cardiac Arrest Registry to Enhance Survival) data, which tracks out-of-hospital cardiac arrest or sudden death. The data would be helpful in identifying some potential activities in targeted communities.

Justification:

Together, heart disease and stroke, along with other cardiovascular disease, are among the most widespread and costly health problems facing the nation today. They result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. They are also among the most preventable health problems

In New Jersey, heart disease is the leading cause of death, with nearly 19,000 deaths attributed to it each year. The age-adjusted death rate for heart disease has been declining for many years but increased in 2020, with over 19,700 deaths reported that year. Additionally, NJSHAD reports that more than 1 in 3 adults in New Jersey live with some form of cardiovascular disease.

The Cardiac Arrest Registry to Enhance Survival (CARES) is a collaborative initiative between the Centers for Disease Control and Prevention (CDC) and Emory University aimed at improving survival rates from sudden cardiac arrest. CARES helps communities establish standard outcome measures for out-of-hospital cardiac arrest (OHCA), enabling local quality improvement efforts and benchmarking capabilities to enhance care and increase survival rates. By participating in the registry, communities can compare patient populations, interventions, and outcomes, identifying opportunities to improve the quality of care provided.

Outcomes:

NJDOH seeks to accomplish the following with PHHSBG funding:

- Strengthen collaboration between 911 centers, first responders, emergency medical services (EMS) agencies and hospitals;
- Provide a simple, confidential process for assessing patient outcomes in compliance with HIPAA;
- Offer technical assistance to help community leaders identify and prioritize opportunities to improve EMS performance; and
- Generate annual national and statewide reports for benchmarking capability

SMARTIE Objectives:

- By September 30, 2026, NJDOH will provide funding to the Office of Emergency Medical Services to support and expand cardiovascular data collection through the Cardiac Arrest Registry

Evidence/Promising Practice:

This is an evidence-based data system designed to collect demographic information, circumstances of cardiac arrest, resuscitation-specific data, emergency department and hospital data, and survival status.

Evaluation:

Data collection is based on the Utstein style definitions for cardiac arrest – a standardized template of uniform reporting guidelines for clinical variables and patient outcomes developed by international resuscitation experts. Patient-level data without personal identifiers can be submitted using a data-entry form on the CARES website or through daily upload from an agency's electronic patient-care record system. The CARES database is geocoded on an annual basis and linked to census-tract variables including: median household income, median age, race, unemployment rate, average household size, population density, and educational attainment.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 230,933.00.00	$ 305,933.00

Program Name: Community Health and Wellness Unit – Epidemiology, Surveillance and Evaluation Data Modernization Project

Healthy People 2030 Objective:
Enhance the use and capabilities of informatics in public health: **PHI-R06**. This is a research objective intended to enhance the use and capabilities of informatics, including data-sharing, data exchange, and application to practice and use in decision-making.

Summary of the proposed project/intervention:
The Community Health and Wellness Unit's Epidemiology, Surveillance and Evaluation Team (CHWU ESE) provides evaluation, surveillance and other data related needs support to the chronic disease program that comprise the CHWU (cancer, tobacco control, diabetes prevention and control, cardiovascular disease prevention, asthma, etc). The team is composed of four members, two analysts and two evaluators. In May 2025 the ESE team along with the Deputy Executive Director of the Office of Healthcare Quality and Informatics (OHQI) began participating in the National Association of Chronic Disease Directors' (NACDD) Data Modernization Action Incubator. This incubator is an accelerated training focused on assessing the status of chronic disease data in the State and the opportunities that exist to enhance and modernize chronic disease data collection, usage and dissemination.

The proposed project will support the development and implementation of a data modernization plan specific to New Jersey. The plan will include:

- an assessment of current data resources
- identification of opportunities to update/enhance current data collection
- identification of partners necessary to enhance the data environment related to chronic disease outcomes
- an integrated set of goals and objectives that support the modernization of data collection across all chronic disease programs
- specific examples of how to connect program outcomes to a set of key indicators (e.g. Chronic Disease Indicators, Healthy People Leading Health Indicators)

In addition to the plan, this proposal would support the purchase and training related to data visualization software (e.g. tableau, Power Bi) for ESE staff and Health Care Quality Informatics staff at NJDOH. This will allow for enhanced collaboration between the CHWU and the staff working on the Centralized Data and Analytics Hub. Data sharing, enhanced use of non-traditional surveillance data, data matching and enhanced use of resources like the Health Information Network (HIN) are the intended outcome.

Justification:
Program evaluation and surveillance are vital to demonstrating outcomes in public health interventions. The CHWU implements several chronic disease prevention programs that each have unique requirements for data capture and reporting (7 federal evaluation plans and reports required annually). A significant portion of CHWU ESE staff time is spent building evaluation plans, developing tools for data/indicator capture and working with program staff to ensure proper metrics are collected that match interventions implemented. Part of this process includes identifying and utilizing data sources that assist in measuring changes in the health outcomes for populations of interest. Enhancing the resources of the CHWU ESE team to use expanded data sources and to create enhanced data visualizations will improve the communication and dissemination of data in public spaces (NJDOH website, to CDC and other partners).

SMARTIE Objectives:

- By September 30, 2026, the CHWU ESE team and OHQI staff will create the NJDOH Chronic Disease Data Modernization Plan

- By September 30, 2026, the CHWU ESE team and OHQI staff will install, train and utilize enhanced data visualization software with a focus on creating and disseminating data that addresses leading health indicators
- By September 30, 2026, the CHWU ESE team and OHWI staff will attend a conference or other training opportunity to share out lessons learned

Evidence/Promising Practice:
This objective currently has "research" status, meaning it is a high-priority public health issue that doesn't yet have evidence-based interventions developed to address it. NJDOH will utilize lessons learned from the NACDD Incubator project as well as shared resources from CDC, NACDD and other states to support plan development and implementation.

Evaluation:
The Chronic Disease Data Modernization Plan will include detailed measures of success including but not limited to number and type of partners engaged, data resources created/utilized, integrated data collection across programs, creation of data collection tools, and expansion of surveillance resources. In addition, staff training, updated software usage and data product development will also be measured and reported.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 25,000.00	$ 25,000.00

Program Name: Violence Prevention Program

Healthy People 2030 Objective:

AH-R11 Reduce the rate of adolescent and young adult victimization from violent crimes.

Summary of the proposed project/intervention:

This program proposes the implementation of a multi-prong evidence-based strategy to create protective community environments and to intervene to lessen harms and prevent future risk associated with youth violence in Newark, New Jersey (in collaboration with 3 middle and high schools). The NJDOH will award 3 grants to schools that have a demonstrated history of implementing youth violence prevention and intervention programs that are evidence-based and evidence-informed in three (3) middle and high schools within the City of Newark. The awardees will be expected to link at-risk youth to a myriad of resources available through New Jersey executive branch agencies, including but not limited to: 1) University Hospital, a Hospital Based Violence Intervention Program (Department of Law and Public Safety) grantee; 2) the Youth Summer Employment and Apprenticeship Programs (Department of Labor and Workforce Development); 3) the Adolescent Health Program (Department of Health); the Department of Education – Office of Higher Education; and 5) the Department of Children and Families.

Justification:

According to the Center for Disease Control and Prevention (CDC), homicide is the third leading cause of death for young people ages 10 to 24 years. Nearly 1 in 5 high school students reported being bullied on school property in the last year, and about 1 in 7 were electronically bullied (via texting, Instagram, Facebook, or other social media platforms). In addition to the physical harm to youth, these events present a major challenge for public health and healthcare systems with the CDC estimating that medical and productivity losses associated with youth violence exceed $20 billion annually.

Areas of New Jersey that present the greatest challenges related to youth violence are the inner cities like Newark, NJ. These communities are disproportionately populated with individuals, who live in poverty, have lower educational attainment, low social connectedness, reside in subpar housing, work in low-wage and unskilled industries, and poor social determinants of health (such as, access to: high performing schools; healthy food and beverage choices; medical and behavioral health services; and pathways to positive post-secondary school opportunities).

Outcomes

NJDOH seeks to accomplish the following:

- reduce school delinquency among the target youth by ten percent (10%).
- reduce poor behaviors among the target youth, as reported by their schools, by ten percent (10%).
- reduce alcohol and tobacco use among youths ages 10 to18 years by twenty percent (20%).
- reduce substance use among the target youth by ten percent (10%).
- reduce youth violence by ten percent (10%) in the identified communities.
- increase by fifteen percent (15%) the number of age-appropriate youth in target communities that enroll in apprenticeship and/or Summer Youth Employment program after participation in CYVP program.
- increase by fifteen percent (15%) the number of age-appropriate youth in target communities that enroll in community college after participation in CYVP program.

SMARTIE Objectives:

- By December 31, 2025, NJDOH will provide mentoring programs/peer-to-peer education service delivery models for youths in schools, churches, businesses, or other community settings in Newark, NJ.
- By June 1, 2026, NJDOH will provide "Life Skills Training" to youth that focusses youth empowerment and reducing tobacco, alcohol, and other substance abuse to 3 Newark based schools.
- By December 1, 2025, NJDOH will partner with Newark's local law enforcement agency.
- By June 1, 2025, NJDOH will collaborate with Law enforcement to direct youths into the CYVP programs to avail services one and two of the Communities That Care in 3 Newark-based schools.

Evidence/Promising Practice:

The CDC's Approach to Community Violence Prevention details the critical roles of multiple sectors in preventing youth violence. It is recommended that strategies include education Systems, community based organizations, Law enforcement/justice systems, and more. The Community Preventive Services Task Force (CPSTF) recommends school-based anti-bullying interventions to reduce bullying experiences and improve mental health among students. Systematic review evidence shows that when interventions are implemented in schools, students report fewer episodes of bullying perpetration, fewer episodes of bullying victimization, and fewer mental health symptoms such as anxiety and depression. Interventions provide group education sessions for students, training and consultation to school staff, or both. Student sessions may enhance interpersonal and emotional skills. School staff may be trained to deliver student sessions and implement evidence-based anti-bullying policies and practices. Interventions may focus on traditional face-to-face bullying, cyberbullying, or both.

Evaluation:

Evaluation will be used to determine the outcomes and impact of objectives of the program. The NJDOH will use the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Evaluation Framework as a guide during the planning process and will develop evaluations for each strategy. As a first step, NJDOH will establish an Evaluation Planning Team (EPT) to guide and carry out the evaluation activities. The NJDOH CYVP Program will evaluate its success based upon progress toward both the CDC and Healthy People 2030 (youth violence) objectives. Healthy People 2030 objectives include:

- Reduce homicides – IVP-09
- Reduce nonfatal physical assault injuries — IVP-10
- Reduce physical fighting among adolescents – IVP-11
- Reduce gun carrying among adolescents — IVP-12
- Reduce the rate of minors and young adults committing violent crimes – AH-10
- Reduce the rate of adolescent and young adult victimization from violent crimes – AHR11
- Reduce the proportion of adolescents and young adults who aren't in school or working — AH-09
- Increase the proportion of schools with policies and practices that promote health and safety — EH-D01.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 300,000.00	$ 350,000.00

Program Name: Rape Set-Aside-Mental Health Supports for Victims/Survivors of Gender Based Violence

Healthy People 2030 Objective:

Healthy People 2030: IPV D04: Reduce intimate partner violence (i.e. contact sexual violence, physical violence and stalking) across the lifespan.

Summary of the proposed project/intervention:

DOW proposes to implement counseling accessible victim-centric, trauma informed counseling offered via culturally relevant and linguistically appropriate interventions. The funding will create pathways for the partners to deliver quality, accessible, inclusive mental health counseling and holistic services to survivors of sexual assault.

Survivors from underserved communities may lack access to mental health services for a variety of reasons -and while these may not be well understood or documented through published literature, there is an understanding that it is needed. There are also barriers that survivors from marginalized or underserved communities also encounter such as stigma, language barriers, discrimination, oppression and not knowing the availability of resources. Other factors such as individual beliefs, practices and how communities reach out for supports may preclude them from accessing formal supports.

Through this funding, identified DOW partners who have built trust and already engage with underserved and marginalized communities will offer high quality Master's Level counseling and/or offer holistic services that are relevant to the identified community. Hiring therapists that speak the language and understand the social, cultural and religious norms for underserved communities remains a priority for DOW and this funding will complement this approach.

Justification:

Over the past several years, DCF committed to prioritizing race equity across our institution and among our programs and services. Through the integration of the Office of Applied Research and Evaluation, we use data analytics to understand disparity and disproportionality across our department's public forms of interventions (child welfare, behavioral health, etc.) As part of its 2019-2025 Strategic Plan, DCF formed a Race Equity Steering Committee to examine how the department's policies and practices affect historically marginalized populations and specifically communities of color. In March 2021, DCF began training all 6,600 staff on implicit bias and systematic racism through nationally recognized experts. Staff attended various trainings, ranging in topics from understanding the impact of racism, disproportionality and disparity in child welfare agencies, and how to address racial inequity within the institutions.

Furthermore, the Division has also prioritized equity throughout our gender-based violence work. The partners selected to receive this funding will also receive training to address equity from the New Jersey Coalition Against Sexual Assault (NJCASA) and their consultants. This is a strategic goal for both DOW and NJCASA.

SMARTIE Objectives:

1. From October 1, 2025- September 30, 2026 the providers will deliver 250 sessions of counseling to survivors/victims of sexual assault from underserved and historically marginalized communities

a. The identified partners are culturally specific programs that have been created by the community and for the community with a specific purpose of ensuring their services and programs are accessible and inclusive. The partners have an expertise at delivering culturally relevant and linguistically appropriate services to victims and survivors of gender-based violence through other funding streams awarded by the Division on Women.

Evidence/Promising Practice: This concept does not have an evidenced based approach or promising practice at this time.

Evaluation: NJDCF-DOW collects quantitative data through monthly service reports. This data is collected and analyzed for trends and gaps and informs ongoing technical assistance, as well as program development and resource allocation. NJ DCF-DOW has an Evaluation Coordinator (Master's Level) who create feedback loops to demonstrate impact.

DCF engages in Continuous Quality Improvement (CQI) to identify and analyze strengths and areas needing improvement. DCF is committed to the process of ongoing evaluation as a vehicle to learn and develop solutions to improve the quality of services. Through participation in the Program Model Development offered by DCF's Office of Strategic Development, each partner will engage in ongoing CQI to ensure programs are systematically and intentionally increasing positive outcomes for individuals and families they serve.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 193,919.00	$ 193,919.00

Program Name: NJ State Physical Activity & Nutrition (SPAN) Program

Healthy People 2030 Objective:

AHS-08 Increase the proportion of adults who get recommended evidence-based preventive health care

Summary of the proposed project/intervention:

This program proposes the implementation of a multi-prong evidence-based strategy to improve statewide physical activity and nutrition access. (1) Worksite Wellness - implement evidence-based nutrition and physical activity strategies and policy, systems and environmental changes in the workplace. (2) Physical Activity – implement evidence-based physical activity and policy/systems/environmental interventions in communities. (3) Food Access -Increase food access in clinical settings and expand use of mobile health units in the community, having clinical mobile platforms ride tandem with mobile healthy food markets, and connect people to care

Justification:

Adults who are obese are at increased risk of morbidity from hypertension, high LDL cholesterol, type 2 diabetes, coronary heart disease, stroke, and osteoarthritis. In 2020, the proportion of adults who had a body mass index (BMI) greater than or equal to 30.0 kg/m was 28.6%, higher than previous years. Of these adults the highest proportion of obesity occurred in Black and Hispanic Adults (39.9% and 36.1% respectively).

Maintenance of a physically active lifestyle is recognized in public health as one of the essential features of a healthy life. While it has long been known that physical activity can prevent heart disease, newer studies suggest that, on average, physically active persons outlive those who are inactive. Between 2011 and 2017. According to the NJ State Health Assessment Data, the estimated percentage of adults in NJ, who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination, decreased from 53.2% to 49.2%.

Outcomes:

NJDOH seeks to accomplish the following:

- Increase access to healthy and affordable foods & beverages by 10%
- Increase public skills and knowledge to support healthy food & beverage choices
- Increase food security by 10%
- Promote worksite environments that increase physical activity and healthy food & beverage choices
- Increase access, for people of all ages and abilities, to indoor/outdoor places for physical activity

SMARTIE Objectives:

- By December 30th 1, 2025, the Worksite Wellness initiative will create educational videos for participants to use for creating a personal wellness plan.
- By June 1, 2026, the Worksite Wellness initiative will Implement a program at 2 sites that can recruit at least 25 participants willing to join the workforce wellness program.
- By June 1, 2026, the Worksite Wellness initiative will evaluate the Intervention

- By June 1, 2026, the Food Access Initiative will increase at-risk population's connection to healthy, nutritious food by 15% in Southern New Jersey through the use of mobile health units and local food resources.
- By June 1, 2026, the Physical Activity Initiative will partner with community stake holders in Southern New Jersey to develop policy/environmental intervention aimed at increasing physical activity in at-risk populations.

Evidence/Promising Practice:

The Community Preventive Services Task Force (CPSTF) recommends worksite programs intended to improve diet and/or physical activity behaviors based on strong evidence of their effectiveness for reducing weight among employees. Work site nutrition and physical activity programs are designed to improve health-related behaviors and health outcomes. These programs can include one or more approaches to support behavioral change including informational and educational, behavioral and social, and policy and environmental strategies.

Evaluation:

Evaluation will be used to determine if the objectives of the program are met. Process and performance measures will be utilized to guide programmatic implementation and short-term outcomes, while outcome measures will be utilized to measure overall programmatic success. The evaluation results will guide program planning and development with the guidance of the National Healthy People 2030 Plan. This evaluation framework, guided by The U.S. Food and Drug Administration's Health Educator's Nutrition Toolkit, sets strategy specific evaluation questions along with performance measures, data sources, key stakeholders, and methods for communication of evaluation results. This approach will enable NJDOH to engage in continuous quality improvement for strategy implementation, while also understanding the advantages and challenges of working collaboratively across health systems. The purpose of this monitoring and evaluation is to maximize quality, effectiveness, and efficiency of obesity reduction for underserved, disparate populations through quality assurance and improvement activities including EBIs.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 785,000.00	$ 800,000.00

Program Name: Maternal/Child Health & Chronic Disease

Healthy People 2030 Objective:

MICH-05 Reduce severe maternal complications identified during delivery hospitalizations

Summary of the proposed project/intervention:

This program proposes the implementation of 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. NJDOH will identify partners that can implement self-management programs and oral health interventions for perinatal people.

Justification:

According to the Center for Disease Control and Prevention (CDC), maternal health is closely linked to chronic diseases, as health problems such as diabetes, high blood pressure, and depression can arise during pregnancy, posing risks to both the mother and the infant. The risk of developing chronic conditions like hypertension and gestational diabetes increases with age, leading to poorer maternal health outcomes. Additionally, chronic health conditions can increase the risk of complications such as infertility, preterm birth, and pregnancy loss. Addressing these issues is crucial for improving maternal and infant health.

Furthermore, oral health during pregnancy can be affected by hormonal changes, increasing the risk of gum disease (gingivitis) and periodontitis. Good oral hygiene is important to prevent common issues such as gingivitis, cavities, and dental erosion. It is safe to get routine dental cleanings and procedures while pregnant. A mother's oral health status can predict her child's oral health status. Oral health is important part of perinatal care, given that poor oral health during pregnancy can lead to poor health outcomes for the mother and baby.

The New Jersey Department of Health-Health Care Quality & Informatics-Health Services Research's *Maternal Characteristics, Birth Outcomes & Maternal Morbidity, 2021 Report* indicates in 2021, 13% of birthing people who gave birth at a hospital were diabetic, which is a 1% increase from 2020. Racial and ethnic disparities were observed, with the highest rate of diabetes among Non-Hispanic Asian birthing people at 22.9% compared to non-Hispanic White birthing people at 10.4%. In 2021, approximately 10% of birthing people who gave birth in a hospital were hypertensive. Similarly, racial and ethnic disparities were observed with the highest rate being among non-Hispanic Black birthing people (16.5%) and the lowest among Non-Hispanic Asian birthing people (6.9%).

Outcomes

- Increase the number of perinatal people identified as hypertensive by five percent (5%)
- Increase the number of perinatal people receiving oral care by five percent (5%)
- Increase the number of perinatal people diagnosed with gestational diabetes into self-management programs by five percent (5%)

SMARTIE Objectives:

- By December 31, 2025, NJDOH will identify and partner with two (2) health care organizations to deliver chronic disease interventions to perinatal patients

- By June 30, 2026, two (2) health care organizations will implement a minimum of three evidence-based interventions to improve oral health, cardiovascular disease, and gestational diabetes outcomes for perinatal patients.
- By September 30, 2026, NJDOH will coordinate three (3) learning sessions for health care providers on the importance of chronic disease interventions for perinatal people.

Evidence/Promising Practice:

The Community Preventive Services Task Force (CPSTF) recommends lifestyle interventions delivered during the first two trimesters of pregnancy to reduce the risk of gestational diabetes. The CPSTF finds strong evidence of effectiveness for lifestyle interventions that provide supervised exercise classes, either alone or in combination with other components; and sufficient evidence of effectiveness for lifestyle interventions that provide education and counseling for diet or physical activity, diet activities, or a combination of these components.

In 2019, CDC and the American Academy of Pediatrics (AAP) launched Protect Tiny Teeth. This initiative has resources to help health care professionals talk with their pregnant patients about their oral health care needs. The toolkit also offers resources for pregnant women and new parents to promote good oral health during pregnancy and infancy. Perinatal care providers play a crucial role in screening pregnant patients for chronic and acute oral health conditions. They can educate these patients on the significance of oral health for their families and refer them to dental professionals.

The Hypertension in Pregnancy Change Package (CDC), the National Hypertension Control Initiative (OMH, HRSA), the SMBP Forum and SMBP QI work (CDC), the CDC-supported National Hypertension Control Roundtable, and the HHS Federal Hypertension Control Leadership Council support initiatives aimed to accelerate nation-wide implementation of SMBP (self-measured blood pressure) during pregnancy and postpartum. SMBP is a best practice defined as the regular measurement of blood pressure by the patient at home or other setting with clinical support. Based on a large body of evidence, SMBP is recommended in both national and international guidelines for the detection and control of HTN in adults and its use postpartum by AHRQ's Systematic Review and Meta-Analysis on the Management of Postpartum Hypertensive Disorders of Pregnancy.

Evaluation:

Evaluation will be used to determine the outcomes and impact of objectives of the program. The evaluation results will guide program planning, development, and quality improvement processes. The NJDOH will use the CDC Program Evaluation Framework to evaluate program effectiveness.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 300,000.00	$ 500,000.00

Program Name: Colorectal Cancer (CRC) Screening Program

Healthy People 2030 Objective:

AHS-08 Increase the proportion of adults who get recommended evidence-based preventive health care

Summary of the proposed project/intervention:

This program proposes the implementation of a multi-prong evidence-based interventions (EBIs) within multi-site Federally Qualified Health Centers (FQHCs) health systems. This initiative aims to to increase and improve the quality of Colorectal Cancer screening and follow-up testing in underserved, disparate populations aged 40-75 years.

Justification:

Colorectal cancer (CRC) is the third leading cause of death from cancer among men and women in the state of New Jersey, and it is estimated that in 2020, CRC will rise to the second leading cause of death from cancer (New Jersey State Cancer Registry, 2020; American Cancer Society, 2020). Incidence of CRC among non-Hispanic white men and women, non-Hispanic black women, and Hispanic men and women in New Jersey is higher than national averages. More than half of all New Jersey counties report age-adjusted CRC mortality rates higher than the national average (13.7). Despite meeting the Healthy People 2020 objective to reduce the CRC death rate to 14.5 deaths per 100,000 population (HP-C5), the objective was not met for all New Jersey residents. When compared by gender and race/ethnicity, the CRC mortality rates in New Jersey are highest among men and non Hispanic black people.

Disparities in screening rates are also prevalent among both racial and geographical demographics. Only 59.9% of age-eligible Hispanics report being current with CRC screening, and 16 of the 21 counties in New Jersey have lower CRC screening rates than the national average (68.8%). For both men and women of all races diagnosed with CRC, 60% were diagnosed with CRC at a late stage which contributes to decreased survival rates. The New Jersey State Cancer Registry indicates both Hispanic and black men had lower percentages of early-stage diagnoses compared to white men for CRC. Approximately 66% of New Jersey adults aged 50-75 years report being current with CRC screening recommendations indicating that 34%, over 900,000 age-eligible residents, are not current with CRC screening recommendations.

As indicated by the Health Resource Services Administration's Bureau of Primary Care Health Care Uniform Data System, the CRC screening rate in Federally Qualified Health Centers (FQHCs) is significantly lower than the statewide average at 43.6%. New Jersey did not meet the Healthy People 2020 colorectal cancer screening objective (HP-C16) of 70.5% statewide or in FQHCs. CRC screening effectively reduces morbidity and mortality associated with the disease.

Outcomes

The NJDOH aims to increase clinic-level CRC screening rates in FQHCs by 25%. Through increasing clinic-level CRC screening rates, the NJDOH will increase the percent of CRC cases diagnosed at an early stage and decrease the rate of mortality in underserved, disparate populations aged 50-75 years.

SMARTIE Objectives:

- By December 31, 2025, the NJDOH will establish a partnership to support implementation of EBIs

- By December 31, 2025, 4 partnering FQHCs will complete a readiness assessment.
- By June 1, 2026, at least two (2) evidence-based interventions will be implemented at each FQHC
- By December 1, 2025, NJDOH will establish a referral system for each of the 4 FQHCs to a local health system for diagnostic follow up.
- By June 1, 2025, NJDOH will collect baseline clinic-level data for each of the four FQHCs.

Evidence/Promising Practice:

The Community Guide's Community Preventive Services Task Force (CPSTF) recommends patient navigation services to increase colorectal cancer screening by colonoscopy, fecal occult blood test (FOBT) or fecal immunochemical test (FIT), among historically disadvantaged racial and ethnic populations and people with lower incomes. The CPSTF finding is based on evidence from a systematic review, of which 27 studies evaluated intervention effects on colorectal cancer screening. Patient navigation interventions increased colorectal cancer screening for all types of screening and were more cost effective. Similarly, The U.S. Preventive Service Task Force recommends screening for colorectal cancer in all adults aged 50 to 75 years.

Evaluation:

Evaluation will be used to determine if the objectives of the program are met. Clinic-level data and additional measures of success will be utilized to further monitor programmatic activity. Process and performance measures will be utilized to guide programmatic implementation and short-term outcomes, while outcome measures will be utilized to measure overall programmatic success. The evaluation results will guide program planning and development with the guidance of the New Jersey's 2020-2025 Comprehensive Cancer Control Plan. This evaluation framework, guided by the National Colorectal Cancer Roundtable Evaluation Toolkit, sets strategy specific evaluation questions along with performance measures, data sources, key stakeholders, and methods for communication of evaluation results. This approach will enable NJDOH to engage in continuous quality improvement for strategy implementation, while also understanding the advantages and challenges of working collaboratively across health systems. The purpose of this monitoring and evaluation is to maximize quality, effectiveness, and efficiency of CRC care for underserved, disparate populations within FQHCs through quality assurance and improvement activities including EBIs.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 900,000.00	$ -

Program Name: Diabetes Capacity Building

Healthy People 2030 Objective:

D-09 Reduce the rate of death from any cause in adults with diabetes

Summary of the proposed project/intervention:

Through the NJDOH-NJ 211 Diabetes Waiver, which expires on June 30 2026, NJ 211 will screen all phone calls for a diabetes diagnosis and refer callers to the appropriate resources, such as the National Diabetes Prevention Program, Diabetes Self-Management Education (DSME) services, and the Diabetes Self-Management Programs (DSMP).

Justification: In NJ, diabetes is the 8th leading cause of death, with 17.6 deaths per 100,000 age-adjusted in 2021[1]. The goal of the NJDOH's Diabetes Prevention and Control Program is to reduce the burden of diabetes in NJ residents by implementing community-clinical linkages and health systems interventions that increase awareness of the disease, control disease-related complications, and increase quality improvement processes in health systems, in the delivery of services to residents with diabetes. The aforementioned proposed programs will aid in the efforts to achieve this goal.

SMARTIE Objectives:

- Between 10/1/2025 and 9/30/2026, NJDOH will partner with NJ 211 to screen and refer at least 500 callers with diabetes to appropriate diabetes-self management resources in the State of New Jersey.
- Between 10/1/2025 and 9/30/2026, NJDOH will partner with a state, county, or community-level organizations to become an approved CDC Umbrella Hub Organization.
- Between 10/1/2025 and 9/30/2026, Grantee Partner will establish a network of subsidiaries to pursue sustainable reimbursement from healthcare payers for the NDPP lifestyle change program and DSMES to offer other services, including technical assistance to all subsidiaries to help them enhance their diabetes education program.

Evidence/Promising Practice: Evidence Based

Evaluation: The program will be monitored and evaluated by program staff and an internal evaluation team, utilizing the CDC's Framework for Evaluation in Public Health. Process and outcome evaluation efforts include semi-annual visits, monthly meetings and quarterly program performance surveys that aim to collect quantitative and qualitative data about program reach an impact. The results of these efforts will be used to determine the impact of the project and inform ongoing program planning. Progress will be based on contract deliverables, programmatic and fiscal monitoring, site visits, and quarterly reports by a Program Officer.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 350,000.00	$ 400,000.00

Program Name: Diabetes Eye Disease Screening

Healthy People 2030 Objective:

D-04 Increase the proportion of adults with diabetes who have a yearly eye exam.

Summary of the proposed project/intervention:

The Commission for the Blind and Visually Impaired (CBVI) provides a wide range of services intended to save sight and restore vision whenever it is medically possible. These include vision screenings at schools and other institutions, a diabetic outreach program, eye-health nursing services and use of a mobile eye examination unit to help reach under-served groups such as special needs children and adults, migrant farm workers and the elderly. The program will partner with FQHCs, hospitals, and other healthcare facilities to bring ophthalmologists, nurse educators, and the screening technology onsite for patients. By way of an agreement, each host site commits to providing at least two in-kind health services (foot screening, dental screening, blood pressure screening, hemoglobin A1c screening, and nutrition counseling) at the DEDD screening event to support a larger goal of diabetes prevention.

Justification:

According to the New Jersey State Health Assessment data, 66.5% of New Jersey residents with diabetes had an annual dilated eye exam in 2021[1]. Diabetic retinopathy causes the most blindness in U.S. adults, and people with diabetes should have a complete eye exam through dilated pupils at least once a year. To uphold a fairly high percentage of annual dilated eye exams, programs offered by the CBVI are necessary to ensure that residents have access and are able to find the resources they need to maintain their health.

SMARTIE Objectives:

- Between 10/1/2025 and 09/30/2026, the Diabetic Eye Disease Detection Program (DEDD) will maintain 1 program, with statewide capacity, to provide free eye examinations for people with diabetes who are uninsured, underinsured and low-income.
- Between 10/1/2025 and 09/20/2026, the DEDD program will identify pathologies detected via DEDD eye screening events and make client referrals for appropriate follow-up care services and treatments.
- Between 10/1/2025 and 09/30/2026, the Diabetic Eye Disease Detection Program (DEDD) program will conduct between 750-900 eye examinations for underserved residents with Type 2 diabetes.

Evidence/Promising Practice: Evidence-Based

Evaluation:
The program will be monitored and evaluated by program staff and an internal evaluation team, utilizing the CDC's Framework for Evaluation in Public Health. Process and outcome evaluation efforts for CBVI include semi-annual site visits, monthly meetings and quarterly program performance surveys from grantees that collect quantitative and qualitative data about program reach and impact: demographics, number of eye screenings conducted, pathologies detected, and community clinical linkages established to increase residents' access to medical services.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 125,000.00	$ 125,000.00

Program Name: Behavioral Health & Chronic Disease

Healthy People 2030 Objective:

AHS-08 Increase the proportion of adults who get recommended evidence-based preventive health care

Summary of the proposed project/intervention:

This project seeks to address behavioral health and chronic disease by implementing Chronic Disease Self-Management Education and Supports workshops to residents residing within the state's three psychiatric hospitals and 10-20 long-term care facilities in connection with their discharge planning for residents who need to understand self-management of their chronic illnesses.

Justification:

New Jersey is facing a chronic illness crisis that was exacerbated by the effects of the COVID-19 pandemic. Chronic illnesses and conditions, such as hypertension, heart disease, diabetes, and arthritis, are prevalent among older adults. According to the CDC, 60% of all Americans have at least one chronic condition and 40% have two or more. For older adults, the prevalence of illness is higher. In New Jersey the prevalence of chronic disease among residents aged 65+ has risen 2.2% annually between 2016 and 2022.[vi] According to a 2023 report published by the New Jersey Hospital Association, nearly 60% of the State's residents aged 65+ have a staggering eight or more chronic conditions. Within the three state run psychiatric hospitals, New Jersey has nearly 350 resident patients aged 60+ who have several chronic disease co-morbidities that complicate their behavioral health diagnoses.

The need for Chronic Disease Self-Management Education and Support programming is evident. Greystone Park Psychiatric Hospital (GPPH) is located in Morris Plains, in northern Morris County. Operated since 1876, GPPH has 149 current patients aged 60 and over that have underlying mental health conditions and multiple chronic disease co-morbidities. Trenton Psychiatric Hospital (TPH), founded in 1848, is located in Ewing, New Jersey, in central Mercer County, less than five miles from the State Capitol in Trenton. TPH has 42 patient residents of the same age bracket with mental health and chronic disease co-morbidities. Finally, Ancora Psychiatric Hospital (APH) is located in Hammonton, in Southern Atlantic County. APH was founded in 1955 and has 149 patient residents at or above age 60 that have mental health diagnoses and chronic disease morbidities.

Outcomes:

- Increase the number of individuals who participate in evidence-based CDSME programs
- Increase partnerships and collaboration between the Aging and Disability Services Network, behavioral health providers, and other key organizations
- Increase the knowledge of the field by developing and disseminating resources for other organizations to replicate similar projects in their communities

SMARTIE Objectives:

- By June 1, 2026, NJDOH will develop capacity (e.g., instructors, partnerships, and referral networks) to increase the number of older adults and adults with disabilities in the target population who participate in evidence-based chronic disease self-management education (CDSME) and support programs.
- By December 1, 2025, NJDOH will develop and disseminate 508-compliant resources to enhance knowledge in serving the target population and aid in the sustainability of programs.

Evidence/Promising Practice:

New Jersey's Chronic Disease Unit combines strategies to improve integration and coordination of chronic disease prevention and self-management education activities among relevant New Jersey agencies, organizations, and individual stakeholders. New Jersey's Plan strategically aligns with CDC's Self-Management Education Programs for Chronic Health Conditions Guidelines. Such strategies have demonstrated reductions of symptoms and improved quality of life. The Community Guide's Community Preventive Services Task Force (CPSTF) recommends patient navigation services to increase self-management education for a numerous of chronic diseases including Depression, Cancer, Asthma, Diabetes, Obesity, Heart Disease & Stroke, Arthritis etc. This recommendation is echoed by The U.S. Preventive Service Task Force.

Evaluation:

Evaluation will be used to determine if the objectives of the program are met. Clinic-level data and additional measures of success will be utilized to further monitor programmatic activity. Process and performance measures will be utilized to guide programmatic implementation and short-term outcomes, while outcome measures will be utilized to measure overall programmatic success. This approach will enable NJDOH to engage in continuous quality improvement for strategy implementation, while also understanding the advantages and challenges of working collaboratively across health systems. The purpose of this monitoring and evaluation is to maximize quality, effectiveness, and efficiency of Chronic Disease Self-Management Education.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 300,000.00	$ 500,000.00

Program Name: Tribal Health & Chronic Disease

Healthy People 2030 Objective:

AHS-08 Increase the proportion of adults who get recommended evidence-based preventive health care

Summary of the proposed project/intervention:

This program proposes the implementation of culturally appropriate evidence-based interventions a to improve chronic disease outcomes in New Jersey Tribal communities. NJDOH will partner with the NJ State Department and experienced organizations to work with the recognized tribes of New Jersey and implement chronic disease priorities and interventions selected by the tribal communities.

Justification:

According to the Indian health Services (HIS), the American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.

Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of American Indian and Alaska Native deaths (2009-2011). American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively).

American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.

Outcomes

NJDOH seeks to accomplish the following:

- Deliver holistic, culturally responsive, and community driven chronic disease prevention interventions
- Support cultural practices for wellness
- Strengthen tribal public health infrastructure and capacity

SMARTIE Objectives:

- By December 31, 2025, NJDOH will attend two Tribal Elders meetings to learn their health priorities.
- By September 30, 2026, two (2) NJ-recognized Tribes will implement a minimum of two (2) evidence-based interventions to improve chronic diseases outcomes in their communities.

Evidence/Promising Practice:
This is a promising practice. Intervention science with Native communities has also been limited by the absence of validated measures. Indeed, community-level measures that utilize appropriate Indigenous

theories to guide measurement development and consider the unique cultural and socio-ecological contexts of tribal settings are so lacking that they are virtually nonexistent.

Evaluation:

Evaluation will be used to determine the outcomes and impact of objectives of the program. The evaluation results will guide program planning, development, and quality improvement processes. NJDOH will work with Tribal communities to identify appropriate evaluation methodologies.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 225,000.00	$ 400,000.00

Program Name: Addressing Dental Disease Through Prevention Services and Data Surveillance

Healthy People 2030 Objective:

OH-08 Increase the proportion of children, adolescents and adults who use the oral health care system

Summary of the proposed project/intervention:

The Oral Health Services Unit (OHSU) intends to allocate funding for two initiatives: 1) to connect Head Start and Early Head Start (HS/EHS) center participants in need of preventive oral health services, dental homes, treatment and counseling to Federally Qualified Health Centers (FQHCs), NJ Family Care dental providers and other local dental clinical care resources to receive caries risk assessments, dental screenings, and fluoride varnish applications; and 2) The New Jersey Department of Health (NJDOH) conducted its inaugural Basic Screening Survey (BSS) for third-grade students three years ago. In alignment with best practices for public health surveillance, this survey should be repeated every three years to ensure the collection of current and actionable data.

Justification:

Dental caries is the #1 chronic disease in children. More than 530 million children worldwide suffered from tooth decay in their primary teeth, which can lead to pain, infection, tooth loss, and missed school days *(National Association of School Nurses Newsletter, March 2021).*

Fluoride varnishes are dental coatings containing 5% sodium fluoride in a resin base. They provide a highly concentrated, temporary dose of fluoride to the tooth surface which is proven to prevent the development of caries. The use of fluoride varnish is limited to those individuals deemed to be at moderate to high-risk for developing dental caries. Fluoride varnish programs are more likely to be effective where caries risk is high yet where carious lesions have not yet occurred. According to the American Dental Association Council on Scientific Affairs, fluoride varnish should be the only professionally applied fluoride for children younger than age six because it combines caries prevention efficacy with safety and versatility.

The Basic Screening Survey (BSS) is a tool for gathering data to be used for immediate oral health actions, including the guiding, planning, implementation, and evaluation of programs to prevent and control disease. As a public health surveillance activity, the BSS measures and monitors the burden oral disease at a level consistent with the Healthy People objectives in oral health including the prevalence of dental caries experience, untreated dental decay, dental sealants, permanent tooth loss, and use of the dental care system.

For nearly 30 years, until 2019, New Jersey was without a State Dental Director. Unfortunately, during those years the Department of Health (DOH) was not collecting nor monitoring surveillance data in oral health. Thus, a basic screening survey (BSS) has never been conducted, leaving New Jersey as 1 of 3 states that have not submitted oral health surveillance data which is known as a national benchmark for oral health care for states.

Jointly, the community-based intervention (fluoride varnish) and statewide surveillance activity (BSS) will prevent and reduce early childhood dental caries in high-risk children, increase referrals to dental homes and provide baseline data on the prevalence and treatment of dental caries among New Jersey's third grade children, which is critical to identifying gaps in preventive oral health/dental services in the state for elementary school-aged children.

Outcomes:

The suggested outcome of the FVPP intervention is to identify children in Head Start/Early Head Start programs and other students at high risk for dental caries and to provide fluoride varnish and referrals to dental homes for a total of 8,000 children including in HS/EHS, thus improving oral health utilization rates and preventing excessive dental restorative care due to caries.

SMARTIE Objectives:

- **Objective 1: Fluoride Varnish Pilot Project (FVPP)**
  - By September 30, 2025, the Office of State Health Unit (OSHU) will allocate funding to current and/or new Children's Oral Health Program (COHP) grantees to implement the Fluoride Varnish Pilot Project (FVPP) for 8,000 children enrolled in HS/EHS centers and other school age children across New Jersey

- **Objective 2: Basic Screening Survey Project (BSSP)**
  - By September 30, 2025, the OSHU will allocate funding to current and/or new COHP grantees to implement the Basic Screening Survey Project (BSSP) for 3,000 third-grade students across 525 New Jersey schools

Evidence/Promising Practice:

Using the evidence and documented activities to prevent the prevalence of dental caries, increase access to preventive services, and to create an oral health surveillance system, the OHSU will implement six (6) evidence-based strategies when conducting the community-based intervention and state-wide survey activity. These include the following:

1. Oral Health programmatic interventions in schools (school-based/centered)
2. Improve access to oral health care
3. Build and support epidemiologic and surveillance systems/databases
4. Identify a Dental Home for patients.
5. Collect and monitor accurate data on the burden of disease and disability
6. Enhance oral health promotion and literacy

Evaluation:

The Oral Health Services Unit (OHSU) establishes goals and objectives that target CDC Division of Oral Health priorities and support State-driven preventive initiatives for each grantee agency to implement. The process evaluation method includes reviewing monthly and annual reports, conducting site visits to the Head Start centers to observe operations, and the analysis and interpretation of survey data. The suggested outcome of the community-based interventions (FVPP) is to provide oral health screenings and education, fluoride varnish services, and dental home referrals to a total of 15,000 Head-Start and Early-Head Start children. For the state-wide activity (BSSP), the suggested outcome is to gather vital oral health data from approximately 3,000 third grade students who represent a sample of the nearly 95,000 third graders enrolled in New Jersey schools.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 250,000.00	$ 275,000.00

Program Name: Childhood and Adult Asthma Program

Healthy People 2030 Objective:

Reduce emergency department visits for people aged 5 years and over with asthma — RD-03

Summary of the proposed project/intervention:

The New Jersey Department of Health's Childhood and Adult Asthma Program (CAAP) works to reduce asthma-related health disparities by improving access to care, coordinating medical management, providing self-management education, and addressing environmental triggers. The program aims to lower asthma-related emergency visits and hospitalizations for both children and adults. CAAP partners with Southern New Jersey Perinatal Cooperative (SNJPC) in Camden County and Hackensack Meridian Health in Essex, Passaic, and Hudson Counties to implement evidence-based EXHALE strategies in communities with high asthma burdens. These areas were selected based on data showing inequitable asthma impacts.

Justification:

Asthma is a chronic condition that causes inflammation and narrowing of the airways, making breathing difficult. It is triggered by allergens, smoke, cold air, exercise, or infections, leading to symptoms like wheezing, chest tightness, and coughing. The severity of symptoms varies, with some experiencing regular flare-ups and others fewer symptoms. Managing asthma involves medication, lifestyle changes, and avoiding triggers. In New Jersey, asthma affects about 8.7% of adults, with higher rates among Black (12.2%) and Hispanic (5.8%) residents. Minority children, particularly Black children, experience higher rates of asthma-related complications, including emergency visits and mortality, due to poor housing conditions and greater exposure to triggers. Addressing these disparities is critical to reducing asthma's impact.

SMARTIE Objectives:

- Between 10/2022 and 09/2027, reduce asthma related emergency department visits among individuals aged 5-18 years who experience severe asthma episodes by 5%.

Evidence/Promising Practice:

The CDC's National Asthma Control Program (NACP) recommends EXHALE strategies to help public health professionals improve asthma management. The New Jersey Childhood and Adult Asthma Program uses these six strategies to reduce asthma-related emergency visits for individuals aged 5-18. These strategies include expanding access to asthma self-management education, reducing tobacco and secondhand smoke exposure, increasing home visits for trigger reduction, improving access to asthma medications, promoting coordinated care, and implementing environmental policies to reduce asthma triggers.

Evaluation:

The evaluation will follow the CDC program evaluation framework, including evaluation questions, methods, indicators, data sources, and a timeline.

Budget:

Scenario 1: $4,950,511	
Budget A	**Budget B**
$ 290,000.00	$ 350,000.00