

New Jersey Preventive Health and Health Services Block Grant
FFY26 Program Priorities

Program Name:

Chronic Disease Prevention- Chronic Disease and Maternal Health (CDMH)

Healthy People 2030 Objective:

MICH-05 Reduce severe maternal complications identified during delivery hospitalizations

Summary of the proposed project/intervention:

This program proposes the continuation of implementing 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 collaborate with 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

NJDOH seeks to accomplish the following:

- 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:

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- By December 31, 2026, NJDOH will identify and partner with two (2) health care organizations to deliver chronic disease interventions to perinatal patients.
- By June 30, 2027, 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, 2027, 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: \$500,000

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Program Name: Chronic Disease Prevention -Tribal Health (NJ Department of State)

Healthy People 2030 Objective:

PHI-08 Increase the proportion of tribal communities that have a health improvement plan

Summary of the proposed project/intervention:

The main objective of the program is to finalize and begin implementation of an evidence-based plan to address the chronic health needs of New Jersey's three state-recognized tribes and inter-tribal communities. In collaboration with The Food Trust, the planning process will include outreach to departments of state government to identify resources that are not currently accessed by the tribes. The project and tribal coordinators will attend community coalition meetings, attend the NJ Preventative Health Advisory Committee Meetings, conduct focus groups and inter-community outreach, conduct community surveys, and generate tribal health materials for distribution to community members.

Justification:

New Jersey Tribal communities experience serious chronic disease health issues, some of which represent disparities from the general New Jersey population, and some of which demonstrate the results of long-standing environmental disregard, which has placed one of the Tribal areas on the national Super Fund list twice. Nationally, Native Americans have a life expectancy that is 4.4 years less than the U.S. all races population, and continue to die at higher rates than other Americans in many categories of preventable illness, including chronic liver disease, diabetes, and chronic lower respiratory diseases.

SMARTIE Objectives:

- 1) Review and finalization of the Health Improvement Plan by the Tribal Councils and Tribal Membership. A contract will be drawn with academic institutions to support developing performance measures for CHIP evaluation. Tribal leadership will determine the finalization of CHIPs based on the performance measures agreed upon with academic institutions
- 2) Program and Tribal coordinators will collaborate to include office hours at tribal locations two (2) days a week, hold bi-weekly educational calls, and arrange telehealth support
- 3) To convene a conference to bring Tribal youth and elders together to share information regarding Tribal health history and current issues, that will be part of the final plan, as well as the special plan for young people.
 - Notes from the convening will be reviewed to identify concerns and opportunities for Tribal youth and elders to work together to improve the health of their communities.
- 4) The program will collaborate with five (5) departments of state government. The departments of state government will engage and support the work of the NJ Commission on American Indian affairs. This will include attendance at two or more quarterly Commission meetings per year to present information on services and resources, to provide requests for applications to the Commission for dissemination to Tribal communities, and to provide technical assistance on proposals.

Evidence/Promising Practice:

A September 2025 gathering of the Ramapough Lenape Indian Nation, environmentalists, and a toxicology team from NYU Langone in Ringwood, home to many of the Ramapough Lenape Tribal

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Nation, warned that residents are still being sickened by toxic waste, 50 years after the Ford Motor Company stopped dumping paint sludge and the borough closed its landfill to begin “a painfully slow cleanup.” (NJ.com September 16, 2025) A recent study by NYU Langone of air and water samples from the site shows “alarming levels of lead, benzene, arsenic and cadmium, which are considered potential carcinogens.” A health study of 140 residents, 90 of whom identify as members of the Turtle Clan of the Ramapough Lenape Indian Nation, showed high levels of asthma, bronchitis, eczema and lead. During the operation of a motor company, it is estimated that 25 million gallons of paint sludge down Peters Mine and Cannon Mine. There have been a series of cleanups, but the sludge has continued to seep up through the ground and has continued to place the Tribe at hazard, as well as being a threat to the Wanaque Reservoir.

The Nanticoke Lenni-Lenape Tribe of Cumberland County has not experienced a similar environmental disaster, but has experienced chronic health issues. A survey done by the Tribe in 2023 identified a number of health issues. Among the 38 respondents, 71% indicated health problems, many indicating diabetes, arthritis, asthma, hypertension, and kidney disease. There was also mention of depression and PTSD. It was notable that many respondents encouraged a greater role for youth in these matters.

In addition, in its report to Governor Corzine in 2007, the NJ Committee on Native American Community Affairs recommended that the NJ Commission be strengthened by the addition of ex-officio representatives of several departments of State government, including Children and Families, Human Services, Health, Education, Environmental Protection and Community Affairs. Although this recommendation was never formally implemented, key elements of this grant proposal related to participation of key departments of government, call upon on-going participation of these departments in the implementation of the Health Improvement Plan.

Evaluation:

At the beginning of the project period, laptops and phones will be provided to tribal coordinators to track and report their progress which will be compiled by the project coordinator for American Indian Commission review. Through the project coordinator and tribal coordinators, the American Indian Commission ensures accurate data review and verification throughout the project period. Through regular meetings, the American Indian Commission incorporates opportunities for health education as well as for peer discussion and sharing of best practices related to all tribal health areas, including data quality and performance measures.

The plan will be compiled, in collaboration with The Food Trust, by the 6th month and circulated in draft to the Commission members and Tribal Councils for final review and additions or revisions. By the end of the 8th month the project will be complete. The project will demonstrate outreach to key agencies and response for future action.

Upon completion of the project, key agencies and community partners will have been identified and community led initiatives will be implemented. These initiatives will be based on data collected over the course of the project and used to build capacity within the community. These initiatives will continue to serve the tribal community beyond the project's end date, ensuring health education resources continue to be available to the community.

Budget: \$135,000

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Program Name: Chronic Disease Prevention -Tribal Health (The Food Trust)

Healthy People 2030 Objective:

1. Increase the proportion of tribal communities that have a health improvement plan — PHI-08
2. Reduce household food insecurity and hunger - NWS-01

Summary of the proposed project/intervention: The Food Trust (TFT) will collaborate with the New Jersey Department of Health (NJDOH), NJ Department of State (NJDOS), the NJ Commission on American Indian Affairs (Commission), the Tribal Councils of at least two of the three NJ state designated tribes, and state and local departments/organizations to implement recommendations from the recently developed Tribal Health Improvement Plan (HIP) to increase access to, and usage of, nutrition, health and income support programs. TFT will work with the Nanticoke Lenni-Lenape Tribe, Powhatan Renape Nation and the Ramapough Lenape Nation to implement key health and nutrition recommendations and increase the availability of resources that address the identified problems in the HIP. The tribal community will be involved in all aspects of the project to implement recommendations from the framework that was developed in the previous NJDOH grant.

Justification: Members of the three Native American tribes in NJ, experience more food insecurity and diet-related diseases than other residents of the state. Native Americans born today have a life expectancy that is 4.4 years less than the United States' all races population, and die at higher rates than other Americans in many categories of preventable illness, including chronic liver disease and cirrhosis, diabetes, and chronic lower respiratory diseases. Some of the leading diseases and causes of death among Native Americans are heart disease, cancer, unintentional injuries, diabetes and stroke with a high prevalence and risk factors for mental health, obesity, diabetes, liver disease, and hepatitis. Many of these diseases could be prevented or lessened with a healthy diet, physical activity and improved access to health care.

SMARTIE Objectives:

- **Objective 1:** TFT will identify and develop at least one new or strengthen existing relevant partnerships to support the recommendations from the tribal HIP by 12/31/26.
- **Objective 2:** TFT will coordinate with existing relevant national, state, county and/or community organizations to implement at least 3-5 recommendations from the recently developed tribal HIP that supports equitable nutrition and health services by 6/30/27
- **Objective 3:** TFT will continue to gather information from NJ Native Americans to ensure the HIP's recommendations and future work support cultural practices for wellness and are designed to meet tribal needs by 1/31/27.
- **Objective 4:** TFT will collaborate with Native American leaders and the community to identify at least three additional opportunities to strengthen tribal public health infrastructure and capacity by 1/31/27.
- **Objective 5:** TFT will work with the community and the Commission to identify at least three additional potential funding opportunities to ensure sustainability by 3/31/27.

Evidence/Promising Practice:

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Food insecurity and chronic diet are significant concerns in Tribal communities. Through the development of tribal HIP, key health problems and potential solutions will be utilized in the development of evidence/promising practices. In TFT's earlier NJDOH grant, tribal members expressed an interest in the following resources to help address food insecurity and improve health. We anticipate additional recommendations that will update and refine this list and form the basis of the specific objectives, outputs and outcomes in the implementation of the tribal HIP

1. Education and recipes on traditional Native foods, identifying edible and medicinal plants.
2. Education and supplies to preserve traditional foods including canning.
3. Education and resources grow their own food at home or community gardens/greenhouses.
4. Farmers markets in their communities.
5. Tours to showcase growing Native plants to the larger community.
6. Integrating more Native foods into food pantries/food banks.
7. Regional food banks to improve the quality and type of foods.
8. Preventing chronic diseases common among Native Americans through education on healthy eating and healthy lifestyle.

Evaluation: TFT will work with the NJDOH, as part of an Evaluation Planning team, to develop a system to track and assess project results and outcomes for all objectives as follows:

Objective 1: TFT will identify and develop at least one new or strengthen existing relevant partnerships to support the recommendations from the tribal HIP by 12/31/26

1. *The number of partnerships developed or strengthened throughout the grant period.*
2. *The number of meetings with different partners and progress addressed in each meeting.*
3. *The number of meetings attended with the NJDOH, NJDOS and other state departments.*

Objective 2: TFT will coordinate with existing relevant national, state, county and/or community organizations to implement at least 3-5 recommendations from the recently developed tribal Health Improvement Plan (HIP) that supports equitable nutrition and health services by 6/30/27.

1. *The extent to which recommendations from the tribal HIP were implemented,*

Objective 3: TFT will continue to gather information from NJ Native Americans to ensure the HIP's recommendations and future work support cultural practices for wellness and are designed to meet tribal needs by 1/31/27.

1. *The number of meetings with Tribal members, Tribal councils, the Commission, NJDOS and community and faith-based groups during the grant period, with notes from each one to review progress over time.*

Objective 4: TFT will collaborate with Native American leaders and the community to identify at least three additional opportunities to strengthen tribal public health infrastructure and capacity by 1/31/27

Listing and addressing identified challenges or barriers when implementing and the HIP and identifying potential solutions to address the challenges.

Objective 5: TFT will work with the community and the Commission to identify at least three additional potential funding opportunities to ensure sustainability by 3/31/27.

1. *The number of additional funding sources identified in the sustainability plan. The number of contacts with business entities that will be contacted for sustainability of this work. These will likely include the food industry and health care companies.*

Budget: \$135,000

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Program Name: Chronic Disease Prevention -Tribal Health (Robert Wood Johnson University Hospital)

Healthy People 2030 Objective: AHS-08 – Increase the proportion of adults who get recommended evidence-based preventive health care and PHI-08 Increase the proportion of tribal communities that have a health improvement plan

Summary of the proposed project/intervention: Tribal Resilience through Innovation, Building Ecosystems for Holistic Equity and Long-Term Transformation in Health (TRI-BAL HEALTH) is a statewide, community-driven initiative led by Rutgers Robert Wood Johnson Medical School in partnership with the New Jersey Commission on American Indian Affairs to strengthen tribal public health infrastructure, advance health equity, and develop a culturally responsive Tribal Community Health Improvement Plan (CHIP) for New Jersey's state-recognized tribal communities.

The initiative will establish a Tribal Health Advisory Group (THAG) composed of tribal leaders, elders, youth, community members, and partners to guide all project activities, ensure cultural integrity, and co-develop the CHIP. Through community listening sessions, surveys, and stakeholder engagement, the project will identify priorities related to diabetes, hypertension, chronic disease prevention, and access to care while respecting tribal data sovereignty and community ownership.

A key innovation is the integration of YourHealthKiosk (YHK), a proven digital health navigation and education platform that will provide culturally tailored health education, screening awareness, referral support, and care navigation. The project also incorporates a workforce development pipeline that engages Native American high school students and medical students in community-based health promotion activities, fostering future health equity leaders.

By the end of the project period, TRI-BAL HEALTH will deliver a tribal-led Community Health Improvement Plan, strengthen tribal public health planning capacity, increase community engagement, and establish sustainable strategies to improve prevention and management of diabetes, hypertension, and other chronic diseases. Through trusted partnerships, digital innovation, and community leadership, TRI-BAL HEALTH will create a sustainable framework for improving health outcomes and reducing long-standing health disparities among Native American communities across New Jersey.

Justification: Although New Jersey does not have federally recognized tribes or reservations, it is home to three state-recognized tribal nations—the Nanticoke Lenni-Lenape Tribe, Powhatan Renape Nation, and Ramapough Lenape Nation—and significant Native American populations reside in Middlesex, Hudson, Essex, Bergen, Camden, Monmouth, and Union counties. The absence of federal recognition limits the availability of state-specific health surveillance data; however, national evidence consistently demonstrates that American Indian and Alaska Native (AI/AN) populations experience disproportionately high rates of diabetes, hypertension, and cardiovascular disease. Diabetes prevalence exceeds 20% in some AI/AN communities, nearly double the U.S. average.

These disparities are rooted in historical trauma, systemic underinvestment, food insecurity, economic hardship, and limited access to culturally responsive healthcare. Native Americans continue to experience significant barriers to preventive care, including lower rates of diabetes-related screenings and chronic disease management services. Traditional healthcare models often fail to effectively engage tribal communities due to fragmentation, limited trust, and insufficient cultural alignment.

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Evidence supports community-led, culturally grounded interventions that integrate health education, navigation, mentorship, and digital health technologies to improve chronic disease outcomes. Building on established partnerships with tribal leaders and community organizations, Rutgers University, GoMo Health, and YourHealthKiosk will implement a community-centered model that combines culturally tailored outreach, digital engagement, and personalized navigation to improve access to preventive services, chronic disease management, and health education.

YourHealthKiosk has enrolled more than 2,000 participants statewide, including Native American and Alaska Native individuals, demonstrating the feasibility of engaging underserved populations through trusted community-based approaches. This project will expand those efforts to strengthen tribal health infrastructure, improve access to care, and reduce diabetes and hypertension disparities among Native American communities across New Jersey.

SMARTIE Objectives:

- Develop a Tribal Community Health Improvement Plan (CHIP): By September 30, 2027, formally engage the tribal stakeholders through the Tribal Health Advisory Group (THAG) and complete implementation-ready updates to the CHIP, incorporating Year 1 findings and Year 2 community input. Incorporate environmental and climatic exposures (e.g., extreme heat) and their impact on community health into planning documentation.
- Increase engagement in culturally responsive chronic disease prevention activities: Between October 1, 2026 and September 30, 2027, enroll at least 50 Native American community members in program activities, with a focus on increasing participation in preventive screenings and referrals supported by YourHealthKiosk.
- Expand community-informed data collection and evaluation activities: By September 30, 2027, conduct follow-up surveys, at least 3 to 4 focus groups and/or listening sessions, and ongoing analysis of program participation and referral data to better understand community needs, environmental exposures, barriers to care, solutions/recommendations from the community, and program impact/implementation.
- Strengthen public health infrastructure and community capacity: By September 30, 2027, support at least 2-3 community engagement or training activities (e.g., youth engagement sessions, outreach events, or data sharing meetings) that build awareness, participation, and capacity to use health information for decision-making.

Evidence/Promising Practice: The TRI-BAL HEALTH approach is grounded in established public health practices that emphasize community-engaged research, culturally responsive interventions, and mixed-methods needs assessment. Evidence supports the use of community-led planning processes, such as Community Health Improvement Plans (CHIPs), to identify priorities and guide coordinated action. In addition, the project builds on promising practices demonstrating that combining qualitative methods (e.g., focus groups, listening sessions) with quantitative data collection improves understanding of barriers to care and increases relevance of interventions in underserved populations. Culturally tailored health education and navigation approaches, including the use of digital tools to support screening and referrals, have also shown promise in improving participation in preventive care, particularly when paired with community-based outreach and trusted local partnerships.

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WRI's role in conducting applied research, facilitating community input, and translating findings into actionable recommendations reflects best practices in program evaluation and community-informed public health planning.

Evaluation: The evaluation of TRI-BAL HEALTH will be completed in partnership with the Senator Walter Rand Institute for Public Affairs (WRI) at Rutgers-Camden. WRI will help to lead the applied research and evaluation activities. WRI brings extensive experience in community-engaged research, needs assessment, and program evaluation with a focus on translating research findings into actionable insights for policy and practice.

Building on the Year 1 Needs Assessment findings, the Year 2 evaluation will focus on deepening the understanding of the community's needs and incorporating environmental and climate hazards into the evaluation and work on finding solutions/recommendations. There will be increased engagement with the TRIBAL HEALTH program, and access to preventive care, WRI will work to design and begin the implementation of a mixed-methods approach that includes expansion of surveys and completing follow-up data collection and additional focus groups and listening sessions with the tribal community members and stakeholders. This approach will allow the project team to continue to understand the barriers to screening, referral completion, local knowledge of environmental hazards, and access to care.

WRI will also support the analysis of data collected through the YHK platform and examine the participating patterns, screening completion rates, and referral activity. Rather than developing new data systems, WRI will work with the existing data sources and team members to identify key trends and summarize the findings in clear and actionable formats.

Findings will be synthesized into periodic summary presentations and/or briefs for the Tribal Health Advisory Group (THAG) and project partners. These deliverables will highlight key findings, emerging needs, and opportunities for program refinement.

Budget: \$135,000

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Program Name: Chronic Disease Prevention- Behavioral Health (Office of Health Care Resiliency)

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: The Office of Health Care Resiliency (OHCR) will expand access to evidence-based Chronic Disease Self-Management Education (CDSME) programming across New Jersey long-term care facilities and state psychiatric hospitals. This project will develop sustainable in-facility capacity training to upskill 10 certified Trainers through workshop leaders, who will deliver CDSME workshops to at least 100 older adults with multiple chronic conditions. The program equips residents with skills to better manage chronic illnesses, communicate effectively with healthcare providers, and reduce avoidable hospitalizations. The model strengthens facility workforce capacity while embedding chronic disease self-management principles into resident care planning.

Justification: Chronic disease is the leading health burden among older adults in New Jersey's long-term care facilities. Approximately 90% of nursing home residents have multiple chronic conditions, averaging 6.3 chronic diseases per individual. High rates of hypertension (72%), diabetes (33%), COPD (24%), arthritis (48%), and heart disease (28%) contribute to preventable hospital transfers, 25–40% of which are considered avoidable. Residents in psychiatric hospitals face additional challenges from mental health comorbidities and limited access to chronic disease education. These systemic gaps result in reduced quality of life, frequent exacerbations, and increased healthcare utilization. Delivering CDSME directly within facilities addresses these barriers and creates long-term capacity for prevention and resident empowerment.

SMARTIE Objectives:

1. Between January–September 2027, OHCR in collaboration with facility-based leaders will deliver 10 six-week CDSME workshop series, reaching at least 100 residents aged 65+ with chronic conditions.
2. By project completion (September 2027), at least 60% of participants will demonstrate measurable improvements in chronic disease self-management behaviors (such as medication adherence, symptom management, and physical activity). Participants will be counted as “improved” if they report positive change in one or more of these behaviors using the self-reported survey tool.
3. 70% of participants will report improved communication with healthcare providers, contributing to reduced re-hospitalizations (through post-session satisfaction self-reported survey and qualitative feedback collected at the end of the workshop sessions which will capture whether participants feel more prepared, and confident in communication with their healthcare providers).
4. By September 2027, OHCR will recruit at least 7 high-need Long-Term Care Facilities serving diverse racial, ethnic, socioeconomic, and disability populations to participate in CDSMP, ensuring equitable access for residents with chronic diseases.

Evidence/Promising Practice: The **Chronic Disease Self-Management Program (CDSMP)** is a nationally recognized, evidence-based intervention that improves health behaviors, increases self-

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efficacy, and reduces hospitalization among adults with chronic conditions.

Research demonstrates consistent improvements in symptom management, physical activity, medication adherence, and patient-provider communication. The project uses the Stanford SMRC train-the-trainer model, a proven approach that builds sustainable capacity within institutional settings by certifying onsite leaders to continue delivering workshops beyond the grant period. The CDSME program selected for implementation is the Chronic Disease Self-Management Program which directly addresses the chronic disease burden in long-term care settings and psychiatric hospitals.

Evaluation: The project will be evaluated to determine whether it achieved improved chronic disease self-management, increased provider communication, and reduced hospital readmissions. Key components include:

Process Evaluation

- Tracking number of certified Trainers
- Tracking number of facility-based leaders trained
- Monitoring workshop delivery fidelity and attendance
- Facility level monitoring of participation metrics

Outcome Evaluation

- Pre/post assessments of resident self-management skills
- Satisfaction surveys and qualitative feedback
- Monitoring changes in health behaviors (medication adherence, symptom management, physical activity)
- Analysis of reductions in avoidable hospital readmission rates

Sustainability Evaluation

- Documenting lessons learned
- Creation of toolkits and facility-based infrastructure for ongoing CDSME
- Establishing a post grant continuation plan through trained staff and existing partnerships.

Budget: \$110,000

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Program Name: Chronic Disease Prevention- Behavioral Health (Union County Office of Health Management)

Healthy People 2030 Objectives

- AHS-08: Increase the proportion of adults who get recommended evidence-based preventive health care
- OA-01: Increase the proportion of older adults with one or more chronic conditions who receive self-management support

Summary of Proposed Project/Intervention

The Living Well Older Adult Program will deliver patient navigation and advocacy services to older adults residing in or attending day and long-term care facilities across Union County, New Jersey. UCOHM program staff will conduct twice-weekly outreach visits to senior facilities providing health education, care coordination, and baseline health screenings. Program activities include facilitating at least 28 health education sessions on chronic disease prevention topics such as nutrition, physical activity, sleep, mental health, and preventive screenings; providing individualized care coordination to at least 80 older adults through healthcare appointment scheduling and referrals to NJCEED and medication assistance through our Ask-a-Nurse program; and administering at least 95 health screenings with follow-up referrals for elevated readings. The program aims to serve and empower a minimum of 200 older adults to actively engage in preventative health behaviors during the grant.

Justification

Union County's older adult population faces a disproportionate burden of chronic disease. Nationally, 85% of Americans over age 65 have at least one chronic condition and 60% have two or more (National Council on Aging). In New Jersey, the prevalence of chronic disease among residents aged 65+ rose 2.2% annually between 2016 and 2022, and nearly 60% of the state's residents aged 65+ have eight or more chronic conditions (NJ Hospital Association, 2023). The CDC further reports that the percentage of adults aged 65+ reporting fair or poor health increased from 23.5% in 2022 to 24.3% in 2024. The COVID-19 pandemic worsened these trends, with 84% of New Jersey's COVID fatalities occurring among residents aged 65+. Older adults in community and long-term care settings face significant barriers to preventive care, including difficulty navigating healthcare systems, social isolation, and limited access to health education. UCOHM has a demonstrated and established capacity to address these needs. In 2025, the agency conducted 122 community health events, 39 of which specifically targeted older adults across multiple Union County senior facilities — including Casano Community Center (19 events), O'Donnell Senior Center (6 events), Pinewood Hall (3 events), Farley Towers (2 events), and Ford Leonard Towers (2 events) — reaching 684 senior participants. This track record, combined with active facility partnerships and existing referral networks, positions UCOHM to be fully operational immediately upon receipt of award.

SMARTIE Objectives

Health Education

- By September 30, 2027, deliver at least 28 health education sessions at senior facilities throughout Union County, reaching a minimum of 200 older adults with actionable chronic disease prevention

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information, with intentional outreach to facilities serving low-income, minority, and linguistically diverse older adult populations.

Care Coordination

- By September 30, 2027, improve access to care and service navigation for at least 100 older adults in Union County through direct care coordination, including scheduling healthcare appointments and providing referrals to NJCEED cancer screenings, NJ Institute of Osteoporosis in Cranford, NJ, and medication assistance through our Ask-a-Nurse program, with priority given to older adults with limited English proficiency and those without a primary care provider.

Baseline Screenings

- By September 30, 2027, administer at least 95 health screenings at senior facilities across Union County, with follow-up referrals provided to all participants with elevated readings to ensure connection to appropriate care.

Evidence/Promising Practice

The Living Well Program – Older Adult Health is grounded in CDC’s Self-Management Education Programs for Chronic Health Conditions guidelines and aligns with the Community Preventive Services Task Force (CPSTF) recommendation for patient navigation services to increase chronic disease self-management education. The CPSTF recommendation is echoed by the U.S. Preventive Services Task Force and supports patient navigation as an effective strategy for improving preventive care utilization across chronic disease areas including diabetes, heart disease, cancer, arthritis, and asthma. Programming includes Cooking Matters at the Store (nutrition education), Heart Health Bingo at Plainfield Senior Center, and a coordinated mini-health fair at Pinewood Hall in partnership with Walgreens, HolaDoctor, Elara Home Care, and RWJ Snap-Ed. These programs demonstrate UCOHM’s ability to deliver multi-faceted, community-driven interventions at scale. Paired with nutrition education, this approach promotes strong participant engagement and extends reach to seniors across Union County facilities.

Evaluation

Program outcomes will be evaluated using both quantitative and qualitative methods throughout the grant period. Key Performance Indicators (KPIs) include: number of health education sessions delivered, total unduplicated participants reached, number of care coordination encounters completed, referrals made and confirmed, and number of screenings administered. Program staff will maintain activity logs, referral tracking systems, and screening records, conducting monthly data reviews to assess progress toward all objectives and make real-time program adjustments as needed. Pre/post knowledge surveys will be administered at health education sessions to assess changes in participant knowledge and intent to adopt health-promoting behaviors. Program staff will conduct monthly data reviews to assess progress toward all objectives and make real-time program adjustments as needed. A final summary report documenting all activities, outcomes, and lessons learned will be submitted to NJDOH CHWU at the close of the grant period.

Budget: \$110,000

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Program Name: State Physical Activity & Nutrition (SPAN) Program (Virtua Health)

Healthy People 2030 Objective: Healthy People Objective NWS-04: Reduce the proportion of children and adolescents with obesity.

Summary of the Proposed Project/Intervention:

Virtua has a mobile fleet of services – the Eat Well mobile food markets (Eat Well), Pediatric Mobile Services (Peds Mobile), and the Mobile Health and Cancer Screening Unit (MHCSU) – which brings health sustaining resources to areas of high socio-economic need in southern New Jersey. In many of these communities, mobile programs are the only source of fresh, affordable food and preventive health services. Our community health workers (CHWs) further address barriers to care by referring people to other vital services. By co-locating Mobile Farmers Market/Grocery Store with one of the clinical programs, people can access all these resources at one time and place. Eat Well's newest Mobile Grocery Store vehicle includes additional cold storage and a semi-private clinical space designed specifically for health screenings – an enhanced capacity that has already allowed Eat Well to conduct preventive screenings when not travelling in tandem with Peds Mobile or MHCSU. The program also anticipates bringing the Mobile Grocery Store to more tandem events, offering patients a greater selection of healthy foods beyond produce.

Justification:

Large pockets of health disparities persist in the focus region. The NJ Primary Care Association and the Health Resources & Services Administration designated 23 census tracts in the catchment area as medically underserved areas (MUA). Many of these neighborhoods are also considered food deserts – communities with little to no access to fresh, healthy food. Even in neighborhoods where fresh produce is available, many residents face the impossible choice of buying healthy food or paying their bills. The 2025 Community Health Needs Assessment showed that these communities face high burdens in the following five areas: chronic disease, transportation and housing, mental health, financial strain, and differences in education. In FFY24, mobile teams provided a total of 4,437 cancer screenings, health education sessions, pediatric health services, and/or physical activity options. Our project served a total of 4,638 people.

Objectives:

- **Objective 1:** Between 10/01/2026 and 9/30/2027, Eat Well will increase at-risk populations' connection to healthy, nutritious food by 5% over baseline in southern New Jersey by participating in 135 mobile health events (tandem + additional Eat Well events), resulting in 17,991 healthy food transactions.
- **Objective 2:** Between 10/01/2026 and 09/30/2027, the Virtua Mobile Health Acceleration Project will increase the number of southern NJ residents in at-risk communities who receive a preventive health visit by 5% over the baseline population served (baseline of 4,437 screenings).
- **Objective 3:** Between 10/01/2026 and 9/30/2027, the Virtua Mobile Health Acceleration Project will make 4,616 total referrals to community resources (5% increase over baseline of 4,396 referrals). Of these referrals, 400 will be warm handoffs (e.g., phone call to social service agency, help applying for an assistance program) facilitated by a mobile staff member to help ensure that people connect with available services.

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- **Objective 4:** Between 10/1/2026– 9/30/2027, the Mobile Health Acceleration Project will implement a market-side physical fitness and nutrition education program utilizing age appropriate exercises and equipment (e.g., mini basketball hoops, thera bands), anticipating 255 children and adults (at least 90% of whom will be new participants) will participate in the program. Our mobile health teams will lead a curriculum developed by Virtua Occupational/Physical Therapists/Exercise Physiologists and Registered Dietitians.

Evidence/Promising Practice:

Affordability and physical access to healthy foods persist as barriers to good nutrition. The evidence has made clear that an unhealthy diet isn't simply a matter of education, but a symptom of social inequity (Tewahade et al., 2022; Herman et al., 2015). In many marginalized neighborhoods, buying fresh produce requires traveling a great distance or paying high prices for low quality options. Food insecurity is closely linked to other costs of poverty, such as housing insecurity and low access to care (Hood, 2005). Within our MUAs, Virtua's mobile clinics are often residents' only source of affordable produce and preventive health services. A growing evidence base shows the promise of mobile health clinics and mobile produce markets to empower healthy choices (Hsiao et al., 2019; Zepeda & Reznickova, 2013). Over the last four years, our fleet has demonstrated the impact of these programs on community health:

- In FFY24, Eat Well delivered 187,913 pounds of healthy, affordable food to community members.
- In FFY24, 4,437 individuals received a preventive health service.
- In calendar year 2025, the Mobile Health Acceleration Project prevented 1,053 emergency department visits and saved 67 life years, according to Harvard's Mobile Health Map (see Figure 2).

Evaluation:

Outcome 1: Increase the amount of food distributed to at-risk populations by 5% through 135 mobile health community events.

Outcome 2: We will increase preventative health screenings by 5% (baseline of 4,437 screenings) resulting from the 135 mobile health events.

Outcome 3: We will make a total of 4,616 referrals to community resources (5% increase over baseline of 4,396 referrals). Of these referrals, 400 will be warm handoffs (e.g., phone call to social service agency, help applying for an assistance program) facilitated by a mobile staff member to help ensure that people connect with available services.

Outcome 4: Between 12/1/2025– 9/30/2026, the Mobile Health Acceleration Project will implement a market-side physical fitness and nutrition education program utilizing ageappropriate exercise equipment, anticipating 255 children and adults will participate in the program. Our mobile health teams will lead a curriculum developed by Virtua Occupational/Physical Therapists/Exercise Physiologists and Registered Dietitians.

At the project's end, findings will be submitted to the Community Preventive Services Task Force (CPSTF), a division of the Centers for Disease Control, which does not list a similar initiative seeking to connect mobile food and mobile preventive healthcare services.

Budget: \$200,000

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Program Name: State Physical Activity & Nutrition (SPAN) Program - (Rutgers Cooperative Extension)

Summary of the Proposed Program

The Work Well intervention was developed using the Health Belief Model and integrates USDA aligned messaging with evidence-based content to promote healthier dietary behaviors, increased physical activity, and improved stress management. Delivered entirely online, the program enhances accessibility for employees who face time or geographic barriers, while maintaining engagement through concise and interactive educational materials.

The Work Well program includes several core components:

- **Educational Videos:**

Short, 5-minute lessons addressing healthy eating, physical activity routines, stress-reduction strategies, and mindfulness practices.

- **Live Webinars that are used as educational videos:**

Sessions led by experts in nutrition, fitness, mental health, and financial wellness, providing interactive learning and opportunities for real-time questions and discussion.

- **Worksheets and Educational Materials:**

Printable resources such as nutrition guides, exercise plans, mindfulness activities, and budgeting tools designed to reinforce learning and support daily behavior change.

In addition to digital content, the program incorporates environmental cues and messaging strategies within the workplace. Posters, digital signage, and recurring wellness messages in newsletters and emails are used to encourage healthy choices and sustain motivation.

Recognizing the unique needs of vulnerable worker populations, Work Well provides tailored supports such as connections to community resources, text-message reminders, behavioral nudges to encourage healthier choices at work, and strategies for managing limited time or resources.

Overall, Work Well represents a proactive approach to improving the health and well-being of New Jersey's workforce. By offering accessible, engaging, and supportive educational resources, the initiative seeks to empower employees to adopt sustainable lifestyle changes that enhance personal health and workplace productivity. Through collaboration among employers, community organizations, and Rutgers University, Work Well aims to strengthen health outcomes, reduce healthcare costs, and promote equity across the state.

Program Objectives

Work Well is a health promotion program designed to strengthen employee skills in nutrition, physical activity, and mindfulness while advancing the Healthy People 2030 objectives, which calls for increasing the number of worksites offering wellness programs. The enhanced Workforce Wellness program was designed to:

1. **Develop 24 educational videos** in both English and Spanish that provide accessible, evidence-based content aligned with current wellness priorities.
2. **Build one package including bilingual resources**—including newsletters, videos, resource sheets, and recipes—to create standardized educational modules for program participants.
3. **Deliver the redesigned 12-week Work Well program** across Monmouth and Hudson Counties, as well as additional New Jersey sites, to expand access to high-quality workforce

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wellness education to at least 100 participants (FFY24 goal 50 participants. Reached 230 participants)

4. **Utilize technology-enhanced tools.** Adopt at least two technology-enabled tools to track participant engagement in real time using Qualtrics, Zoom, or YouTube and generate quarterly evaluation reports, and improve program quality, consistency, and replicability across all program sites.
5. **Deliver 35 Wellness Wednesdays Webinars** focused on topics that are relevant for New Jersey residents and reach at least 1000 participants.

Evaluation Plan

Evaluation of the Work Well program will use a mixed-methods approach to measure participant engagement, behavior change, and program effectiveness, while ensuring the intervention remains replicable and responsive to employee needs. Pre- and post-surveys will be administered electronically to assess changes in nutrition behaviors, physical activity levels, stress-management practices, and self-efficacy—core constructs of the Health Belief Model on which the program is based. Digital analytics will track completion of videos, webinars, and resource materials, providing real-time insight into participant engagement across worksites and counties. Qualitative feedback collected through open-ended survey items and optional focus groups will further illuminate participant experiences, barriers, and suggestions for improvement. The evaluation system will also integrate technology-enhanced tools such as automated reminders, engagement dashboards, and mobile-friendly survey formats to improve response rates and data quality. Findings will be compiled into standardized evaluation summaries to support consistency across program cohorts and guide ongoing curriculum refinement. Together, these strategies will generate actionable, evidence-based insights that strengthen program outcomes and enhance scalability.

Evaluation, Accomplishment and Outcomes 2025-2026

The Work Well study, approved by the Rutgers University Institutional Review Board, was conducted across three worksites to evaluate its effectiveness in improving workforce wellness. Pre- and post-surveys measured changes in participants' health behaviors and perceptions. These evidence-based interventions enhanced participant well-being and provided a scalable framework for reducing chronic disease. The Work Well program engaged more than 240 participants, delivering accessible education that led to measurable improvements in key health outcomes.

Wellness Wednesdays with FCHS reached over 5,000 individuals through live webinar attendance, offering practical tools and sustainable strategies for maintaining long-term health. By promoting nutrition, physical activity, mindfulness, and inclusive practices, these programs strengthen community health, reduce healthcare costs, and advance **Healthy People 2030 objectives** - serving as a model for building healthier and more resilient communities.

Budget Narrative – \$75,000

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Project Name: State Physical Activity & Nutrition (SPAN) Program – (The Food Trust)

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:

To increase the number of community-based organizations providing population-based primary prevention, The Food Trust (TFT) will continue an expansion of its successful Healthy Corner Store Initiative including Heart Smarts across New Jersey (NJ), along with the Food Bucks Rx (produce prescription) program in Camden, Mercer and possible additional counties. The Healthy Corner Store Initiative and Heart Smarts transform small stores into community health hubs, improving the capacity of small store owners to sell fresh and healthy food and to increase nutritional knowledge among their shoppers, while Food Bucks Rx connects healthcare partners and fresh food retailers around a common goal of increasing access to affordable, fresh produce. This project will deploy community-based strategies through a participatory model and build upon over 10 years of experience in developing community-clinical linkages.

TFT foresees ongoing needs and opportunities to continue these community partnerships in the upcoming year. TFT proposes to continue providing health screenings, nutrition incentives and technical assistance in collaboration with the 240 corner stores statewide. In addition, staff will continue to strengthen the community clinical linkages of these programs through online nutrition education resources, partnerships with local healthcare providers and in-person nutrition education, whenever feasible.

Justification:

Lack of access to nutritious, affordable foods, coupled with a lack of education on how to make healthy choices, are major contributors to diet-related diseases like diabetes, stroke, and heart disease. TFT's priority social determinant of health addressed by the Healthy Corner Store Initiative (HCSI), Heart Smarts and Food Bucks Rx produce prescription programs is community-clinical linkages and, secondarily, food and nutrition security. TFT has been championing this work in NJ for over 10 years, most recently introducing its successful Food Bucks Rx program, originally developed in Pennsylvania over 20 years ago.

Recognizing that NJ's lower-income areas have high rates of diet-related diseases, the NJ Food Marketing Task Force—a public-private partnership including leadership from the supermarket industry, state and local governments, community and economic development, and public health and philanthropy sectors—issued a report and set of recommendations calling upon the state of NJ to prioritize food retailing for the comprehensive redevelopment of communities. TFT's statewide corner store programming detailed above prioritized stores according to the NJEDA's mapping of highest priority food desert communities. Additionally, according to the Trenton Health Team Community Assessment, residents of Trenton reported language as a key barrier for receiving health services in Trenton (119.4% more than in Mercer County as a whole), with 36% of residents of Trenton identifying as Latino or Hispanic. To ensure community needs are best met, TFT employs bilingual staff with an expertise in small businesses, store owner trainings and nutrition education.

SMARTIE Objectives:

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- Between 10/1/2026 and 9/30/2027, TFT will distribute over \$45,000 in nutrition incentives—including Food Bucks and Food Bucks Rx—at healthcare and other community settings.
- Between 10/1/2026 and 9/30/2027, TFT will distribute and redeem approximately \$20,000 in Heart Bucks nutrition incentives to individuals who participate in on-site nutrition education at corner stores participating in the NJ Healthy Corner Store Initiative while providing training and technical assistance to store owners
- Between 10/1/2026 and 9/30/2027, TFT will provide direct nutrition education at farmers markets and other community sites utilizing several evidence-based curricula: Heart Smarts, Cooking Matters for Caregivers and Just Say Yes to Fruits and Vegetables.
- Between 10/1/2026 and 9/30/2027, TFT will partner with healthcare partners and community service providers to offer health screenings at 8 Camden corner stores along with supporting stores that received blood pressure machines in previous fiscal years.

Evidence/Promising Practice:

More healthcare clinical sites are looking to address health-related social needs through programs that make healthy food more affordable and accessible, causing these programs to be in high demand. In addition, ongoing data collection around Food Bucks Rx produce prescriptions shows significant increases in fruit and vegetable consumption. Heart Smarts, the nutrition education lesson created by TFT is evidenced-based, practice-tested and has been accepted into the national SNAP-Ed toolkit.

Evaluation:

TFT has established research partnerships and protocols that align with this project. For example, as a state funded implementing agency in NJ, TFT works with an outside evaluator through Montclair State University's Center for Research and Evaluation on Education and Human Services (CREEHS) to assess HCSI and Heart Smarts programming. For Food Bucks Rx, supported by the USDA GusNIP program, TFT works with the national evaluator Center for Nutrition and Health Impact. For nutrition education, healthy corner store programming and nutrition incentives, TFT uses several evaluation tools, including:

- Participant surveys for nutrition education (components include demographics and behavior change questions)
- Survey tool that captures changes in stores and owner/customer feedback
- Field notes kept by educators, documenting all visits and interactions with store owners, are tracked on internal calendars, spreadsheets and entered into the NJDOH reporting system (PEARS)
- Tracking Heart Bucks, Food Bucks and Food Bucks Rx distribution and redemption through UPC codes and an internal database
- Food Bucks Rx pre/post-survey tool to capture participant outcomes, including changes in fruit and vegetable consumption as well as to collect qualitative data about the patient experience (*Note: may not be conducted at all sites)
- Project-specific surveying with community members, as needed

Budget: \$200,000

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Program Name: State Physical Activity & Nutrition (SPAN) Program – (Union County Office of Health Management (UCOHM))

Health People 2030 Objectives

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

Summary of Proposed Project/Intervention

The Living Well Program is a community-based chronic disease prevention initiative designed to improve health outcomes among older adults living with Arthritis in Union County, New Jersey. The program will provide health education, patient navigation, and baseline health screenings at senior housing facilities and community centers to support older adults in preventing and managing chronic conditions. Program activities will include structured health education workshops addressing key chronic disease risk factors — including nutrition, physical activity, sleep, mental health, and preventive screenings. Screenings will be offered at least 28 times over the seven-month grant period. Participants will also receive individualized patient navigation services. Our screenings are possible with our partnerships - cancer screenings through NJCEED and bone density screenings through the NJ Institute of Osteoporosis in Cranford, and medication assistance through our Ask-a-Nurse program where seniors can ask general questions about medications they are taking. Baseline health screenings include blood pressure checks, blood glucose screenings, and basic mental health screenings. They will be offered during program sessions to promote early detection and encourage follow-up care. Through these combined strategies, the Living Well Program will strengthen community-clinical linkages and empower at least 200 older adults to actively engage in preventive health behaviors during the grant period.

Justification

Chronic diseases such as cardiovascular disease, diabetes, arthritis, and hypertension are leading causes of disability and reduced quality of life among older adults. Nationally, 85% of adults aged 65 and older live with at least one chronic condition and 60% have two or more (National Council on Aging). In New Jersey, the burden is acute and growing: the prevalence of chronic disease among residents aged 65+ rose 2.2% annually between 2016 and 2022, and nearly 60% of the state's residents aged 65+ have eight or more chronic conditions (NJ Hospital Association, 2023). Older adults in community and senior housing settings often face additional barriers to preventive care, including difficulty navigating complex healthcare systems, limited access to health education, and social isolation — all of which contribute to delayed care, unmanaged conditions, and preventable complications. UCOHM has a demonstrated and immediate capacity to address these needs. In 2025, our agency conducted 122 community health events — 39 specifically targeting older adults — across Union County's senior facilities include Casano Community Center (Roselle Park), O'Donnell Senior Center (Elizabeth), and Pinewood Hall (Roselle), reaching 684 senior participants. This existing infrastructure, established community trust, and active facility partnerships positions UCOHM to implement the Living Well Program immediately upon award, in full alignment with CDC's Self-Management Education Program guidelines and the Community Preventive Services Task Force recommendation for patient navigation services.

SMARTIE Objectives

- **Health Education:** By September 30, 2026, deliver at least 28 health education sessions at senior facilities across Union County, reaching a minimum of 200 older adults with actionable chronic

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disease prevention content, with intentional outreach to facilities serving low-income and minority older adult populations.

- **Care Coordination:** By September 30, 2026, improve access to care and service navigation for at least 50 older adults through direct patient navigation support, including healthcare appointment scheduling and referrals to NJCEED, the NJ Institute of Osteoporosis, and medication assistance programs.
- **Baseline Screenings:** By September 30, 2026, administer at least 95 screenings at senior facilities across Union County, with follow-up referrals provided to all participants with elevated readings.
- **Participant Reach:** By September 30, 2026, engage a minimum of 200 unduplicated older adults in Living Well Program activities across Union County senior facilities.

Evidence/Promising Practice

The Living Well Program is grounded in CDC's Self-Management Education Programs for Chronic Health Conditions guidelines and aligns with the Community Preventive Services Task Force (CPSTF) recommendations for patient navigation services to increase chronic disease self-management. Evidence-based patient navigation programs have demonstrated effectiveness in improving health outcomes, increasing preventive care utilization, and strengthening community clinical linkages across multiple chronic disease areas including diabetes, heart disease, cancer, and arthritis. UCOHM's 2025 programming directly incorporated evidence-based models, such as Project Healthy Bones (an osteoporosis and osteoarthritis management program emphasizing strength, balance, and flexibility). Our proven evidence-based models, paired with nutrition education, will promote strong participant engagement and reach seniors across Union County facilities. The Living Well Program will build on these models with expanded reach, structured outcome tracking, and deeper integration of referral pathways, all while growing our established trust directly within our communities.

Evaluation

Program outcomes will be evaluated using both quantitative and qualitative methods throughout the grant period. Key Performance Indicators (KPIs) will include: number of health education sessions delivered, total unduplicated participants reached, number of care coordination encounters completed, referrals made and followed through, and screenings administered. Pre/post knowledge surveys will be administered at health education sessions to assess participant knowledge gain and self-reported intent to change health behaviors. Program staff will maintain activity logs, referral tracking systems, and screening records to monitor progress toward objectives on an ongoing basis. Program staff will conduct monthly data reviews to assess program effectiveness, identify areas for improvement, and make real-time program adjustments. Evaluation findings will be compiled in a final summary report submitted to NJDOH Community Health and Wellness Unit (CHWU) documenting all activities, outcomes, and lessons learned to inform future chronic disease prevention programming in Union County.

Budget \$150,000

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Program Name: Sexual Violence Prevention- Division on Women

Healthy People 2030 Objective:

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.

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.

DOW anticipates serving 250 new survivors of sexual assault residing in New Jersey. While the organizations are located in a specific county, the partners are set up to respond to survivors and victims independent of geographic boundaries.

Justification

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.

SMARTIE Objectives:

1. Specific-
 - a. Sexual violence counseling to victims/survivors of sexual assault
2. Measurable-
 - a. From October 1, 2026- September 30, 2027 the providers will deliver 250 sessions of counseling to survivors/victims of sexual assault from underserved and historically marginalized communities
3. Achievable
 - a. The identified partners have experience in delivering these services to the community
4. Realistic
 - a. We will capture data for new survivors served through SOSA funds only.
5. Time-bound
 - a. Services will be delivered from October 1, 2026 through September 30, 2027
6. Inclusive
 - 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

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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.

7. Equitable

- a. Funding awarded through SOSA will be awarded to community based organization who serve marginalized and historically underserved communities.

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: \$193,919

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Program Name: Youth Violence Prevention Program -SafeNJ Nurse Liaison Support 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:

The Stop School Violence - SafeNJ program is the first-of-its-kind trauma-informed, human and healing-centered approach, an anonymous reporting system (ARS) and school safety program for students, staff, families, and communities. SafeNJ meets the needs of families by providing access and linkages to basic, crisis, and mental health resources while ensuring the privacy and dignity all people deserve. SafeNJ has the full capabilities, safeguards, and escalation procedures of an ARS, while keeping incidents managed locally, and reducing the lift on exhausted school personnel. The SafeNJ app teaches students about the importance of asking for help as a life skill. Everyone in the community (students, staff, families) is encouraged to ask for help for themselves and others involved in the school community at the earliest point possible.

SAFE NJ platform, offers a trauma-responsive, healing-centered model that prioritizes prevention, fosters trust, and equips students with the tools and confidence to seek help. Already adopted by 150 school districts across New Jersey and serving more than 250,000 students, SAFE NJ provides 24/7/365 access to live crisis responders, anonymous two-way messaging, and a curated list of local, state, and national support services, all while protecting user privacy and dignity. By embedding trusted, trauma-informed digital tools like SAFE NJ into school systems, especially in communities historically impacted by underfunding and limited resources, New Jersey has a vital opportunity to reduce youth suicide, violence, and chronic absenteeism while building a more connected, supportive school environment for all learners. Investing in proactive, inclusive strategies is essential to ensure that every student feels safe, supported, and empowered to ask for help.

To strengthen the impact, reach, and sustainability of the SAFE NJ initiative, the proposed program model incorporates two complementary leadership roles through the Preventative Health and Health Services grant: the SAFE NJ Nurse Liaison Supervisor and the SAFE NJ Program Strategy and Community Impact Lead. Together, these positions create an integrated structure that bridges clinical expertise, community engagement, program strategy, and systems-level coordination across schools, families, and health and social service partners. This dual-role structure is designed to ensure that SAFE NJ functions not only as a digital reporting platform, but as a comprehensive trauma-informed prevention and response ecosystem that supports students before crises escalate.

Justification:

The SAFE NJ Nurse Liaison Supervisor plays a critical role in translating the SAFE NJ reporting and referral system into meaningful, coordinated care for students and families. Acting as the primary clinical liaison between participating schools, families, and SAFE NJ program partners, the Nurse Liaison ensures that students identified through anonymous reporting, crisis alerts, or referral pathways are connected to appropriate support services in a timely and culturally responsive manner.

In practice, the Nurse Liaison serves as the bridge between education systems, health care providers, and community-based organizations. The role also involves collaboration with school administrators, behavioral threat assessment teams, and counseling staff to identify trends in anonymous

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reporting and emerging safety concerns. These insights support targeted interventions and early response strategies aimed at preventing escalation of risk.

Another critical component of the Nurse Liaison role is capacity building within schools. By providing consultation to educators, school staff, and administrators on trauma-informed care, early warning signs of mental health distress, and referral pathways, the liaison strengthens the ability of school communities to respond proactively to student needs. The Nurse Liaison also contributes to the development and delivery of workshops for staff, students, and families, ensuring that SAFE NJ is not only a reporting tool but also a mechanism for education, prevention, and community engagement.

The Nurse Liaison Supervisor further supports the program through data-informed quality improvement. By tracking engagement, referrals, and service utilization outcomes, and sharing de-identified insights with the New Jersey Department of Health and partner organizations, the role helps inform program evaluation, continuous quality improvement, and policy decisions that support long-term program sustainability.

Ultimately, the Nurse Liaison strengthens the SAFE NJ program by extending its reach beyond digital reporting to include direct human support, coordinated care navigation, and trauma-informed school partnerships. This approach ensures that the program not only identifies concerns but also helps families and schools respond effectively.

SMARTIE Objectives:

- **Objective 1:** By September 30, 2027, Implement trauma-informed mental health and crisis prevention and response programs in at least five high-need school districts to enhance program integration and ensure a coordinated approach to student well-being as measured by the number of schools served.
- **Objective 2:** By September 30, 2027, facilitate a minimum of five presentations per school district related to trauma-informed care for schools, family mental health & resilience, youth safety & wellness, crisis responses, and the SAFE NJ app as measured by the number of presentations provided and attendance logs.
- **Objective 3:** By September 30, 2027, collaborate with the Nurse Liaison Supervisor, the Safe NJ Program Strategy and Community Impact Lead, Empower Somerset, and Lightspeed Systems to ensure a 20% increase in SafeNJ app usage as measured by the Lightspeed app data utilization reports.
- **Objective 4:** By September 30, 2027, evaluate the effectiveness of the SAFE NJ Program implementation by developing a continuous quality improvement (CQI) process including, youth, school staff, and PCG focus groups, pre/post surveys, and app utilization reports to ensure the efficacy of the SAFE NJ program model as measured by CQI process documentation and final meta-level utilization reports.

Evidence/Promising Practice:

Preventing school violence requires more than physical security measures, it demands proactive, accessible, and student-centered systems that address the social-emotional factors contributing to unsafe school climates. A growing body of research shows that anonymous reporting systems, especially those embedded in trauma-informed, prevention-focused frameworks, play a critical role in empowering students to share concerns, seek help, and prevent harm before it escalates.

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A University of Michigan study involving 19 middle schools in the Miami-Dade County Public Schools system evaluated the impact of the Say Something Anonymous Reporting System (SS-ARS) on student behavior and perceptions. The study found that, at both 3-month and 9-month intervals, students using SS-ARS showed significant improvements in self-efficacy and intentions to report potentially harmful behaviors. By the 9-month follow-up, students also reported increased perceptions of school safety and reduced exposure to violence, demonstrating how accessible, anonymous help-seeking pathways can foster safer, more connected school environments (Hsieh et al., 2022).

These findings directly support the rationale behind the SAFE NJ initiative, which uses STOPit Solutions' HELPme platform to provide anonymous, trauma-informed help-seeking tools for students, caregivers, and school staff. By eliminating common barriers to seeking help, such as fear of retaliation, stigma, or lack of trusted adults, HELPme empowers students, caregivers, and school staff to share concerns early and safely. These systems not only support timely intervention but also strengthen trust, build school connectedness, and enhance the overall climate of care. In doing so, SAFE NJ creates the conditions for safer, more supportive learning environments where every student feels protected, valued, and heard.

Evaluation:

An external evaluation consultant will provide expert support in survey design for the app users, instrument clarity, data analysis, and outcome reporting. Any evaluation tools will be user-friendly, culturally appropriate, and aligned with the intended outcomes of the program.

Evaluation will be coordinated in partnership with Epiphany, who will design a customized survey instrument to assess program reach, user satisfaction, perceived safety, and help-seeking behavior among students, caregivers, and school staff. In partnership with Lightspeed, Epiphany will compile, analyze, and summarize results.

LightSpeed Systems will collect app usage information and release school-level utilization reports, including metrics such as 2nd Floor Youth Helpline connections and other integrated referral usage. LightSpeed Systems will also provide meta-level data across all participating schools including identifying trends, geographic differences, and potential gaps in engagement. These insights will inform targeted outreach and marketing strategies to increase utilization in underrepresented groups or low-engagement districts.

By combining survey data, platform utilization metrics, and qualitative feedback, Empower Somerset will ensure that SAFE NJ is continuously refined to meet the needs of its program populations. This data-driven approach will also provide evidence of impact for stakeholders, strengthen school-community trust and support the long-term sustainability of the initiative.

Budget: \$325,000

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Program Name: Child and Adulthood Asthma Program (CAAP) – (Hackensack University Medical Center)

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 Child and Adulthood Asthma Program (CAAP) aims to reduce asthma-related Emergency Department visits among children aged 5-18 years in Bergen, Essex, Hudson, and Passaic counties by (1) increasing health literacy about asthma exacerbations and triggers; (2) providing referrals for follow-up care; (3) identifying tobacco use in the home, educating families about its link to asthma exacerbations, and offering referrals for tobacco treatment; and (4) assessing health-related social needs and connecting families with resources to address barriers to effective asthma management, such as health insurance coverage and medication costs. Across the emergency departments of 2 hospitals, Hackensack University Medical Center (HUMC), and Palisades Medical Center (PMC), the program aims to deliver asthma education and/or facilitate linkages to additional services to about 25 patients each month.

Justification: Asthma is one of the most common chronic diseases affecting children in the United States and remains a leading cause of emergency department (ED) visits, and missed school days. According to the Asthma and Allergy Foundation of America, approximately 4.9 million children in the United States have asthma, and asthma-related exacerbations disproportionately impact children from low-income households and communities with higher exposure to environmental triggers such as tobacco smoke and air pollution.

Bergen, Essex, Hudson, and Passaic counties include diverse populations that experience barriers to effective asthma management, including limited access to primary care, gaps in health insurance coverage, and unmet social needs. Consequently, children with poorly controlled asthma and their caregivers are more likely to heavily rely on the emergency department for care and experience preventable asthma exacerbations that could be managed through timely outpatient care, education, and support.

The Child and Adulthood Asthma Program (CAAP) addresses these challenges by providing targeted asthma education, identifying household triggers, facilitating follow-up care, and connecting families to critical resources. By intervening immediately following an ED visit, CAAP aims to reduce repeat asthma-related ED utilization and improve long-term asthma self-management among children and their caregivers.

SMARTIE Objectives: From October 1, 2026 to September 30, 2027, the Child and Adulthood Asthma Program (CAAP) will maintain a goal of 25 patients per month receiving education and or linkage to services. We will continue to educate patients and caregivers on asthma self-management and asthma triggers in the home environment. Patients will receive education, resources, and management plans in several ways including in-person interactions while attending community events, physical receipt of education placed in discharge paperwork, and/or over-the-phone case management.

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Evidence/Promising Practice: Recent research supports the effectiveness of structured programs that include asthma education, care coordination, and community-based interventions in improving asthma outcomes and reducing emergency department utilization among children. A 2023 systematic review published in *Pediatrics* found that community interventions including asthma education, care coordination, and connections to social and health services were associated with significant reductions in childhood asthma emergency department visits and hospitalizations by educating caregivers, reducing environmental triggers, and improving access to outpatient care.

Evaluation of pediatric ED-based asthma education tools published in *Allergy, Asthma & Clinical Immunology* (2024) demonstrates the feasibility of providing asthma education during or immediately after an emergency department visit and suggests that interactive and tailored education may improve parent and child asthma literacy, which is an important factor of self-management and future healthcare utilization.

Collectively, these research studies reveal that the Child and Adulthood Asthma Program (CAAP) include key components of asthma education, connection to follow-up care, environmental trigger reduction, and care coordination to a successful intervention. This represents promising, evidence-based strategies for reducing preventable asthma exacerbations and emergency department utilization among children and their caregivers.

Evaluation: Process and outcome evaluations will be performed to track progress. Quantitative data will be collected. Monthly reporting will evaluate and monitor how many patients were sent over in the in basket (asthma, passive exposure, asthma triggers). It will also evaluate what and how many referrals were made when working with patients. This will include referrals to PCP, insurance application assistance, asthma management, smoking cessation, and the different types of asthma education and documents were provided.

Budget: \$110,000

New Jersey Preventive Health and Health Services Block Grant
FFY26 Program Priorities

Program Name: Child and Adulthood Asthma Program (CAAP) – (The Cooperative)

Healthy People 2030 Objective: Reduce asthma related hospitalization and emergency department visits in children ages 5-18

Summary of the proposed project/intervention: The proposed project will build on efforts from FFY24 through FFY25 by implementing the following:

- Deliver provider training on asthma related topics including Asthma Self-Management Education (AS-ME), asthma and environmental triggers including dust, pollen, second and third hand tobacco smoke exposure, through workshops/webinars to clinicians, home visitors, community health workers and to health profession students.
- Deliver patient education about asthma as part of Virtua Pediatric Mobile Services outreach efforts, sports physical exams and vaccination clinics.
- Deliver patient and community education about Asthma Self-Management Education (AS-ME) using the American Lung Association's Kickin' Asthma and Open Airways for Schools curricula in schools and community settings
- Provide education on environmental asthma triggers (including dust, pollen, 2nd and 3rd hand smoke, mold, etc.) in community settings.
- Disseminate educational materials in English and Spanish throughout Camden County in clinical, school, and community settings including pediatricians, primary care, urgent care and emergency services providers, summer programs/camps, and faith-based youth programs.
- Provide resources and tools to Medicaid Managed Care providers to increase utilization of asthma spacers for pediatric patients.
- Incorporate Medicaid re-enrollment messaging into educational programming to families with children suffering from asthma.

Justification:

The proposed intervention works to increase awareness of issues facing youth with pediatric asthma through outreach education, improved screening, and multi-disciplinary self-management of pediatric asthma. The key issues impacting successful management of pediatric asthma in the county include:

- o Limited access to spacers and lack of information about the importance of spacers.
- o Limited interaction with primary care leading to under-diagnosed and undermanaged care for underinsured patients.
- o Lack of education leading to poor self-management skills among patients and parents.

The focus on access points where children with asthma may interact with care (through a clinician, school nurse, or Urgent Care/Emergency Department) as well as provider training and Asthma Self Management Education to individuals and families in schools and community settings supports improved screening and management of pediatric asthma. Addressing access and the importance of using spacers for patients covered by Medicaid will improve medication administration and support self management.

SMARTIE Objectives:

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Objective 1: Between 10/01/2026 and 09/30/27 increase the number of providers reporting provision of AS-ME in various settings throughout the county by 100, as measured by attendance at provider training sessions.

Objective 2: Between 10/01/2026 and 09/30/27 increase the number of people ages 8-16 receiving asthma health education in various settings throughout the county by 80, as measured by attendance at health education programs.

Objective 3: Between 10/01/2026 and 09/30/27 increase by 150, the number of Camden County residents living with children ages 5-18 with asthma receiving education about asthma triggers including mitigating exposure to second and thirdhand smoke and vapor, pollen, dust and other environmental triggers as measured by attendance at Breathe Strong Camden County, Ask Advise, Refer and “Healthy Homes” and “Rinsey the Raccoon” presentations in community and school settings.

Evidence/Promising Practice: Clinical guidelines for the management of asthma support the use of spacers and Asthma Action Plans to communicate with school nurses. These concepts are at the core of provider training and presentations. In addition to increasing provider awareness of these and other best practices through provider training, the American Lung Association’s multidisciplinary EXHALE model, Kickin Asthma and Open Airways for Schools curricula are informed by best practices in asthma self-management for children.

Evaluation:

All training and education programming will be evaluated by attendance and pre- and post- test where possible. In addition, provider training will include a satisfaction survey with an opportunity to request additional patient education resources. Virtua Pediatric Mobile Services will continue to track numbers of people screened for asthma, individually educated about asthma and exposure to triggers through their vaccination clinics, sports physicals and other health screening activities.

Budget: \$110,000

New Jersey Preventive Health and Health Services Block Grant
FFY26 Program Priorities

Program Name: New Jersey Behavioral Risk Factor Survey

Healthy People 2030 Objective: Increase the proportion of adults who get recommended evidence-based preventive health care — AHS-08

The NJBRFS also aligns with the focus areas of: • Cancer • Social Determinants of Health • Quality of Life and Well-Being • Diabetes • Older Adults • Binge Drinking • Smoking • Physical Activity

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 the prevalence of health risk behaviors. Participating states are encouraged to add other CDC created health modules or to develop local questions that are jurisdiction specific. In 2026, the required elements of the core survey, include: access to healthcare, health status, chronic health conditions (hypertension, diabetes, cardio vascular disease, and arthritis), breast and cervical cancer screening, disability, sleep, exercise, tobacco use, alcohol consumption, and oral health, New Jersey will field optional questions that focus on cancer survivorship, childhood asthma, firearm safety, traumatic brain injury, Bethell's Positive Childhood Experiences, and the prevalence of screening for colorectal and lung cancer, cognitive decline, care giver and traumatic brain injury. The survey tool will be administered to a minimum of 8,000 NJ residents; approximately 1,600 of the surveys will be facilitated by the PHHSBG. The additional funding from the PHHSBG ensures a sample size that is sufficient to provide reliable data enabling the derivation of state and county level statistics by demographic status and county of residence.

SMARTIE Objectives:

- (1) Between October 2026 and September 2027, conduct a minimum of 8,000 completed New Jersey Behavioral Risk Factor Survey interviews from a randomly selected sample of New Jersey landline and cell phone users.
- (2) Between October 2026 and September 2027, clean, analyze, and disseminate data collected during the 2025 annual cycle of the BRFS project and post the information to NJSHAD ([NJSHAD - \(state.nj.us\)](https://njshad.state.nj.us)), an online source for data queries and health indicator reports.

Evidence/Promising Practice: Not Directly Applicable to the NJBRFS; the NJBRFS provides reliable data for health-focused programs which can be used 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: \$330,000

New Jersey Preventive Health and Health Services Block Grant
FFY26 Program Priorities

Program Name: Oral Health Program

Healthy People 2030 Objective:

- OH-02: Reduce the proportion of children and adolescents with active and currently untreated tooth decay in their primary or permanent teeth
- OH-D01 (Developmental): Increase the number of states and the District of Columbia that have an oral and craniofacial health surveillance system (high priority public health issue)
- D-01 Reduce the proportion of people with undiagnosed diabetes.

Summary of the proposed project/intervention:

1-Apply Fluoride Varnish to the teeth of elementary school and Head Start (HS)/ Early Head Start (EHS) participants and provide education AND referrals to elementary school and HS/EHS families and staff.

2-Implement the Basic Screening Survey (BSS) from the Association of State and Territorial Dental Directors (ASTDD) to conduct standardized visual oral health screenings among high-risk populations in community settings such as schools and Head Start programs. Data collected on decay, treatment needs, sealants, and dental visit history will be used to identify disparities and inform programs and policies that improve access to oral health care.

3-Implement quarterly medical–dental integration events at dental offices offering free A1c blood pressure assessments, health education, and medical referrals, supported by Community Health Worker follow-up.

SMARTIE Objectives:

- 1- Between 10/01/2026 and 09/30/27, our grantees continue conducting a preventive program including, dental screening, oral health education and fluoride varnish application to the HS and EHS students and elementary school students. Item to be Measured (from Program SMART Objective above): Number of HS, EHS, and elementary school children who receive fluoride varnish
- 2- Between October 1, 2026 to September 30, 2027, one Basic Screening Survey (BSS) will be conducted based on the guideline of ASTDD to assess the oral health status of the target population. Item to be Measured (from Program SMART Objective above): Number of individuals who receive BSS, number of individuals with oral health diseases, and number of individuals who need to be referred to dentists for dental treatments
- 3- Conduct quarterly on-site medical screening events at a dental office to provide free A1c testing, blood pressure assessments, health education, and medical referrals. Item to be Measured (from Program SMART Objective above): Number of individuals receiving Hemoglobin A1c testing, number and percentage of participants with elevated A1c levels number and percentage of participants successfully linked to a medical home, number of follow-up contacts completed by Community Health Workers

Evidence/Promising Practice:

Fluoride Varnish Application - Application of fluoride varnish is an evidence-based preventive intervention recommended by the American Dental Association and the Centers for Disease Control and Prevention to reduce dental caries in children at moderate to high risk. School- and community-based

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fluoride varnish programs have been shown to significantly decrease tooth decay and improve access to preventive oral health services among underserved populations.

Basic Screening Survey (BSS) - The Basic Screening Survey (BSS), developed by the Association of State and Territorial Dental Directors and supported by the Centers for Disease Control and Prevention, is a standardized, evidence-informed oral health surveillance method used nationwide to assess population-level oral health status. It enables public health programs to identify disparities, monitor oral disease trends, and guide data-driven planning, program development, and resource allocation to improve access to oral health care.

Medical–Dental Integration - Medical–dental integration is a promising public health approach that recognizes the connection between oral health and chronic diseases such as diabetes and cardiovascular disease. Organizations such as the Health Resources and Services Administration and the Centers for Disease Control and Prevention support integrated care models to improve early detection of health conditions, expand preventive services, and enhance care coordination for underserved communities.

Evaluation:

Program progress and outcomes will be evaluated through ongoing monitoring of grantee activities, including regular review of progress and performance reports submitted by grantees. The New Jersey Department of Health will assess implementation milestones, service delivery outputs, and outcome indicators to ensure program goals are met. Technical assistance will be provided to grantees as needed to support data reporting, strengthen program implementation, and improve overall program performance.

Budget: \$350,000

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Program Name: Heart Disease & Stroke Prevention 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:

NJDOH plans to partner with up to three health systems and/or one university and an internal NJDOH program to implement targeted initiatives aimed at reducing high blood pressure, and cholesterol levels, thereby preventing heart attacks and strokes in adults. NJDOH will also partner with NJDOH EMS to integrate CARES in the heart disease scope of work to improve survival rates from out-of-hospital cardiac arrest by collecting, analyzing standardized data to guide quality improvement efforts in prehospital and hospital care. This strategic partnership offers grantee partners the flexibility to choose from a range of activities inspired by the Million Hearts initiative, a program jointly led by the CDC and CMS¹ focused on preventing cardiovascular disease or the Healthy Heart Ambassador: a CDC-recognized lifestyle change program that teaches participants about heart-healthy foods and SMPB practices to individuals with hypertension².

The selected activities will encompass a variety of evidence-based strategies, including but not limited to:

- Conducting blood pressure and cholesterol screenings
- Implementing SMBP for priority populations
- Conducting Remote Patient Monitoring
- Offering telehealth services
- Utilizing Medication Therapy Management
- Enhancing patient education on lifestyle changes
- Utilizing health information technology to track patients' progress
- Utilizing referral processes and closing the loop
- Implementing community outreach programs to raise awareness and foster healthier habits
- Participating in NJDOH's diabetes and CVD events
- Collecting and integrating CARES in the CVD and Heart & Stroke Programs

Through these comprehensive efforts, NJDOH seeks to make a significant impact on public health outcomes related to heart and stroke.

Justification:

Heart disease is the leading cause of death among men, women, and people of most racial and ethnic groups, and it accounts for 1 in every 5 deaths in the U.S. and NJ. In 2023, stroke was the fourth leading cause of death in NJ and the U.S., with a total of 162,639 deaths, including 3,465 deaths in NJ³. About 87% of all strokes are ischemic strokes, in which blood flow to the brain is blocked, often leaving individuals with serious long-term disabilities⁴. In 2023, the percentage of New Jersey adults who have been told they have high blood pressure by a health professional was 30.1%. Blacks (39.8%) have highest prevalence of diagnosed high blood pressure compared to Hispanics (30.7%), Whites (30%) and Asians (24.2%) in the state⁵.

Cardiovascular disease (CVD) can often be prevented by effectively managing several key risk factors. High blood pressure, high cholesterol, smoking, diabetes, and obesity are significant contributors to the development of CVD and addressing these can markedly reduce risk. Adopting a heart-healthy

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lifestyle is crucial for preventing CVD. Regular physical activity, such as walking, cycling, or swimming, helps maintain a healthy weight, lowers blood pressure, and improves overall cardiovascular health. To help NJ residents adopt a heart-healthy lifestyle, NJDOH will work with up to three external organizations and one NJDOH program proficient in implementing evidence-based activities, utilizing any of the programs mentioned above to provide education on hypertension management, screen for high blood pressure, cholesterol levels, promote healthy lifestyle changes and collect and standardize cardiac arrest data.

SMARTIE Objectives:

- Between 10/1/2026 and 9/30/2027, NJDOH will partner with up to three organizations including FQHCs, CBOs, and/or universities to implement activities to reduce heart disease by lowering risk factors and improving heart health in adults.
- Between 10/1/2026 and 9/30/2027, Grantee partners will utilize either the Million Hearts or the Healthy Heart Ambassador program to deliver health education, promote best national practices and improve health outcomes to reach a total of 250 adults.
- Between 10/01/2026 and 09/30/27 NJDOH will partner with the NJDOH-EMS will partner with the NJDOH-EMS to integrate CARES in the heart disease scope of work to improve survival rates from out-of-hospital cardiac arrest by collecting, analyzing standardized data to guide quality improvement efforts in prehospital and hospital care. by collecting, analyzing standardized data to guide quality improvement efforts in prehospital and hospital care.

Evidence/Promising Practice: Evidence based strategies for preventing and managing CVD

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: \$225,000

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FFY26 Program Priorities

Program Name: Diabetes Capacity Building – (CBVI Diabetic Eye Disease Detection Program (DEDD) Support)

Healthy People 2030 Objective: D-04-Increase the proportion of adults with diabetes who have a yearly eye exam. (Target: 70.3% Current: 66% (2023))

Summary of the proposed project/intervention: The New Jersey Commission for the Blind and Visually Impaired (CBVI) provides a wide range of services intended to save sight and restore vision whenever possible under Project Better Eye-Health Services and Treatment (BEST). These services include: mobile eye examination unit; vision screening for preschool and school-age children; monthly or semi-monthly eye screenings at more than 28 fixed sites all over the state; onsite screening at institutions and in communities; special diabetic detection and awareness programs; and other specialized eye screening programs which target historically underserved populations (i.e. people with low incomes, minorities, the elderly, migrant farm workers, etc.). The program will partner with FQHCs, hospitals, and other healthcare facilities to bring ophthalmologists, nurse educators, and 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 the larger goal of diabetes prevention.

Justification: Dilated eye examination rates among adults with diabetes declined from 73.3% in 2011 to 66.5% in 2021, reducing opportunities for early detection of diabetic retinopathy, a leading cause of blindness among adults aged 25 to 64. Strengthening screening efforts is critical to prevent avoidable vision loss in New Jersey as early detection, timely treatment, and appropriate follow-up care can reduce a person's risk for severe vision loss from diabetic eye disease by 95%.

SMARTIE Objectives:

- Between 10/1/2026 and 09/30/2027, the Diabetic Eye Disease Detection Program (DEDD) program will conduct between 750-900 eye examinations for underserved residents with Type 2 diabetes.
- Between 10/2026 and 09/2027, the DEDD program will identify pathologies detected via DEDD eye screening events and make client referrals for appropriate follow-up care services and treatments.

Evidence/Promising Practice: Evidence-based

Evaluation: The program will be monitored and evaluated by program staff and the internal evaluation team, utilizing the CDC's Framework for Evaluation and Public Health. Process and outcome evaluation efforts for Grantee Partners will include quarterly meetings, annual site visits, and quarterly program performance surveys, during which Grantee Partners will provide both quantitative and qualitative data on program reach, impact, and health outcomes.

Budget: \$125,000

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FFY26 Program Priorities

Program Name: Diabetes Capacity Building – (Centrastate Medical Center Diabetes Prevention Program (DPP))

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: NJDOH will partner with CentraState Medical Center to expand access to the National Diabetes Prevention Program services by launching 3 new cohorts enrolling a total number of 36 or more participants. These participants will have their A1C tested and enrolled into the appropriate DPP or DSMES program as well as have access to CentraState's Population Health Social Worker to address any social determinates of health needs.

Justification: The population served by the Atlantic Medical Group, CentraState Healthcare System, and their affiliated partners exhibits a significant prevalence of prediabetes and diabetes, particularly among high-risk groups such as older adults, individuals from lower socioeconomic backgrounds, and certain ethnic minorities. Data indicates that these populations are disproportionately affected by these conditions, highlighting the urgent need for effective prevention strategies. Despite the availability of CDC-recognized lifestyle change programs, current utilization rates among the target population remain low. Barriers such as limited access to technology for participating in virtual programs, language differences, and a general lack of awareness about program offerings contribute to this underutilization. Health outcomes among those who are engaged with diabetes prevention programs show some positive trends, such as improved A1C levels and weight loss. However, these benefits have not been uniformly realized across the population, indicating gaps in both reach and efficacy. The planned expansion of the Virtual Diabetes Prevention Program, with the launch of three new cohorts, aims to address these gaps by targeting high-risk populations and utilizing a bilingual lifestyle coach to engage Spanish-speaking participants. The program will also leverage Epic medical record data to identify eligible candidates and work closely with referring physicians to encourage enrollment. We'll also reach out to community- and faith-based organizations to increase awareness of prediabetes and where to go for help. These organizations may include but are not limited to the Bethel African Methodist Church, St. Rose of Lima, Casa Freehold, Neighborhood Connections to Health, and the Community Affairs and Resource Center. Through these efforts, the program intends to achieve 5% weight loss among participants and improve overall diabetes prevention outcomes in the community.

SMARTIE Objectives:

- Between 10/2026 and 9/2027, NJDOH will partner with CentraState to launch 3 new National Diabetes Prevention Program (NDPP) cohorts with 36 or more participants identified through the EMR system.
- Between 10/2026 and 9/2027, CentraState will develop and implement a comprehensive outreach and engagement strategy to ensure at least 80% of participants complete the National Diabetes Prevention Program (NDPP) cohorts and achieve measurable health improvements within the first year

Evidence/Promising Practice: Evidence-based

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Evaluation: The program will be monitored and evaluated by program staff and the internal evaluation team, utilizing the CDC's Framework for Evaluation and Public Health. Process and outcome evaluation efforts for Grantee Partners will include quarterly meetings, annual site visits, and quarterly program performance surveys, during which Grantee Partners will provide both quantitative and qualitative data on program reach, impact, and health outcomes.

Budget: \$50,000

New Jersey Preventive Health and Health Services Block Grant
FFY26 Program Priorities

Program Name: Diabetes Capacity Building – (The Diabetes Foundation)

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: The Diabetes Foundation requests a capacity building grant to increase training to community partners to refer their guests/participants to our DSMES, DPP (online), and other DF education programs listed on our website, under, “Events”.

Justification: As of 2025, about 9.1% of adults in New Jersey are living with diagnosed diabetes, with roughly 55,000 new cases reported each year. The burden of diabetes disproportionately affects racial and ethnic minority groups, with higher prevalence among Black non-Hispanic and Hispanic adults compared with Asian and non-Hispanic White adults. These disparities are influenced by both nonmodifiable factors, such as age and race, and social determinants of health, including limited access to healthcare and nutritious foods. Preventing diabetes complications requires a multifactorial approach that addresses diet, physical activity, blood glucose control, blood pressure, and lipid levels. Because most diabetes care is self-managed by the individual, education and support programs play a critical role in helping patients effectively manage their condition.

The Diabetes Self-Management Education and Support (DSMES) program is an evidence-based intervention that provides patients with personalized guidance from trained healthcare professionals, such as Certified Diabetes Educators, nurses, or pharmacists. Through approximately eight hours of education, participants learn key diabetes management skills including monitoring, medication management, healthy eating, physical activity, coping strategies, and problem-solving techniques. Research shows that increased participation in diabetes education, particularly with 10 or more contact hours, is associated with significant reductions in A1C levels and improved health outcomes. Despite these benefits, participation rates remain low—around 10% of individuals with diabetes—often due to barriers such as transportation, financial limitations, limited awareness, cultural factors, or lack of encouragement from healthcare providers. Increasing referrals through community partners such as food pantries and senior centers may help improve participation and support individuals in achieving better self-management and health outcomes.

SMARTIE Objectives:

- Between 10/2026 and 12/2027, the Diabetes Foundation will make a list of current and new partners in key locations across the state with a maximum of 100 sites.
- Between 10/2026 and 1/2027, the Diabetes Foundation will make a list of 3 BS and/or MS programs in Public Health or Nutrition to engage in internships with the Diabetes Foundation.
- Between 1/2027 and 4/2027 the Diabetes Foundation new Community Relations Manager will be trained by our Program Manager in our health literacy program, diabetes and Diabetes Foundation’s referral process.
- Between 4/2027 and 9/2027, the Diabetes Foundation will build capacity among community partners by visiting and training partner staff and interns, delivering presentations, and providing enrollment support to increase referrals and participation in Diabetes Foundation education programs, including DSMES and the online DPP.

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Evidence/Promising Practice: Evidence-Based Diabetes Self-Management Education and Support (DSMES) is a structured, patient-centered, and often insurance-covered service that empowers people with diabetes to manage their condition, reducing A1C by up to 1.7% and preventing complications. It has been proven to lower healthcare costs and hospital admissions by teaching healthy eating, active living, medication adherence, and healthy coping mechanisms.

Evaluation: The program will be monitored and evaluated by program staff and the internal evaluation team, utilizing the CDC's Framework for Evaluation and Public Health. Process and outcome evaluation efforts for Grantee Partners will include quarterly meetings, annual site visits, and quarterly program performance surveys, during which Grantee Partners will provide both quantitative and qualitative data on program reach, impact, and health outcomes.

Budget: \$50,000

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FFY26 Program Priorities

Program Name: Diabetes Capacity Building – (NJ 211)

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: Through the NJDOH-NJ 211 Diabetes Waiver expiring on June 30, 2028, NJ 211 will screen all phone calls for diabetic related needs 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: Diabetes is the eighth leading cause of death in New Jersey, with an estimated 2,000 residents dying each year from the disease. Furthermore, diabetes-related complications and deaths are highly preventable, particularly for type 2 diabetes, through lifestyle interventions and appropriate medications. The proposed project will direct residents to appropriate lifestyle interventions and supportive services to reduce the burden of diabetes in New Jersey.

SMARTIE Objectives:

- Between 10/1/2026 and 9/30/2027, NJDOH will partner with NJ 211 to screen and refer at least 10,000 callers with diabetes to appropriate diabetes-self management resources in the State of New Jersey.
- Between 10/1/2026 and 9/30/2027, NJ 211 will survey at least 10% callers who were screened and referred to appropriate diabetes-self management resources in the State of New Jersey.

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: \$100,000

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FFY26 Program Priorities

Program Name: Diabetes Capacity Building – (Umbrella Hub Organization for Diabetes Prevention Programs)

Healthy People 2030 Objective: D-D01: Increase the proportion of eligible people completing CDC-recognized type 2 diabetes prevention programs.

Summary of the proposed project/intervention: NJDOH will work with Rutgers to become the first Umbrella Hub Organization (UHO) in NJ. Rutgers will work on behalf of CDC-recognized organizations to receive payments for the National Diabetes Prevention Program (NDPP) lifestyle change program. The main purpose of the UHO is to develop and implement a cost-effective infrastructure for billing healthcare payers, including Medicaid, and to remove the burden of subsidiaries. The UHO will also serve as the sponsoring organization for the subsidiaries and will provide administrative support in other services to help subsidiaries increase the number of programs in communities with high burdens of diabetes and prediabetes. New Jersey has approximately 24 Diabetes Prevention Recognized Programs (DPRP), 26 ADCES Diabetes Self-management Education and Support (DSMES) programs, and 57 ADA DSMES. DSMES programs provide personalized services to help individuals manage diabetes. Specialists help create a plan to teach individuals key self-care behaviors that include healthy eating, being active, medication adherence, and blood sugar monitoring, while DPP focuses on providing a structured program aimed at preventing Type 2 diabetes for individuals at high risk. NJ currently does not have DPRP in Burlington, Cape May, Cumberland, Hunterdon, Passaic, Salem, and Sussex counties.

Justification: The National Diabetes Prevention Program (NDPP) brings together healthcare organizations, CBOs, faith-based organizations, private insurers, employers, and government agencies to build a delivery system that works towards promoting a lifestyle change program to prevent or delay Type 2 diabetes. Organizations work together to create awareness of prediabetes, encourage participation in the lifestyle change program, a covered health benefit, and share information about the NDPP. According to the NJBRFS, 2023, the prevalence of prediabetes in NJ in 2020 for Asian, non-Hispanic was 16.1%, Black/African American, non-Hispanic 17.8%, Hispanic/Latino 11.5% and White, non-Hispanic 10.5%. In 2023, the age-adjusted prevalence of diagnosed diabetes in New Jersey was (9.1%). Blacks (13.6%), Hispanics (12.5%), Asians (11.0%), have a higher prevalence of diagnosed diabetes compared to Whites (6.8%). NJDOH seeks to establish the first UHO in NJ to perform a wide variety of functions that are vital in the process of delivering DPP services. Additionally, once established, the UHO will incorporate additional programs to help subsidiaries increase network capacity, bring in more individuals for DPP/DSMES services, provide technical assistance, build core business skills, and offer other resources to enhance and implement diabetes education services.

SMARTIE Objectives:

- Between 10/1/2026 and 9/30/2027, NJDOH will partner with Rutgers University to become an approved CDC Umbrella Hub Organization.
- between 10/1/2026 and 9/30/2027, Grantee Partner will establish a network of 3 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.

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FFY26 Program Priorities

Evidence/Promising Practice: Evidence-based

Evaluation: The program will be monitored and evaluated by program staff and the internal evaluation team, utilizing the CDC's Framework for Evaluation and Public Health. Process and outcome evaluation efforts for Grantee Partners will include monthly and quarterly meetings, annual site visits, and quarterly program performance surveys, during which Grantee Partners will provide both quantitative and qualitative data on program reach, impact, and health outcomes.

Budget: \$125,000

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Program Name: Data Innovation 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:

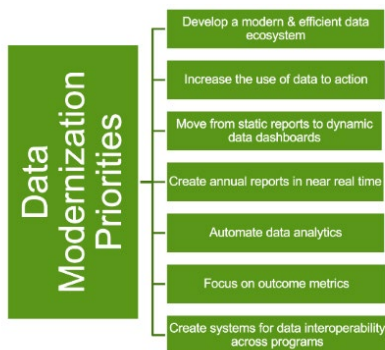
The Community Health and Wellness Unit's Epidemiology, Surveillance and Evaluation Team (CHWU ESE) provides evaluation, surveillance and other data related needs support to the chronic disease programs that comprise the CHWU (cancer, tobacco control, diabetes prevention and control, cardiovascular disease 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. The incubator has a unique focus on chronic disease programs and the subsequent data utilized to determine burden and monitor progress tied to programmatic interventions that address chronic disease burden.

The ESE team used the NACDD incubator project to launch a data innovation planning process with a focus on chronic disease related data that is specific to the Community Health and Wellness Unit. The goal of the project (underway) is a chronic disease data modernization plan that 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)

During year 1 (FY25) of this project, the team assessed NJDOH's data modernization priorities and how the chronic disease section can align with those overarching priorities.

Figure 1. NJDOH Data Modernization Priorities



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Three areas of high focus for implementation in FY26 have been identified from the list above (Figure 1.):

- Increase the use of data to action
- Move from static reports to dynamic data dashboards
- Focus on outcome metrics

The goal with a second year of funding will be to prioritize the focus areas and build internal capacity to accomplish them. This will be achieved through the creation of an integrated data management plan (across all CHWU programs), scaling of software use for data visualization and increased use of data metrics that demonstrate outcomes.

Justification: Program evaluation and surveillance are vital to demonstrating outcomes in public health interventions. 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 October 2027 the CHWU ESE team and OHQI staff increase the use of data to action to assist in guiding chronic disease programs to implement programs that demonstrate effectiveness in communities of highest burden.
- By October 2026 the CHWU ESE team and OHQI staff will install, train and utilize enhanced data visualization software with a focus on moving from static reports to dynamic dashboards.

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 Innovation 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: \$25,000