TITLE V MATERNAL CHILD HEALTH (MCH) BLOCK GRANT

2024 ANNUAL REPORT/2026 APPLICATION

JUNE 18, 2025

NEW JERSEY DEPARTMENT OF HEALTH
55 N. Willow Street Trenton, NJ 08608

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III.A. Executive Summary

III.A.1 Program Overview

The Title V Program (TVP) in New Jersey (NJ) funds important initiatives which reach almost every resident in the state. The Title V funding for these programs, aimed at mothers, children and their families, endeavor to reduce infant deaths, provide better access to quality care services, deliver family-centered, community-based coordinated care for children and youth with special healthcare needs (CSHCN), and increase family access to NJ FamilyCare (State Medicaid). Working closely with community-based organizations, licensed implementing agencies and state partners, our TVP responds to the needs of pregnant and parenting women and their families by funding, creating, implementing and evaluating programs that get to the root causes of the health care and access issues that many NJ residents face.

Title V Block Grant Needs Assessment: Framework

The Title V Maternal and Child Health Block Grant Needs Assessment (T5NA) was a systematic process to collect information about the State's public health system. The information collected during the needs assessment process has been used to guide future efforts to address the varied needs of pregnant women, mothers, infants, children, adolescents, and CSHCN.

The goal of the statewide needs assessment was to improve MCH outcomes and to strengthen partnerships for ensuring the effective implementation of strategies designed to address the needs of the MCH population. The needs assessment was influenced by the theoretical framework of the Socio-Ecological Model (SEM). There is a complex interplay between a person and the environment in which they live, and that health and education outcomes are correlated with the impact of these complex systems on an individual and community. The SEM is a conceptual model-turned theoretical model as it illustrates the various and complicated aspects of context which impact a person's well-being, and, ultimately, their health outcomes.

The below stages highlight the timeline of activities facilitated during the needs assessment process in NJ (November 2023 – June 2025).

Title V Block Grant: Needs Assessment Planning

Phase I: Idea Generation--- Workgroup/Steering Committee led

A. Review data related to 2023 priorities and performance measures
B. Conduct SWOT analysis to assess current situation related to priorities
C. Attend stakeholder meeting, conduct key informant interviews and focus groups
    a. Stakeholder meetings with groups who were already addressing MCH population issues
        i. Ask about current priorities for stakeholder's group of focus
        ii. How they anticipate priorities changing over the next five years
        iii. Suggestions for improving services
        iv. Emerging issues for their populations

Phase II: Review, Evaluate and Narrow Points

A. Review
B. Evaluate
    a. Magnitude
    b. Severity
    c. Trend
    d. Feasibility
    e. Degree of gaps in services
    f. Opportunity for a Systems Approach
C. Community Evaluator Model
    a. People with lived experience
    b. Trained and hired as community evaluators
D. Title V Public Input Survey

Phase III: Action Planning

A. State Action Plans Review
B. Select meaningful performance measures to monitor progress on each priority
C. Develop Objectives
D. Identify key strategies for the five-year state action plans
    a. Specific focus on implications and unintended consequences of each action plan

Needs Assessment Findings

The needs assessment is regularly conducted in concert with the NJDOH's strategic plan, the State's Health Improvement Plan, and Healthy NJ 2030, which augments the collaborative process with other MCH partners and helps to inform all the activities implemented throughout the state. One of the needs assessment processes working in tandem is that of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. The MIECHV Needs Assessment is a process used to identify and document communities with a high concentration of at-risk families, particularly those facing challenges related to MCH. This assessment helps guide the allocation of resources and ensures that home visiting services are targeted to areas with the greatest need. It also supports the development of strategies to enhance the quality and reach of early childhood home visiting programs.

The T5NA was conducted over a period of 18 months, which consisted of various stages of planning, reviewing, assessing and making determinations as to what is missing in the MCH landscape of services, and ways in which the TVP can fill the gaps identified during this process while prioritizing new areas of focus.

While some of the T5NA findings revealed new needs of the population since the last needs assessment process, many of the responses from both professional stakeholders and service recipients included expressed desires for an enhanced focus on breastfeeding endeavors, perinatal care and postpartum follow-up connection to care, the promotion of healthy youth development with a more precise focus on teen pregnancy and sexually transmitted infections (STIs) as well as improving overall nutrition by considering food security as an important variable.

The T5NA findings corroborated our current understanding of the ongoing needs of certain populations. Within the population of CSHCN, “coordination of care” and “transition to adult services” are themes that were iterated numerous times during the process. Additionally, for maternal and women’s health, “increased accessibility” and “communication support”, including interpretation services, were revealed as areas for consideration. In the perinatal health domain, "breastfeeding education and resources” and “workplace flexibility” were mentioned as necessities, while the needs of children and adolescents in the state iterate the need for “timely developmental screening”, “opportunities for physical education” and “connection to appropriate and timely care.”

While the specific data gathered for each individual health domain spoke to population-level needs and voids within the state, multiple themes emerged that transcend population health domain. These themes include “transportation and mobility help”, “linguistic accessibility of providers”, “better mental health services” and the “streamlining and simplifying of application processes.” These overarching primary themes are considered priority areas for our TVP and are examined in tandem with the ongoing efforts to address the state priority areas that will remain the same.

TVP Role

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

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

To ensure access to enabling services and population-based preventive services, consistent with the findings of the Five-Year Needs Assessment, the goals and SPNs selected by FHS are built upon the work of prior MCH Block Grant Applications/Annual Reports and in alignment with NJDOH's and FHS' goals and objectives.

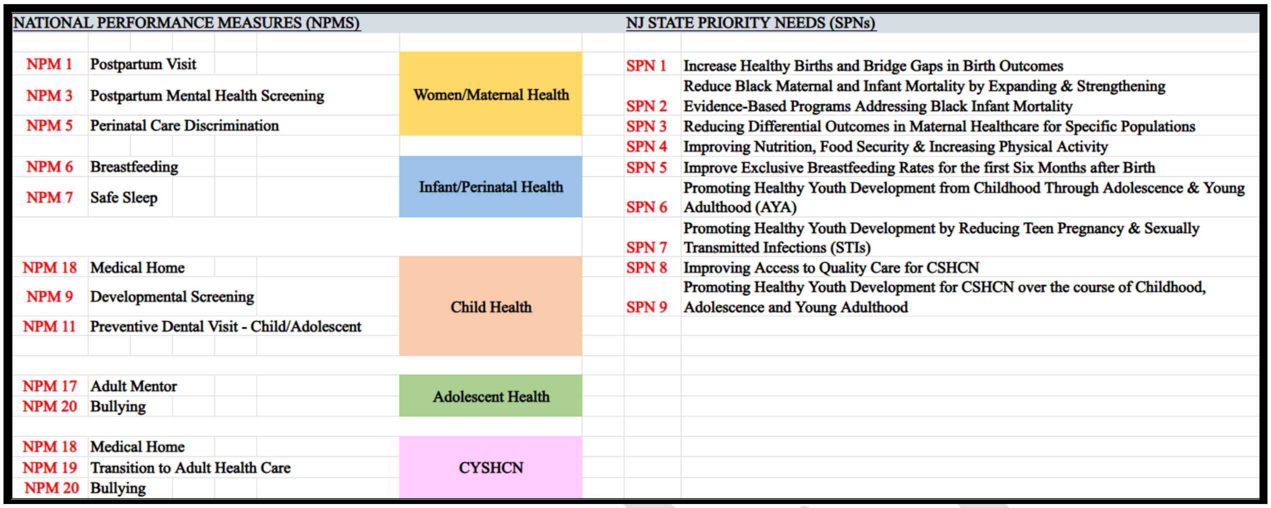
The NJ SPNs are:

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

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

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

Figure 1. NJ's Selection of NPMs and SPNs



NATIONAL PERFORMANCE MEASURES (NPMS)		
NPM 1	Postpartum Visit	Women/Maternal Health
NPM 3	Postpartum Mental Health Screening	
NPM 5	Perinatal Care Discrimination	
NPM 6	Breastfeeding	Infant/Perinatal Health
NPM 7	Safe Sleep	
NPM 18	Medical Home	Child Health
NPM 9	Developmental Screening	
NPM 11	Preventive Dental Visit - Child/Adolescent	
NPM 17	Adult Mentor	Adolescent Health
NPM 20	Bullying	
NPM 18	Medical Home	CYSHCN
NPM 19	Transition to Adult Health Care	
NPM 20	Bullying	

NJ STATE PRIORITY NEEDS (SPNs)	
SPN 1	Increase Healthy Births and Bridge Gaps in Birth Outcomes
SPN 2	Reduce Black Maternal and Infant Mortality by Expanding & Strengthening Evidence-Based Programs Addressing Black Infant Mortality
SPN 3	Reducing Differential Outcomes in Maternal Healthcare for Specific Populations
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State Performance Measures (SPMs) have been reassessed through the needs assessment process. The existing SPMs which will be continued are:

SPM #1 Black Non-Hispanic Preterm Infants in NJ,
SPM # 3 Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening, and who have outpatient audiological follow-up documented.
SPM # 4- Referral from Birth Defects and Autism Registry System (BDARS) to Case Management Unit,
SPM # 5- Age of Initial Autism Diagnosis,
SPM # 6- Teen Outreach Program (TOP), Get Real, Love Notes, Teen Prevention Education Program (PEP) and Lifelines completion
SPM # 7- Black, NH Infant Mortality in NJ.

The Affordable Care Act (ACA) transformed the health insurance landscape in the United States, with coverage (2014) further extending essential benefits to categorical populations such as women, pregnant women, children, homeless individuals, undocumented residents, and CSHCN. However, health differences burden marginal populations the most, as pervasive structural and systemic issues lead to worse health outcomes over time. Nationally, the persistence of these hardships proliferates as there remains a focus on the provision of sick care in place of creating and elevating a system that prioritizes wellness and whole health to mitigate the potential for disease manifestation. However, in NJ, an orientation toward addressing the CHF have prompted greater emphasis on prevention efforts to endorse wellness. This is evidenced by NJ's commitment to expansion of Medicaid benefits for adults without disabled or pregnancy-status and, most specifically, postpartum coverage for up to 365 days postpartum, beyond the federally mandated two months.

The expansion of Medicaid helps ensure continuous insurance coverage for low-income pregnant women. This type of comprehensive service coverage improves the health of those covered those impoverished, who tend to have higher rates of smoking, preeclampsia and diabetes, and lower rates of prenatal visits and breastfeeding initiation (Anstey et al., 2017; Ross et al., 2019). Speaking to the Medical Home NPM, the expansion of Medicaid to populations that existed in the space between "too resourced" to receive Medicaid support and yet "not resourced enough" to connect with medical care at the frequency clinically indicated, leads to morbidities over time that could have been avoided with insurance coverage.

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

Hearing from people with lived experience is paramount to achieving person-centered care programming and correlated positive health outcomes for families in NJ. For this reason, the TVP and state agencies that serve pregnant women, caregivers, children and CSHCN closely with grantees to center the voices of people with lived experience while programming is crafted and implemented. This occurs via focus group engagement, quarterly, biannual and annual feedback opportunities and regular parent meetings, hosted by our statewide parent advocacy partners, or SPAN. People with lived experience are also integrated into the MCH workforce through our community health worker program, providing opportunities for professionals with first-hand experience to offer their perspective on programmatic functionality and efficiency. These efforts to integrate people and communities with lived experience include those who come from marginalized communities, but who are represented in our service recipient populations. The NJTVP consistently priorities the voices of those with lived experience to understand what changes need to be made in policies and programming.

In NJ, multiple state entities are at work to address the gaps that exist in maternal and infant health outcomes. Within the NJDOH FHS, evidence-based and culturally appropriate services are offered to families in the state through the following programs:

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

- Healthy Women, Healthy Families (HWHF): Through the HWHF initiative, the NJ TVP has taken a targeted approach to reduce infant mortality rates beginning in 2018. As a result, partners from the Departments of Labor and Workforce Development, Education, Transportation, Children and Families, Human Services, and Community Affairs, as well as community partners, regularly collaborate with NJDOH to address high rates of infant mortality. One of the most salient aspects of the HWHF initiative is the implementation of specific reduction activities that address the most vulnerable populations. To better address these, recent TVP efforts include an emphasis on the 4th trimester (i.e., postpartum period) and contemporary ways to focus on and expand breastfeeding support and postpartum doula services.

- Doula Learning Collaborative (DLC): To ensure the sustainability of community doula services, NJ TVP partnered with the NJ Department of Human Services (DHS) to offer doula services to women through Medicaid Benefits. NJ Medicaid benefits have been expanded to cover doula services. Presently, NJ pregnant women whom Medicaid covers can receive services from a Medicaid-enrolled community doula. To date, approximately 344 individuals have been trained to become community doulas, and as of December of 2024, 767 births have been supported by doulas during the training process.

- Colette Lamothe-Galette Community Health Worker Institute (CLG-CHWI): NJ TVP has also established and expanded NJ's Community Health Worker (CHW) workforce. Created and hosted by NJDOH, the Colette Lamothe-Galette Community Health Worker Institute (CLG-CHWI) partners with multiple state colleges to deliver courses and trainings that equip Community Health Workers (CHWs) with skills to provide equitable care to their clients. Concurrently, TVP is working with key officials to expand Medicaid benefits to cover CHWs' services. To date, over 800 CHWs have been trained, with a new cohort of Spanish-speaking trainees graduating 16 CHWs in March 2025.

- Connecting NJ: Connecting NJ (CNJ) is a county-level, centralized point-of-entry referral system for pregnant women, fathers, and families with young children, to access programs, services, and supports. CNJ provides:

    - Easy access to resource information
    - Referrals to community services to promote child and family well-being
    - Linkages from pregnancy to age 5
    - Case management services, developmental health promotion, and developmental screening
    - Primary referral source to Evidenced Based Home Visitation programs and NJDOH's HWHF

- MIECHV: The NJ Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program continues to provide 1,811 families with free and voluntary community-based education and in-home support, including evidence-based safe sleep strategies. NJ MIECHV implements three evidenced based models which include: Nurse-Family Partnership, Healthy Families and Parents as Teachers. At-risk families are referred to MIECHV services through the Connecting NJ (CNJ) referral system. CNJ connects New Jerseyans to programs such as HWHF, MIECHV, community resources, medical care, doula programs and social support agencies. As universal home visiting programs expand throughout the state, consumer advisory boards and local service providers will continue to offer feedback to ensure fidelity to the model of care.

- Family Connects NJ: Universal Home Visiting - Family Connects NJ is a program that connects parents with a specially trained nurse for a personalized follow up visit at home within the first two weeks after their child's birth. Visits are offered to all families at no cost, regardless of income, insurance or immigration status.

The primary aim of the Family Connects NJ program is to deliver care in the comfort of the family home, and by a specially trained, registered nurse. During the visit, the nurses assess the health of both the parents and the newborn, offering important information to facilitate the transition. This program is free of cost to all families in NJ, and is available to birth, adoptive, and resource families with a newborn as well as parents experiencing a stillbirth of loss of their newborn. While Family Connects NJ is not supported by Title V funds, the overall objectives of the program align closely with the Title V aims.

Child Health

In addition to Title V funds, the Child and Adolescent Health Program (CAHP) currently holds two federal grants to prevent teen pregnancy and promote youth development- (1) the Personal Responsibility Education Program (PREP) and (2) the Sexual Risk Avoidance Education (SRAE) Project. Through PREP, SRAE, and the Whole School, Whole Community, Whole Child School Health Program, CAHP staff operate a statewide youth engagement initiative consisting of 10 Youth Advisory Boards and the NJDOH Voice of Youth Planning Committee. This is managed primarily by the NJ School Health, SRAE and PREP Program Management Officers with support from the CAH Program Manager.

- Early Childhood Comprehensive System (ECCS) Health Integration: Prenatal to Three (ECCS P-3) Initiative is an initiative of the NJ Department of Children and Families (DCF), in partnership with NJ TVP. The system maintains integrated developmental health promotion and screening as a service of the statewide Connecting NJ system

Adolescent Health

- Training on screening and assessment using the Ask Suicide-Screening Questions (ASQ), Columbia Suicide Severity Rating Scale (CSSRS), SafeSide™ Training for primary care settings, Safety Planning, Adolescent Care and Treatment of Suicide (ACTS Training), and interventions for suicidal teens (Collaborative Assessment Management of Suicide and Attachment-Based Family Therapy).
- The Garrett Lee Smith Suicide Prevention Project (GLS) and MCHBG support a new learning and resource portal for professionals, parents, caregivers, and a youth named Prevent Suicide NJ (PSNJ) https://preventsuicidenj.org/. PSNJ launched in September of 2022 , and to date has provided trainings to 4,383 primary care practitioners, supported screening initiatives for 6,586 youth for suicidal ideation, provided 1,290 referrals and confirmed 684 accessed appropriate treatment. Additionally, GLS began implementation of Lifelines at 5 new school districts throughout NJ to further train school professionals, community partners and students in the 24-month curriculum. In

addition to Lifelines Trilogy, these programs include the Teen Outreach Program (TOP®), Love Notes, and Teen PEP.

- The Whole School, Whole Community, Whole Child School Health NJ Project, the NJ Personal Responsibility Education Program (PREP), and the NJ Sexual Risk Avoidance Education (SRAE) Program. All CAH programs support evidence-based models rooted in Social and Emotional Learning (SEL) and Positive Youth Development (PYD), proven frameworks to reduce bullying by increasing empathy and self-awareness.

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

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

In NJ, families of CSHCN have access to many services to ensure access to necessary services. Within the NJDOH FHS, children with special health care needs receive services through the following programs:

- Newborn Screening (NBS) and Genetics Services provides timely and appropriate follow-up services for all newborns affected by an out-of-range blood spot screening result. NJ currently screens for 61 disorders. NJ remains among the leading states offering the most blood spot screenings. NJ’s newborns are also screened with pulse oximetry through the Critical Congenital Heart Defects (CCHD) screening program.
- Birth Defects Registry (BDR) ensures that all children 0 through five years old who have a congenital disability are registered. Nurses work with the birthing hospitals to verify the diagnoses. Once registered, all children are referred to our Family Centered Care Services (FCCS) for case management services at the county level.
- Autism Registry ensures that all children 0 through 21 years old who have an Autism Spectrum Disorder (ASD) are registered and referred to FCCS for case management. Approximately, 53,000 children have been registered since 2009.
- The NJ EHDI Program abides by the national public health initiative “'1-3-6 Guidelines.” These guidelines seek to ensure that all babies born in NJ receive a newborn hearing screening before one month of age, complete diagnostic audiologic evaluation prior to three months of age for infants who do not pass their hearing screening and enroll in early intervention by no later than six months of age for children diagnosed with hearing loss. The EHDI program offers technical support to hospitals on their newborn hearing screening and follow-up programs.
- FCCS addresses families' medical and social conditions by providing resources, referrals, and support to families in obtaining accessible services within state departments, divisions, and county and municipal agencies. Our FCCS case managers refer children to NJ Early Intervention Services (NJEIS), assist with School IEP requests, transition to adult services and with locating services within their communities.
- Specialized Pediatric Services (SPS) consist of eight Child Evaluation Centers (CECs), three Pediatric Tertiary Centers, and five Cleft Lip/Palate Craniofacial

Anomalies Centers. The SPS program aims to provide access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services to families with CSHCN that are 21 years old or younger.

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

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

Cross-Cutting/Systems Building

The NJ TVP's work within the Cross-Cutting & Systems Building domain includes collaboration across programs within our division, as well as cross division collaborations. This includes:

- MCH and CSHCN program collaboration on informing OB/GYN's about emerging threats that impact both parents and the unborn child. Information about congenital cytomegalovirus (cCMV) and ways to prevent the infection in pregnant women is part of the CSHCN's grant work with the CDC. While pregnant women may not experience any symptoms if they contract CMV, the virus can have profound effects on the fetus. Newborns with cCMV can have birth defects including microcephaly and hearing loss.
- MCH & Community Health Division collaborations for oral health prevention and intervention efforts. The Oral Health Services Unit (OHSU) continues to educate the public about the importance of preventive oral health services and good oral health, with programs predominately targeted to school-aged children and pregnant women. Other preventative services include dental screening, nutrition counseling, and placement of sealants and fluoride varnish for underserved, uninsured, and underinsured children across NJ. In January of 2023, NJ FamilyCare covering dental insurance for all youth under 19 years old in the state, and irrespective of their documentation status. This comprehensive dental program continues to extend beyond the identified population and to other eligible youth with comprehensive dental and medical benefits. In an effort to continue this important work, the OHSU has also expanded its dental sealant program, an evidence-based practice for low-income children and children at-risk of increased tooth decay.
- The Early Intervention Program for Infants and Toddlers with Disabilities of the IDEA (Part C) is designed to assist any child under the age of three years in NJ who has a disability or developmental delays. Under this program, children are entitled to receive early intervention services identified on an Individualized Family Service Plan (IFSP) which include evaluations, various developmental therapies and coordination of services. The program's main objectives are to enhance children's development and to provide support and assistance to the family to meet the developmental needs of their child

Evaluation efforts are being created and solidified for programs throughout the MCH Unit.

Broad program evaluation efforts have been instituted and are collaborative in nature as NJDOH works closely with Rutgers University, The College of New Jersey and Johns Hopkins University to evaluate program implementation efforts and outcome measures utilizing standardized procedures and evidence-based evaluation metrics to ensure aims are met and modifications are made when necessary. On a mezzo level, evaluation and quality improvement efforts are growing to enhance communication and standardize follow-up on quantitative efforts on a monthly and quarterly basis.

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

The NJDOH established the Performance and Grant Management Unit (PMU) in August 2024 to enhance health outcomes through improved program evaluation, quality improvement, data integration, grant management and grant acquisition, and strategic alignment. Collaborating with department leaders, the PMU is developing mechanisms that fully captures and set performance standards, and align all programs, whether related to public health surveillance, grants, policy implementation, or other services, ensuring that they contribute to the Department's strategic goals and strengthens NJDOH's impact on public health.

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

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

NJ's TVP:

1) Serves as the main funding source used by the NJ TVP to support MCH populations in accordance with Title V and other federal and state guidelines to protect and promote the health and well-being of women, children, and families and children with special health care needs.
2) Supports NJ's state-priority MCH efforts throughout all 21 counties
3) Supports the infrastructure needed to sustain Special Child Health Services including but not limited to evaluation and treatment centers.
4) Supports specialized pediatric services across the state to ensure access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services.
5) Supports the Birth Defects and Autism Registries, NBS activities,

and county-based free case management services to children birth through age 21 who have special health care needs. Supports Home Visiting with braided MIECHV funding

6) Supports school health programming and works compatibly with CDC funding to reach impoverished and underserved communities.
7) Supports the capacity for developing data-informed strategies to prevent maternal mortality and morbidity, and any gaps that exist.
8) NJ Fetal Infant Mortality Review (FIMR) - to fund grantees to conduct FIMR-related activities (e.g., Chart review, family interview); these activities that seek to identify ways to strengthen the systems of care and resources available to families to prevent future deaths.
9) School Health NJ- to fund grantees working with underserved school districts in NJ to create school nurse led school health teams and implement evidence based social-emotional learning programming aligned with the CDC Whole School, Whole Community, Whole Child framework.

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

III.A.3 MCH Success Stories

CHWs

CHW's are at the heart of public health. They bridge the gap between health care providers and the communities they serve. As trusted members within their neighborhoods, CHWs play a pivotal role in promoting health, preventing diseases, and fostering well-being. The Colette Lamothe-Galette Community Health Worker Institute (CLG-CHWI) empowers CHWs to become change-makers in public health. The CLGI launched its first bilingual Spanish cohort in the fall of 2024 in partnership with Union College of Union County. The cohort was facilitated without a textbook by Deryan Coba, MPH and supported by DOH staff Jocelyn Rodriguez who provided technical assistance and translation. On March 3rd the CLGI graduated 14 CHWs, now equipped to bridge the gap between healthcare providers and their communities. The next Spanish cohort will launch in April 2025.

HWHF (CHW)

Through the HWHF Program, our grantee, the Partnership of Maternal and Child Health of Northern NJ, reported that one of their Community Health Worker (CHW) sub-grantees, Women's Rising, provided support to a family with nine children (with one being a newborn), that was impacted by domestic violence (DV), living in a motel. This CHW assisted with linking the family to obtain financial assistance, a Section 8 voucher, and the family was able to reclaim their property. The CHW from Women Rising was also able to assist with necessary baby pantry items for the newborn. Women's Rising also connected a client to Northeast Legal Services for assistance with a bullying claim not being addressed in the child's school, which resulted in successfully getting the child transferred. Consequently, the school started taking other bullying cases seriously.

III.B. Overview of the State

III.B.1 State Description

While NJ is the fifth smallest state in land area in the United States (7,354 square miles), the state houses over 9.2 million residents, making it the most densely populated state in the nation, and ranking it as 11th most populous overall (Figure 2.) Furthermore, NJ is the only state in which every one of its 21 counties is deemed "urban" by the US Census Bureau (U.S. Census Bureau, retrieved 1/16/25). Moreover, the state boasts the privilege of housing residents from different countries and cultures. In addition to this rich demographic population comes a geographical difference, with different regions experiencing various levels of density per square mile. For example, the central and northern counties of NJ are very densely populated; especially the counties that are situated in the mid-north and north-east of the state and are closer to New York City. The most northwestern counties, and the southern and northwestern counties are more rural and agricultural, and where transportation, healthcare and educational services are not as frequently, or proximally, available to residents.

Figure 2. NJ's Geographic Land Area and Total Population

New Jersey

State in: United States

9,290,841
Population

7,354.9 square miles

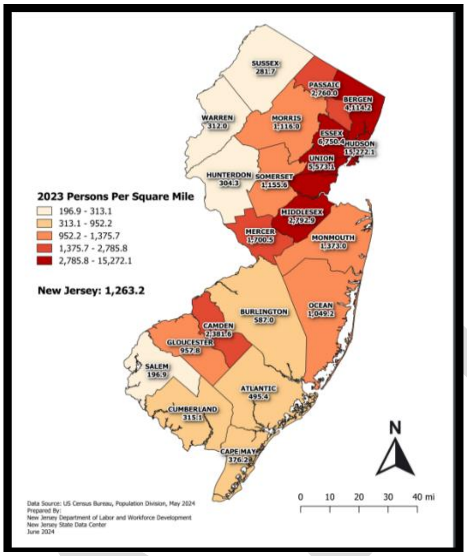
1,263.2 people per square mile

Census data: ACS 2023 1-year unless noted

Data from: U.S. Census Bureau, 2025

In 2023, NJ's (NJ) population density--- persons per square mile, was 1,263.2 to 1. NJ is comprised of 564 municipalities and 21 counties. As of 2023, the most populated counties are Bergen and Middlesex, each with a population of 957,736 and 863,623, respectively. Bergen is also one of the top 5 most densely populated counties in the state at 4,114.2 persons per square mile (Figure 3). The most densely populated county in NJ is Hudson, with a population density of 15,272.1 to 1 (Figure 3). Hudson County has a total population of 705,472.

Figure 3. 2023 Population Density: NJ Counties



Data Source: US Census Bureau, Population Division, May 2024
Prepared By:
New Jersey Department of Labor and Workforce Development
New Jersey State Data Center
June 2024

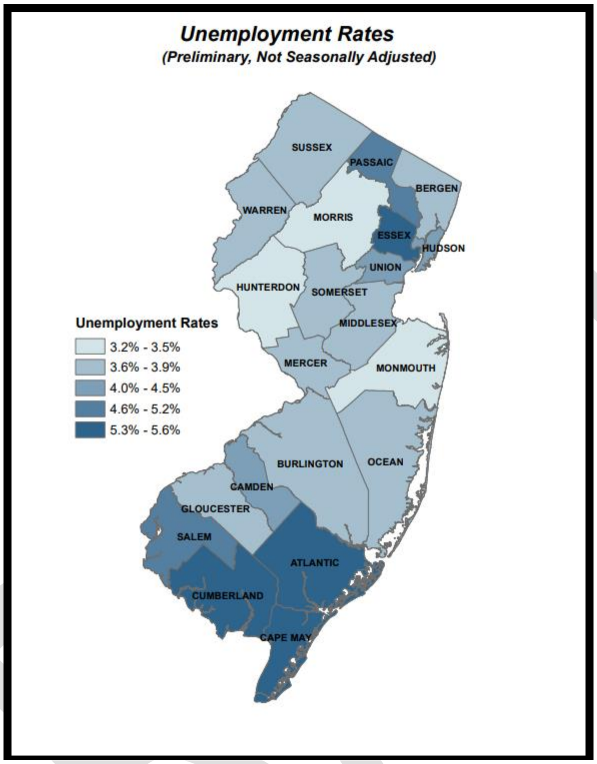
According to the 2023 NJ Population Estimates of race, 52.0% of the population were White, non-Hispanic; 13.0% were Black; 10.4% were Asian; 0.2% were American Indian and Alaska Native; and 1.7% reported two or more races. In terms of ethnicity, 22.7% of the population was Hispanic. The 2023 American Community Survey (ACS) estimates identified that 33.3% of NJ residents (5 years and older) speak a language other than English compared to 22.5% nationally, and which include Spanish, Polish, Italian, Bengali, Mandarin/Cantonese and Haitian. Approximately 24% of all NJ residents are foreign-born persons, which is considerably higher than the national average, which has recently hit an all-time high of 16%. A similar pattern is seen among women of child bearing age.

Unemployment and Uninsured Rates

Unemployment rates are impacted by market factors (ex. GDP, inflation) and individual and social factors (health, race, educational attainment). Unemployment rates in NJ have been variable over the course of the past five years, although rural areas of the state experience higher rates of unemployment than the more suburban, peri-urban and urban locations in the state (Figure 4). Like other states, NJ suffered the impact of COVID-19 related restrictions and limitations, forcing many people to lose their sources of employment. However, the overall unemployment rate has remained stable across NJ in the past year (~4.5%) and relatively coincides with the national unemployment rate (Figure 5; ~4.1% (US Bureau of Labor Statistics, 2025).

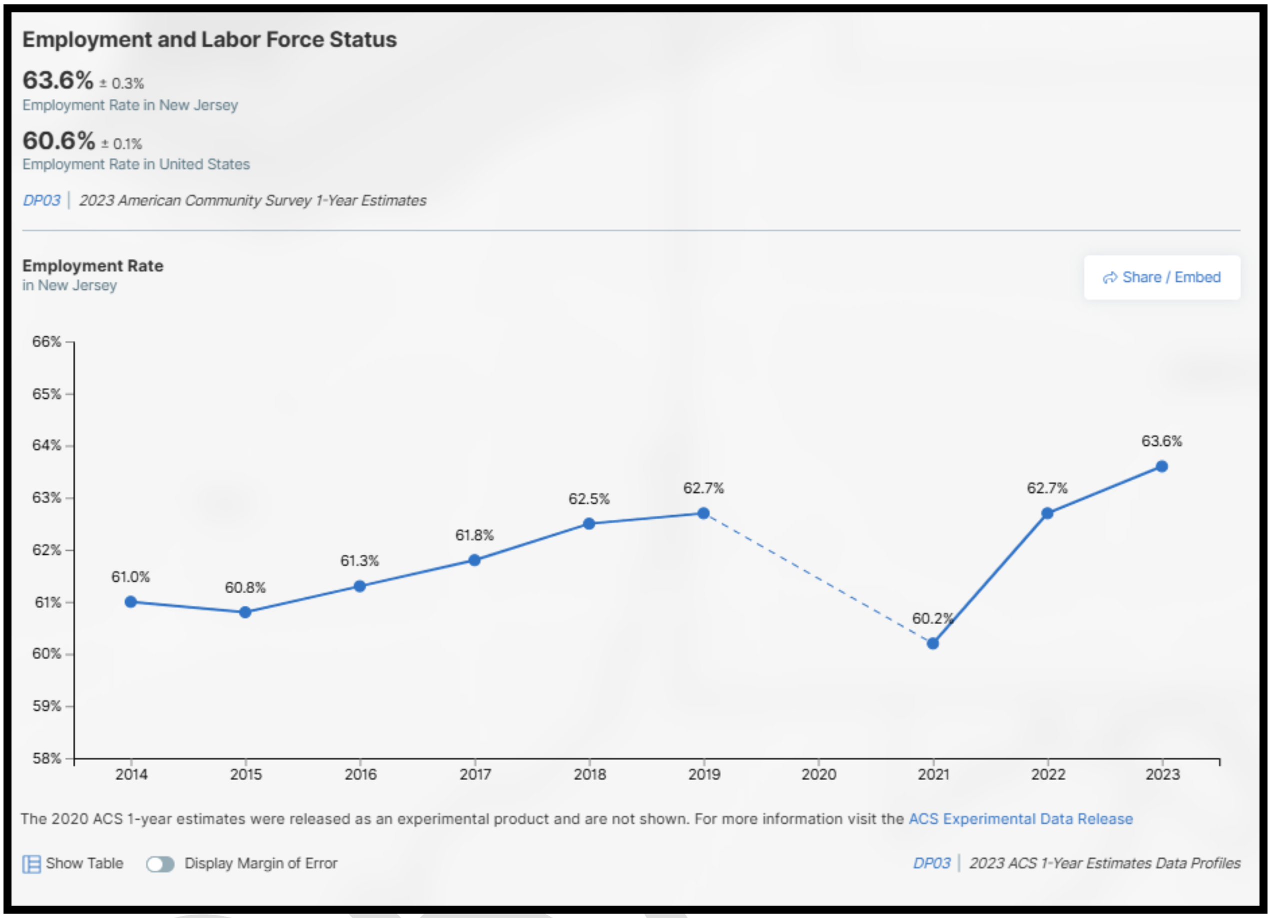
The income spectrum in NJ is quite large, with the median household income around $100,000 dollars, but with an average per capita income of $53,118. These integers demonstrate the large gap between the upper socioeconomic status populations in the State, and the lower-and-impoverished populations in the State. Approximately 10% of all NJ residents live at or below the poverty line, which is slightly less than the national average of 11% (US Bureau of Labor Statistics, 2025).

Figure 4. NJ Unemployment Rates 2024



NJDOL Website: Feb 2025

Figure 5. 10-year Historical Employment Rate in NJ



Employment and Labor Force Status

63.6% ± 0.3%
Employment Rate in New Jersey

60.6% ± 0.1%
Employment Rate in United States

DP03 | 2023 American Community Survey 1-Year Estimates

Employment Rate
in New Jersey

The 2020 ACS 1-year estimates were released as an experimental product and are not shown. For more information visit the ACS Experimental Data Release

DP03 | 2023 ACS 1-Year Estimates Data Profiles

NJDOL Website: Feb 2025

The NJDOH prioritizes the health needs of all its residents', centering in the work populations that have been systematically marginalized and oppressed. This strength is evidenced by a strong public health infrastructure and health care delivery system whose activities are rooted in a contemporary evidence base, are trauma-informed and high quality. The NJDOH partners with local Federally Qualified Health Centers (FQHCs), Community Based Organizations (CBOs), academic institutions such as Rutgers University and The College of New Jersey, as well as with service recipients, to create and deliver the MCH programming in the state. Moreover, to ensure service are funded appropriately, NJ commits a state match that is higher than the dollar-for-dollar match expected of Title V Block Grant funding, with approximately $70 million dollars of state funds invested in MCH services each year, above-and-beyond the ~$11.5 million Title V funds granted to the NJDOH.

Additionally, NJ has a low uninsured rate compared to that of the national average, with 3.8% of children under the age of 18 years old uninsured versus 5.1% of children under the age of 19 years old nationally uninsured. NJ's expansion of Medicaid has also facilitated the decrease of health access differences in the state and between populations and continues to engage in outreach and enrollment efforts to ensure the number of uninsured children continues to decrease over time.

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

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

The NJDOH is the lead state agency providing core public health services to its residents, and whose mission it is to protect the public's health, promote healthy communities and continue to improve the quality of healthcare in NJ. Undergirding this mission is the vision of the department to ensure that all New Jerseyans live long, healthy lives and reach their fullest potential, which NJDOH takes as its primary responsibility. This vision is supported by a public health infrastructure that is growing and strengthening as the state hires more health and allied health professionals. Our leaders are dedicated public servants who are committed to supporting all residents in NJ in achieving their highest health potential, and full actualization. Because the reach of the department is so vast, many types of essential healthcare services are rendered each year. These targeted services include:

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

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

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

Health Care Administration Board

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

State Health Planning Board

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

Public Health Council

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

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

The Governor’s Council for Medical Research and Treatment of Autism (Council) was created by State appropriation in 1999 and has been issuing research, clinical and educational enhancement grants since 2000. The Council’s vision is to enhance the lives of individuals with ASD across their lifespans. The Mission of the Council is to advance and disseminate the understanding, treatment, and management of ASD by means of a coordinated program of biomedical research, clinical innovation, and professional training in NJ.

Maternal Care Quality Collaborative

The New Jersey Maternal Care Quality Collaborative (NJMCQC) is a advisory group that works with multiple departments and is currently residing with the New Jersey Maternal and Infant Health Innovation Authority (NJMIHIA). The NJMCQC will act as a strategic thought partner to NJMIHIA.

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

The following activities are planned for 2025:

1) Hire a full time Healthy NJ Coordinator
2) Refine action plans as needed
3) Use quantitative state public health data as well as the qualitative information gathered for Community Conversations and to establish specific, measurable, achievable, realistic, time-bound objectives to measure success, and to be reached by 2030 for those objectives based on Healthy People guidelines.
4) Collectively, the action plans will become the next State Health Improvement Plan (2025).

Alongside the community-created initiatives borne out of the HNJ function the activities of the NurtureNJ Plan (Figure 6.). The NurtureNJ Plan was spearheaded by our First Lady Tammy Murphy in 2019 as a statewide initiative committed to reducing maternal and infant mortality and morbidity, as well to ensuring healthcare for support for all women in the state. NurtureNJ is a multipronged, multi-agency initiative that aims to make NJ the safest place for women to give birth and raise a child, and to eliminate any gaps in care.

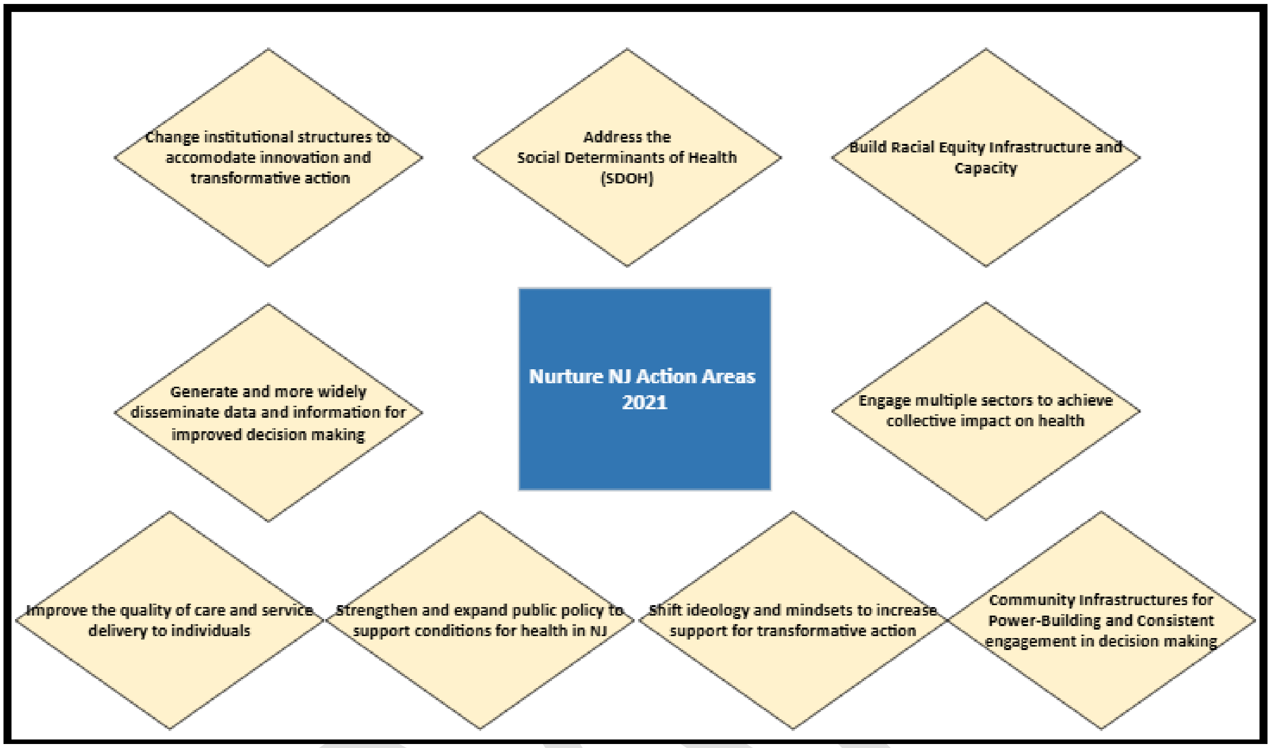
Primary Objectives:

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

Proximal Objectives:

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

Figure 6. NurtureNJ Action Areas



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

The Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model summarizes the selected eight NPMs and aligns the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). The ESMs aim to identify NJ TVP efforts that can contribute to improved performance, relative to the selected NPMs. The Logic Model is organized with one NPM per row. The Logic Model is the key representation that summarizes the Five-Year Needs Assessment process and includes the three-tiered performance measurement system with ESMs, NPMs, and NOMs. The Logic Model represents a more integrated system created by the three-tiered performance measure framework, which ties the ESMs to the NPMs, in turn, influencing the NOMs. Considering the high rate of adverse birth and pregnancy outcomes in NJ, the NJTVP has been collaborating with community-based organizations to strategically address these adverse birth outcomes as they relate to pregnancy and birth outcomes.

Therefore, NJ TVP is taking a targeted approach to improving pregnancy and birth outcomes in the state by enhancing existing programs and creating new programs with an emphasis on this priority population through the CHW Workforce. TVP recognizes the importance of a statewide collaboration of existing traditional and non-traditional partners to address the CHF, which will be instrumental in moving the needle on pregnancy and birth outcomes (Figure 7).

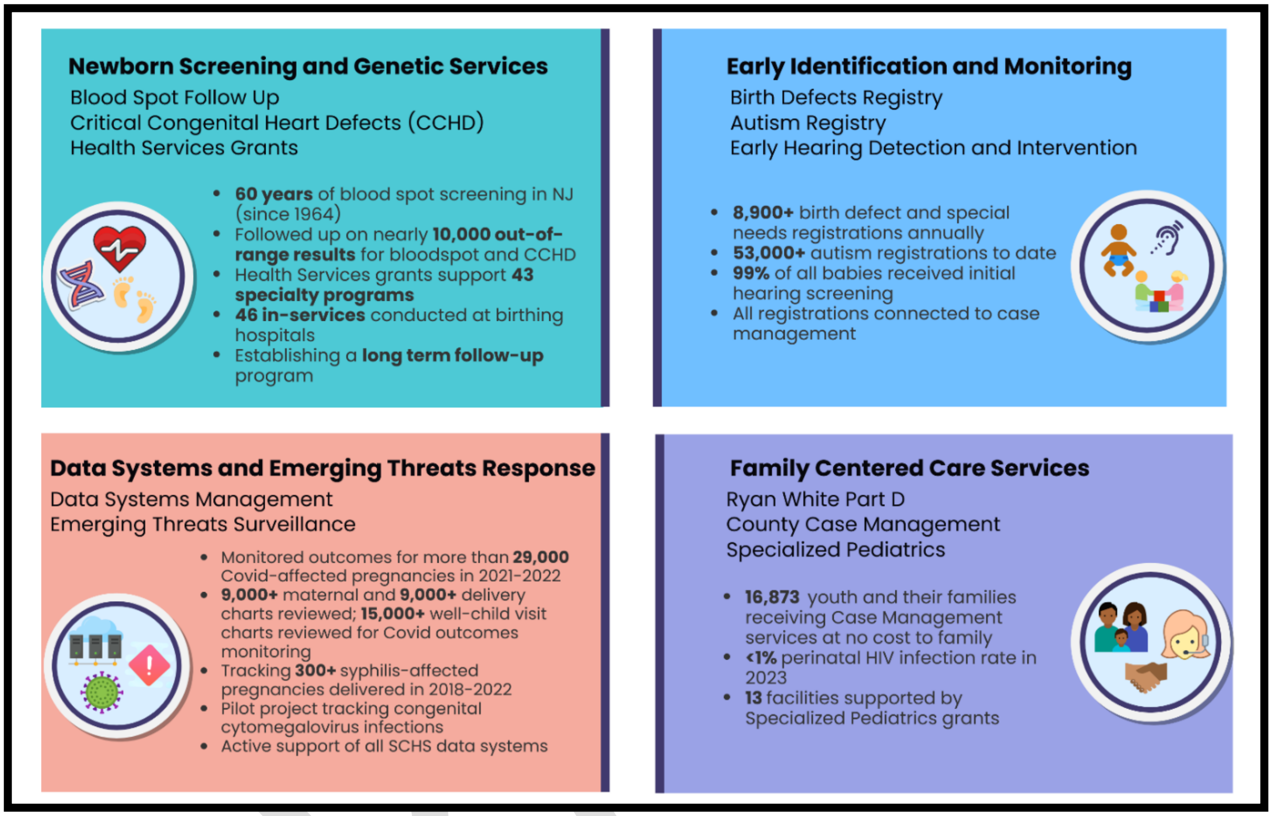
Figure 7. Stakeholder Network

As a result, partners from the Department of Human Services (DHS), Health Systems and Providers, various academic institutions, DOH community and grassroots organizations, and the Community are strategically collaborating and using MCH block grant funds to implement culturally responsive public health interventions in NJ.

Children with Special Health Care Needs (CSHCN)

NJ's CSHCN program is known as Special Child Health Services (SCHS). Our purpose is to identify children with special health care conditions through our NBS programs, register them via our mandated reporting systems, and link them to resources and services via our county-based case management system. In this way, our programs work with each other, other governmental agencies, the medical providers, social services, and families to ensure that the CSHCN population can access services and thrive in NJ (Figure 8). Over 50 staff persons from varying disciplines such as nursing, public health, and epidemiology work together to fulfill our mission.

Figure 8. Special Child Health Services



Newborn Screening and Genetic Services
Blood Spot Follow Up
Critical Congenital Heart Defects (CCHD)
Health Services Grants

- **60 years** of blood spot screening in NJ (since 1964)
- Followed up on nearly **10,000 out-of-range results** for bloodspot and CCHD
- Health Services grants support **43 specialty programs**
- **46 in-services** conducted at birthing hospitals
- Establishing a **long term follow-up** program

Early Identification and Monitoring
Birth Defects Registry
Autism Registry
Early Hearing Detection and Intervention

- **8,900+** birth defect and special needs registrations annually
- **53,000+** autism registrations to date
- **99%** of all babies received initial hearing screening
- All registrations connected to case management

Data Systems and Emerging Threats Response
Data Systems Management
Emerging Threats Surveillance

- Monitored outcomes for more than **29,000** Covid-affected pregnancies in 2021-2022
- **9,000+** maternal and **9,000+** delivery charts reviewed; **15,000+** well-child visit charts reviewed for Covid outcomes monitoring
- Tracking **300+** syphilis-affected pregnancies delivered in 2018-2022
- Pilot project tracking congenital cytomegalovirus infections
- Active support of all SCHS data systems

Family Centered Care Services
Ryan White Part D
County Case Management
Specialized Pediatrics

- **16,873** youth and their families receiving Case Management services at no cost to family
- **<1%** perinatal HIV infection rate in 2023
- **13** facilities supported by Specialized Pediatrics grants

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

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

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

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

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

Special Child Health Programs also work with their community partners and families. We have a long relationship with the NJ Chapter of the American Academy of Pediatrics (NJAAP), family advocacy organizations such as Autism NJ, SPAN Parent Advocacy Network, and University-based programs such as the Boggs Center on Disability and Human Development. Working closely with our services are the county-based case management organizations. Grants are provided local health departments or non-profit entities to provide free resource and referral services to all families with children with special health care needs. These agencies work to connect families to Medicaid, provide support to families as they access medical, social, and educational services for their children.

NJ State Legislation and Regulations relevant to the MCH Block Grant

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

- P.L.2018, c.82 – Entrusts NJDOH to develop an annual NJ Report Card of Hospital Maternity Care. The report is required to include rates of cesarean births, infection, laceration, hemorrhage, and severe maternal morbidity for all birthing hospitals.
- P.L.2019, c.75 - The original public law that created the NJ Maternal Data Center, NJ Maternal Mortality Review (MMRC) Committee, and NJ Maternal Care Quality Collaborative, later revised under P.L.2023, s.3864.
- AR2019 – Encourages NJDOH to develop set of standards for respectful care at birth and to conduct public outreach initiatives.
- P.L.2019, c.85 - Provides Medicaid coverage for doula care.
- P.L.2019, c.86 - Establishes perinatal episode of care pilot program in Medicaid.
- P.L.2019, c.87 - Prohibits health benefits coverage for certain non-medically indicated early elective deliveries under Medicaid program, State Health Benefits Plan, and School Employee Health Benefits Plan.
- P.L.2019, c.88 - Codifies current practice regarding completion of Perinatal Risk Assessment (PRA) form by certain Medicaid health care providers.
- P.L.2019, c.133 - Establishes pilot program to evaluate shared decision-making tool used by hospitals providing maternity services, and by birthing centers.
- P.L.2021, s.4229 - Establishes doula directory in DOH; requires a doula directory to receive reimbursement for doula services rendered to Medicaid beneficiary.
- P.L.2021, c.187 - Establishes a newborn home nurse visitation program (universal home visiting), supplementing various parts of statutory law, and making an appropriation.
- P.L.2021, c.79 - Requires that every hospital that provides inpatient maternity services and every birthing center licensed in NJ shall implement an evidenced-based training for all health professionals who provide perinatal treatment and care to birthing mothers at the hospital or birthing center. Members of various medical licensing boards must also complete a program related to community health factors and approved by the Department of Law and Public safety.
- P.L.2023, s.3864 - Establishes the New Jersey Maternal and Infant Health Innovation Center Authority and moves the Maternal Care Quality Collaborative to the Authority.
- P.L.2023, s.4119 - Requires hospitals and birth centers to develop doula access policies and procedures.
- P.L.2023, a.4223 - Increases Medicaid reimbursement rates for primary care services and aligns with midwifery and physician rates.
- S912/A3887 - Recently signed bill that establishes certain requirements for postpartum care, pregnancy loss, and stillbirth information and develop personalized postpartum care plans.

NJ State Legislation and Regulations relevant to the CSHCN Population

The following laws aimed at ensuring the screening and services to children with special health care needs. These laws are amended overtime to include new services, additional mandated conditions, and/or changes in process or reporting procedures.

- P.L.1977, c.321, s.1; amended 1981, c.357, s.2; 1988, c.24, s.2; 2019, c.296, s.1.
N.J.S.A 26:2-110 through 26:2-112, as amended and supplemented - Establishes the newborn blood spot screening program
- P.L.2001, c.373, s.3
N.J.S.A. 26:2-103.3 through 26:2-103.9 as amended and supplemented – Establishes screening for hearing loss in all newborn children.
- P.L. 2021, c.413 requires all infants born in our state to be screened for congenital Cytomegalovirus (CMV).
- P.L.1983, c.291, s.2; amended 2005, c.176, s.2; 2012, c.17, s.351.
N.J.S.A 26:8-40.2 mandates reporting to the NJ BDR all children diagnosed with a birth defect from birth through five years of age.
N.J.S.A 26:8-40.22 Confidential reports of abortions of fetus with or infant affected by birth defect or severe neonatal jaundice.
- P. L.2007, c.170, s.3; amended 2009, c.204, s.5; 2012, c.17, s.141.
N.J.S.A 8:20-2.3 mandates the reporting to the NJ Autism Registry any person, from birth through 21 years of age, who is a resident of the State of NJ and is diagnosed with autism based on DSM criteria, and who is not known to be previously registered.

III.B.2 State Title V Program

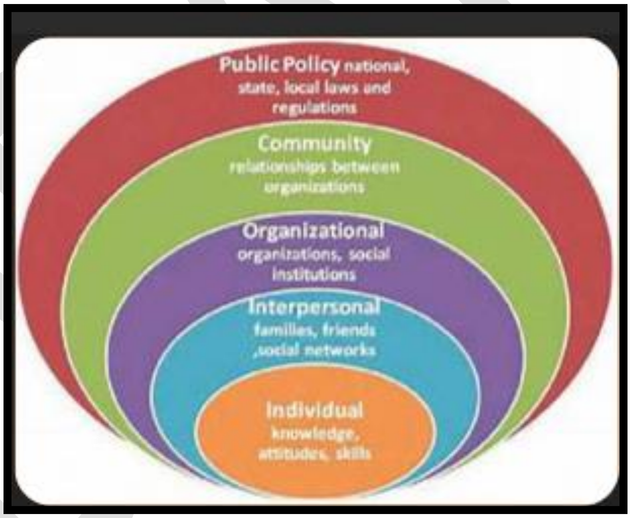
III.B.2.a Purpose and Design

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

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

The TVP recognizes the complex interplay of individual, interpersonal, organizational, community, and societal factors that influence human behavior and health outcomes. For this reason, Bronfenbrenner's Socioecological Model (1974; Figure 9) scaffolds the work of the TVP, explaining the TVP program endeavors and activities. The Socioecological Model postulates that human development occurs within the context of multiple and interacting systems of influence, emphasizing the synergistic nature of these forces as the driver of all human behavior. The interrelated nature of these overlapping and synergistic forces complicates interventions as all levels need to be considered; this includes individual, organizational, communal and societal.

Figure 9. Bronfenbrenner's Socioecological Model



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

The identification of the state’s priority needs emerged from various data gathering initiatives, including the collection of primary data when facilitating key informant interviews, focus groups and committee meetings.

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

One of the greatest successes for our MCH populations in NJ came with the signing of S3864 by NJ Governor Phil Murphy in 2023, also known as the “New Jersey Maternal and Infant Health Innovation Center Act”, which created the NJ MIHIA (or “Authority”). The Authority is tasked with overseeing the NJ Maternal and Infant Health Innovation Center based in Trenton and will be the government entity that continues the vital work of NurtureNJ for years to come. NurtureNJ is the statewide program that was launched by First Lady Tammy Murphy in 2019 to reduce the maternal and infant mortality epidemic in NJ and ensure equitable care among women and children of all races and ethnicities.

The one-of-a-kind Authority is governed by a 15-member Board, with an appointed President and Chief Executive Officer who is currently hiring accompanying staff. The Board will adopt recommendations for action to reduce maternal mortality and morbidity from the NJ Maternal Care Quality Collaborative (NJMCQC). The Board is also required to coordinate with a Community Advisory Committee to support and inform the work of the Authority. The 11-member community advisory committee will represent community groups with relevant experience as providers or recipients of maternal, infant, and child health services.

The Authority serves as a central hub to coordinate among national, State, and local agencies, as well as private organizations, to:

- provide perinatal, infant care, related health services, and other services as outlined in P.L.2023, c.109 (C.26:18-17 et al.) to the residents of the City of Trenton and others who are in need of such services;
- promote equitable maternal and infant health care services;
- implement strategies related to health care and social service delivery, perinatal workforce development, community engagement, data collection, research, and analysis; and
- serve as an incubator of new enterprises, therapeutics, and technological innovations leading to better health outcomes and reduced mortality and morbidity rates for women and children; and
- be responsible for overseeing the design and implementation of programs and services to improve the State’s maternal and infant health outcomes, including, but not limited to, health care and social service delivery, research and innovation, perinatal workforce

> development, education and public awareness, and other initiatives as may be undertaken by the authority. c. The authority shall become the agency primarily responsible for coordinating efforts and strategies to reduce maternal mortality and morbidity in the State at such time as the members of the board are appointed pursuant to section 5 of P.L.2023, c.109 (C.26:18-21) and the board first organizes.

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

Within the TVP, several initiatives have grown in reach over the period of the past calendar year. One such program is the HWHF Initiative. This initiative works toward improving maternal and infant health outcomes for women of childbearing age and their families while reducing population gaps in those outcomes through a collaborative, coordinated, community-driven approach. This coordinated approach uses CHWs to complete social needs assessments, and Connecting NJ Hubs, or county-specific "points of entry," for clinical assessments. Referrals and tracking occur through a central data management platform. To improve upon this innovative endeavor, HWHF re-launched in 2023 with a renewed focus on CHW and postpartum doula support, with doula care expanding to serve postpartum women for the first 12 months after delivery, including breastfeeding education and support for nontraditional groups such as partners, grandparents and siblings.

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

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

Moreover, in response to the substance use crisis in NJ, TVP applied for and received in-depth technical assistance (IDTA) support from the National Center on Substance Abuse and Child Welfare (NCSACW) to develop a State Action Plan. In September 2022, NJ was selected by the NCSACW to participate in the two-year, 2023 Policy Academy: Advancing Collaborative Practice and Policy & Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. The Policy Academy was supported by The Children's Bureau (CB), Administration on Children, Youth and Families (ACYF), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Resources and Services Administration (HRSA). For the past two years, various state entities have been working on the State Action Plan to actively prevent birthing parent and child morbidities and mortalities related to substance use.

This project, led by NJ TVP staff and composed of representatives from the Governor's Office (GOV), the Office of the First Lady, the DCF, the Department of Human Services (DHS), and the DOH included a State Action Plan, developed collaboratively, to increase awareness of and capacity to address substance use disorders (SUD) during and after pregnancy for birthing individuals in NJ. The State Action Plan included four overarching goals, all related to enhancing support for pregnant women with SUD. The project aimed to augment the screening, referral and follow-up services pathways in the state substance use treatment systems of care. The goal of the IDTA group was to understand where resource gaps exist, create a formal Plan of Safe Care (PoSC) to be distributed throughout the state to pregnant women and to craft a protocol for birthing hospitals and other providers to strategically support pregnant women with SUD during and after a birth. These efforts have produced fruit insofar that, as of January 2025, a proposal to change the definition of "substance exposed infant" is under review by the leadership of the state agency DCF. Moreover, the pathways for child involvement in the welfare system have been further defined to limits differential treatment of priority populations and increase objectivity in determining who, how and when a child gets connected to DCF.

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

These TMaH efforts will provoke enhanced collaboration between the state's Medicaid agency and our MCH Unit. Many of the goals within the new model's pillars are aligned with ongoing efforts within NJ FamilyCare and our NurtureNJ initiative, and with many of the aims of the FHS Division.

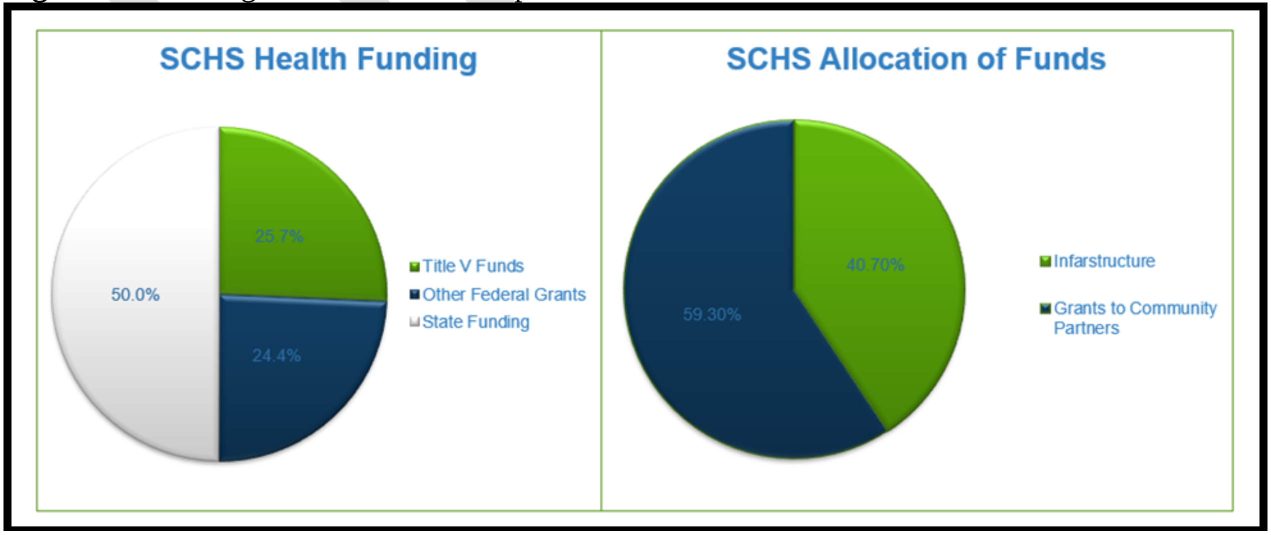
III. B.2.a Children with Special Health Care Needs (CSHCN)

NJ's CSHCN program is known as Special Child Health Services (SCHS). Within the organizational unit, there are four programs: Newborn Screening Follow-up and Genetic Services (NSGS), Early Identification and Monitoring (EIM), Data Systems and Emerging Threat Response (DSET), and FCCS. These programs work together to accomplish three main goals. Our first goal is to identify children with special health care needs. Secondly, we refer the identified children for services and support. And lastly, we focus on the epidemiology of the mandated conditions that we monitor.

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

SCHS uses a combination of HRSA Block grant funds, other federal funds, and state funds. In total, approximately 20 million dollars support the SCHS program. This does not include the Early Intervention System which has a $130 million-dollar operating budget. Approximately one-fourth of the funds are from Title V (Figure 10). The CSHCN program is allocated 38% of the total block funds. In FFY 2024, that equated to approximately five million dollars. Other federal funds such as our HRSA EHDI and RWPD grants, and our CDC EHDI and Birth Defects Prevention grants, are also used to sustain our infrastructure and core activities.

Figure 10. Funding and Allocation of Special Child Health Services



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

NBS and Genetic Services

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

Due to the critical nature of many of the disorders for which NJ newborns are screened, follow-up staff act on presumptive positive results identified by the NBS Laboratory for these disorders six days per week and most holidays to maximize timely referral to the appropriate specialists. The NBS Short-Term Follow-Up (STFU) staff contact primary care providers (PCPs) and specialty care providers to ensure timely evaluation, confirmatory testing, connection to ongoing treatment and care, as needed, and to obtain a final diagnosis.

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

Additionally, the NSGS program holds one federal grant to enhance the information system and support efforts to establish long-term follow-up. The program will be working with the FCCS team to reach out to families over time to see if their needs are met and or changed over time.

Early Identification and Monitoring

The EIM program has three components: Early Hearing Detection and Intervention (EHDI) program, the BDR, and the Autism Registry. In addition to the HRSA Block grant, this program has three other federal grants and dedicated autism funds to support the registration, follow-up, and quality assurance of our data. Once children are registered, they are referred to our FCCS program. Registry staff create reports and resources for both providers and families and continue to update our systems to improve data accuracy and overall surveillance efforts.

EHDI

The NJ EHDI Program abides by the national public health initiative "'1-3-6 Guidelines." These guidelines seek to ensure that all babies born in NJ receive a newborn hearing screening before one month of age, complete diagnostic audiologic evaluation prior to three months of age for infants who do not pass their hearing screening and enroll in early intervention by no later than six months of age for children diagnosed with hearing loss. The EHDI program offers technical support to hospitals on their newborn hearing screening and follow-up programs. NJ EHDI works with health care providers, local and state agencies that serve children with hearing loss, and families to ensure that infants and toddlers receive timely hearing screening and diagnostic testing, appropriate habilitation services, and enrollment in intervention programs designed to meet the needs of children with newly identified hearing loss.

The BDR

Dating back to 1928, NJ is proud to have the oldest requirement in the nation for reporting birth defects. Over the years, our BDR has become a robust population-based registry for children through the age of five with birth defects and provides invaluable surveillance and needs assessment data for service planning and research. All 47 birthing hospitals and hundreds of non-hospital-based practices report to the BDR through our electronic registry-the BDARS. Fetal deaths with birth defects are also registered to ensure the accuracy of our birth defects reporting, and death certificates information is also added to assist with long-term follow-up efforts.

The NJ Autism Registry

In 2009, Autism Spectrum Disorder (ASD) was added as a mandated reportable condition for all children through the age of 21. One of only a handful of mandated registries in the country, the NJ Autism Registry data provides useful information about the prevalence of autism across time and across different populations. The Registry rates compare to the CDC’s rates and can provide rates across all counties and additional information about perinatal risk factors and comorbidities. To date the registry has over 50,000 children registered and provides important data about the prevalence of autism over time and by race and ethnicity as well as explores the epidemiological and perinatal risk factors associated with autism.

FCCS

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

Special Child Health Services Case Management (SCHSCM)

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

SCHS also refers children ages birth to three to the NJEIS, which serves the developmental and health-related needs of eligible children. Early intervention services are designed to address a problem or delay in development as early as possible. NJEIS provides quality services in a child’s natural environment (settings in which children without special needs ordinarily participate and that are most comfortable and convenient for the family) by enhancing the capacity of families to support their child and creating a partnership between practitioners and families. NJEIS provides several services, some of which are: occupational, physical, and speech therapy, as well as developmental intervention.

SPSP

The SPSP aims to provide access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services. With support from the State and Title V funds, almost 4 million dollars was distributed to eight Child Evaluation Centers (CECs), three Pediatric Tertiary Care (PTC) Centers and five Cleft Lip Cleft Palate-Craniofacial (CLCPC) Centers. Patients receiving services at these locations may have mandated-congenital or non-mandated diagnoses such as ADHD, Speech delay etc. Approximately 63% of the children served are uninsured or are covered via Medicaid/Medicare programs. The most common diagnoses seen at the Child Evaluation Centers are Autism/ASD (18%), ADHD (17%), and Speech Language Delay/Disorder (16%). The top clinical services utilized by the Craniofacial patients are Plastic Surgery and Speech/Language (14% each), Nursing (11%), and Orthodontics (10%). The top clinical services utilized by Tertiary patients are General Pediatrics (14%), Orthopedics and Cardiology (11% each), and Oncology (8%).

Ryan White Part D (RWPD)

The Ryan White Part D program aims to provide comprehensive, culturally competent, coordinated care for women, children, youth, and families with HIV infection throughout the State of NJ. The RWPD Network offers HIV specialty care, family medical case management, access to clinical drug trials, referral and follow-up services, outreach, counseling, and testing. Since 1988, the RWPD Network has focused its efforts on developing FCCS facilities designed to provide or arrange for comprehensive treatment for women, children, youth, and families infected with or affected by HIV disease. The centers have become highly skilled in providing psycho-social services, and medical and nursing care to families dealing with HIV as a chronic illness. Over 2,000 families receive services at seven sites throughout the State of NJ. The RWPD Network clinics have also helped reduce the overall NJ perinatal HIV transmission rate to less than 1% with some years with zero reported mother-to-baby HIV transmissions. Since 2014, 1,316 perinatal transmissions did not occur due to the work of the RWPD Network providers. That is a cost savings of $553,095,060. This cost savings is calculated looking at the total number of HIV negative babies born to a HIV positive mother multiplied by the estimated lifetime cost of HIV care ($420,285).

Data Systems and Emerging Threat (DSET) Response

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

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

III.B.2.b Organizational Structure

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

III.B.3 Healthcare delivery system

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

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

NJ Hospital Information:

- There are 113 total hospitals in NJ, including specialty hospitals. There are 72 acute care hospitals in NJ.

- The New Jersey Hospital Association's (NJHA) membership includes 108 hospitals, plus affiliate members including nursing homes, home health agencies, long term care hospitals and other healthcare providers, bringing the total member count to more than 400.

- NJ hospitals employ more than 150,000 individuals. Collectively, healthcare is the largest private sector employer in NJ and ranks second only to government as the state's largest employment sector.

- NJ hospitals provide $23.6 billion in jobs, spending and other economic benefits to the state's economy

- NJ hospitals provide about $1.9 billion in free and discounted healthcare annually to the uninsured, senior citizens and those in financial need

- NJ hospitals care for more than 15 million patients each year

- NJ hospital emergency departments provide care and comfort to 3.8 million individuals annually.

- NJ hospitals provide $2.8 billion in community benefits annually including health clinics, screenings, education and free and discounted care for the poor and uninsured.

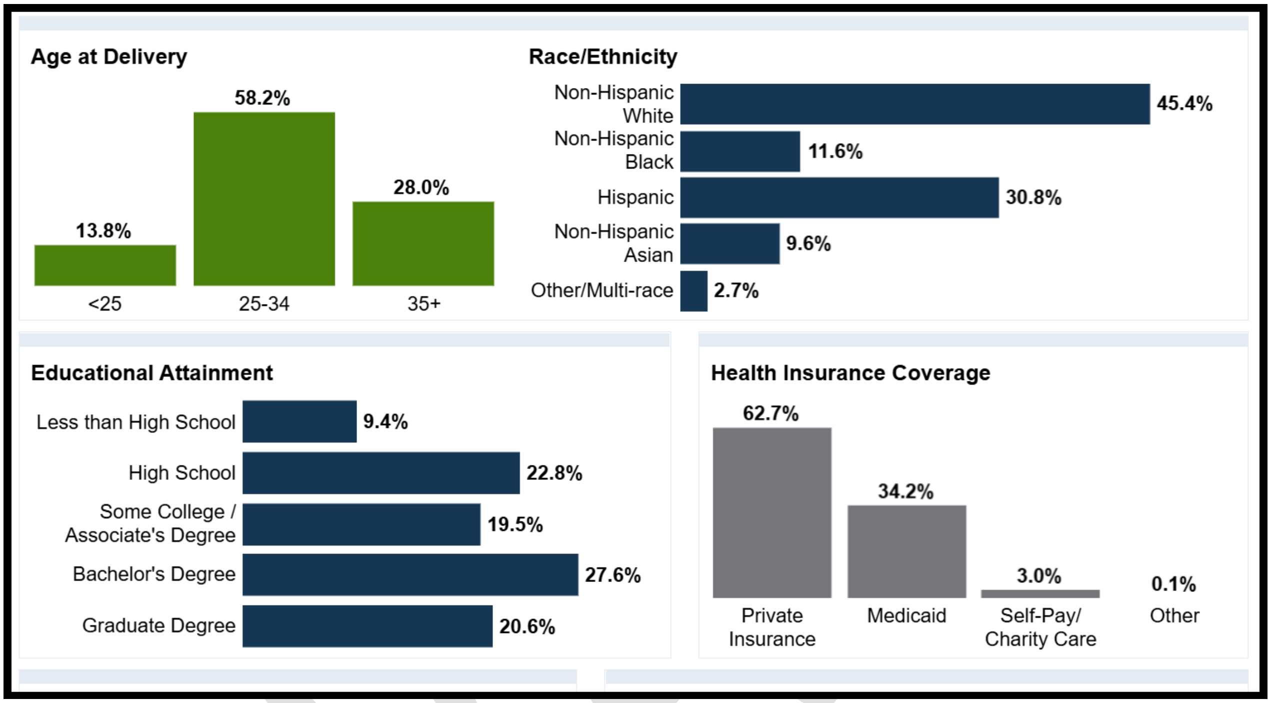
Birthing Healthcare infrastructure and patient population & outcomes (Figure 11):

- There are 45 active birth hospitals in the state
- The racial/ethnic profile of NJ's pregnant women is changing; racial and ethnic groups that are not non-Hispanic White represent 55% of all births in 2023 compared to 46% in 2000.
- There were 95,106 live births at licensed birthing general acute care hospitals compared to 96,944 live births in 2022.
- The number of pregnant women covered by Medicaid was 59,597 compared to 62,373 in 2022, and those covered by private insurance was 32,508 compared to 30,885 in 2022.
- The rate of cesarean birth was 32.6%, which was nearly the same as the 2022 rate (32.4%).
- The rates of obstetric hemorrhage increased to 58 from 52 per 1,000 delivery hospitalizations in 2022; post-admission infections to 22 from 21 per 1,000 delivery hospitalizations in 2022; and severe maternal morbidity (SMM) with transfusion to 25 from 23 per 1,000 delivery hospitalizations in 2022.
- There were higher rates of cesarean deliveries with complications as compared to vaginal deliveries per 1,000 delivery hospitalizations: obstetric hemorrhage (130 cesarean versus

23 vaginal); post-admission infections (29 cesarean versus 19 vaginal); and SMM with transfusion (48 cesarean versus 14 vaginal).

Data source: New Jersey Hospital Maternity Care Report Card: January 2025

Figure 11: Birthing mother key demographics



In the past five years, NJ has taken critically important steps to address the acute issues in the health care system such as: 1) improving the data available through the nationally recognized Report Card of Hospital Maternity Care, 2) expanding investment in community-based doulas through training and Medicaid reimbursement, and 3) non-payment for early elective deliveries through Medicaid and State Health Benefits Plans. The TVP, in conjunction with the work of HNJ2025 and NurtureNJ, continues to build on this excellent foundation by ensuring women have consistent access to evidence-based care framed in quality improvement measures for accountability, and ensuring improved preventive health and wellness for women across the life course.

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

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

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

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

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

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

NJPCA Clinical Quality Communities

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

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

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

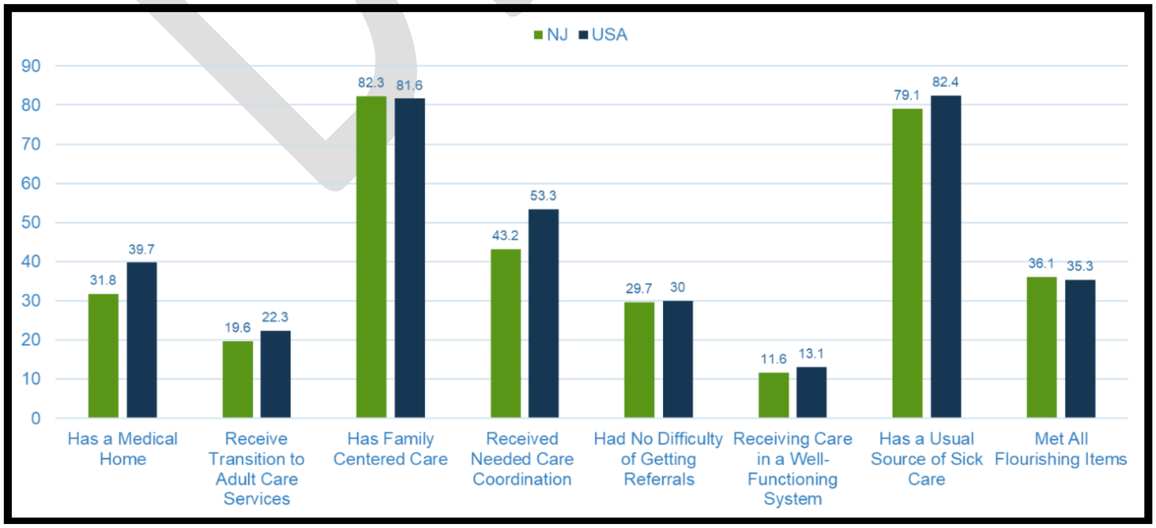
b. With the recent availability of birth control at local pharmacies in NJ and statewide access to emergency contraception, teen pregnancy and unplanned pregnancies to young adults carried to term are very low in NJ. In 2023, the teen birth rate in NJ was 13.2 births per 1,000 females aged 15–19. This is a record low for this age group and a 3% decrease from 2022. A focus on access to all maternal and reproductive health services in NJ including abortion could improve the maternal and reproductive landscape for AYAs in NJ.

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

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

The National Survey of Children’s Health estimates that NJ has approximately 400,000 (23%) children 0 through 17 years of age who have a special health care need. In the 2022-2023 survey, 347 families identified as having a child with a special health care need. Title V staff examined six core metrics for the CSHCN population to better understand how the NJ’s CSHCN population was doing. In Figure 12, we see that most families felt they had family-centered care and a usual source of sick care. Interestingly, only a third felt they had a medical home. While NJ’s results are not markedly different than the national results, we clearly have work to do. Only a third of families said they have no difficulty getting referrals, and only 43% said they have the care coordination that they need. For children who are transitioning to adult care, less than 20% received this needed support. Although NJ has many providers, unfortunately only 11% felt the state have a well-functioning system.

Figure 12. National Child Health Survey (2021-22) CSHCN Measures



While the latest survey did not parcel out adequate insurance coverage, the 2017-2018 survey indicated that the 95.8% of the CSHCN were insured, but only 62.3% felt the insurance was adequate and continuous. This difference does underscore the low result for NJ having a well-functioning system.

Through our Title V-funding programs, we are working to improve the care coordination, medical home, and transition services though our FCCS. Additionally, our service grants are provided to strengthen the network of specialized pediatrics services. Our NBS programs and our Early Identification and Monitoring programs work to connect children to the health care delivery system and the family centered support networks that they need to work within our state.

NJ System of Care for CSHCN

NBS and Genetic Services

The NSGS Program is dedicated to ensuring that all newborns and their families receive timely and appropriate follow-up services when a screening result falls outside of the normal range. This effort is supported by a robust infrastructure of internal and external stakeholders which relies on ongoing relationship building to keep the system strong. Key players in this network include hospitals, birthing centers, providers of community births, courier services, our state lab, our software vendor (Revvity), pediatricians, specialists, and the Follow-Up team. The NSARC and its subcommittees are vital to keeping our program up to date, efficient, and effective in the management of blood spot screening. Equally essential to the program’s success are the grantees of our NBS health services grants, access to community-based services, and assist with transition to adult care. This entire complement of services from specimen delivery, screening for 61 disorders, through to reporting of abnormal results and inclusive of grant awards to the community, is all funded by the sale of the blood spot kits (the filter paper used for the screening). These services are all completed at $150 per initial kit, where the initial kit fee also includes any repeat testing and associated follow up. Additionally, the NSGS program has a State NBS System Priorities Program (Propel) award; in year two of the funding opportunity HRSA-23-065 (budget period 07/01/2024 – 6/30/2025, with the potential for a total of five years of funding). This funding has allowed the NSGS Program to begin planning for a Long-term Follow-Up (LTFU) component for the Program. In year one, the team has collaborated with and collected information from multiple states that are further ahead on LTFU for NBS and completed and IRB application. The IRB responded in December 2024 with a notice of determination of non-human subject. Since then, the team has moved forward with plans to use REDCap to manage the LTFU surveys and data collection and plans to begin outreach to families in early February 2025. The plan is to conduct an annual survey with families through their child’s sixth birthday via an online survey, or over the phone.

Some challenges within the NSGS program are keeping up with the dynamic landscape of healthcare, communication with PCPs, an increasing number of parents declining screening, and data management and coordination. While the NSGS program and the NJ NBS Lab regularly collaborate, the programs have purposefully created a 2025 workgroup focused on communication with pediatricians to help us better communicate on all fronts, from the wording on lab mailers to our conversations on the phone and everything in between. In January, staff reorganized information on our website to make it more user-friendly to pediatricians and the families we serve. To further improve data management, bi-weekly meetings are held to ensure data accuracy and quality. Monthly meetings with the lab help the follow-up team review and discuss key data points. Both the lab and follow-up programs contribute data to the Association of Public Health Laboratories (APHL)/NewSTEPs. Additionally, ensuring interoperability remains a continuing challenge as we work toward streamlining processes across the system.

Since 2011, NJ has mandated newborn pulse oximetry screening to detect Critical Congenital Heart Defects (CCHD). The screening mandate was enacted to prevent babies which seem well from being discharged only to become critically ill later. Originally, all babies who failed the screening were registered with the BDR's Pulse Oximetry module. BDR nurses would then follow up with the hospitals. The goals were to validate that all failed screenings were registered, that the children received appropriate follow-up, and that any subsequent diagnoses were reported. To better facilitate the screening results and follow-up, the pulse oximetry screening data was eventually integrated into the population-level screening results section of our Vital Events Registration & Information System (VERI). This system collects all birth-related data on babies born in NJ and includes perinatal risk factors, birth characteristics, demographics, and other maternal and newborn related data. We established a robust surveillance system to cross-reference our findings. Ultimately, by working collaboratively and integrating systems we can now better evaluate the complete CCHD screening process in our birthing facilities, including the effectiveness of and adherence to the screening algorithm.

The CCHD program continues to collaborate with BDAR staff on Component C of a Cooperative Agreement with the Centers for Disease Control and Prevention's (CDC) (Advancing Population-Based Surveillance of Birth Defects; CDC-RFA-DD21-2101). Component C focuses on the timing and method of CCHD detection. To improve data quality, BDAR, and pulse oximetry screening staff collaborated to have new fields added to the BDAR pulse oximetry/CCHD module. The new fields went live in mid-January 2023. The new fields help satisfy the requirements of the CDC project and provide an enhanced picture of pulse oximetry screening follow-up in NJ.

EHDI

The NJ EHDI Program ensures that all babies born in NJ receive a newborn hearing screening before one month of age, complete diagnostic audiologic evaluation prior to three months of age for infants who do not pass their hearing screening and enroll in early intervention by no later than six months of age for children diagnosed with hearing loss. The EHDI program offers technical support to hospitals on their newborn hearing screening and follow-up programs.

NJ hospitals are very successful in ensuring newborns receive hearing screening, with 97% of babies screened. Babies who fail their screening are referred for follow-up diagnostic service with an audiologist. The program staff track these referrals to ensure babies receive timely and appropriate follow-up. NJ EHDI works with health care providers, local and state agencies that serve children with hearing loss, and families to ensure that infants and toddlers receive timely hearing screening and diagnostic testing, appropriate habilitation services, enrollment in intervention programs designed to meet the needs of children with newly identified hearing loss, and connection to Deaf/Hard of Hearing (DHH) adult to family programs.

BDR

Title V fully supports NJ's BDR. The goal of the registry is to ensure that children who have congenital birth defect are linked to resources and supports. All 45 birthing hospitals and hundreds of non-hospital-based practices report to the BDAR through our online registry. Annually, we receive an average of 4,000 birth defect registrations and 4,200 autism registrations. The BDARS allows providers to verify if a child had already been registered for another provider; thus, significantly reducing the burden on our reporting agencies and improved the system's efficiency. This is significant as our mandate requires all children through the age of five with a birth defect and all children 0-22 with ASD to be registered, and since children see many healthcare providers; each needing to verify registration or register the child. Moreover, if a child had been registered, their providers can now any new diagnosis including an autism diagnosis, and review and update the child's contact information.

Since 2021, the BDR expanded its case ascertainment efforts by abstracting charts of NJ children with birth defects who were born at, transferred to, or diagnosed by the Children's Hospital of Philadelphia. This was an important step forward as these children have complex health care needs and would not only be included in surveillance of birth defects, but families would be offered Case Management services. We anticipate future agreements with other border state hospitals so that more children will be included and served. NJ has the statutory authority to capture fetal deaths due to birth defects at 15+ weeks of gestation, and these data has improved the overall quality of the data, thus providing a more accurate understanding about the prevalence of the most serious birth defects. Additional data needs to be collected on fetal demises with congenital anomalies from other licensing facilities throughout NJ besides the 45 birthing hospitals to know the true prevalence rate of the major birth defects. Limitations to case ascertainment include the de-identification of fetal death cases in the BDR, which makes it difficult to further validate the data.

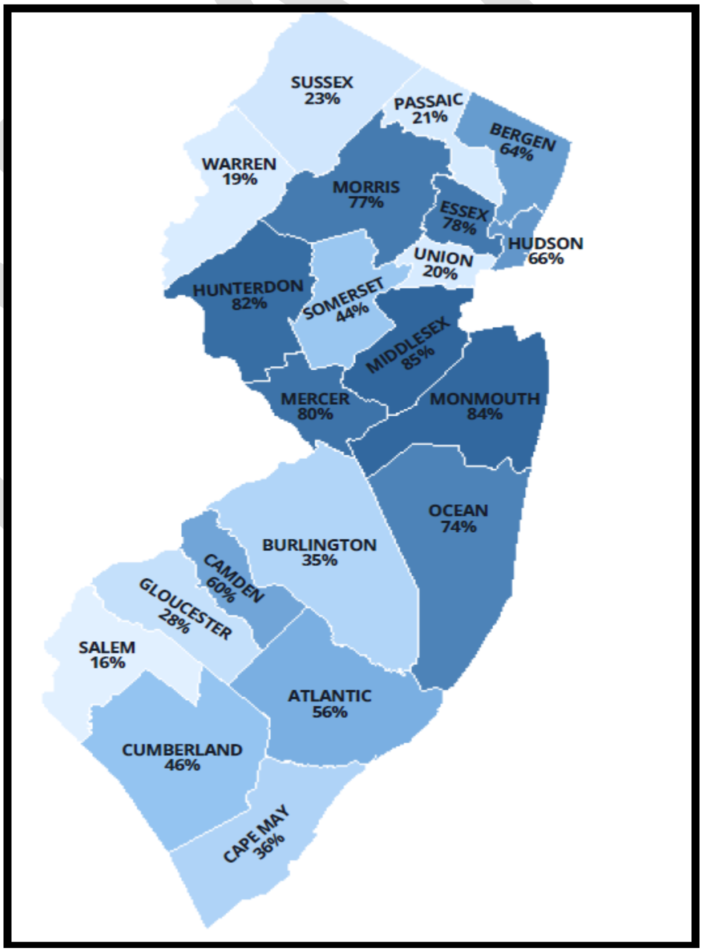
NJ Autism Registries

Since beginning in 2009, the Autism Registry has received more than 58,000 registrations. Each year, health care providers submit between 3,000 and 5,000 new registrations. The Autism Registry is included in the BDARS platform. The autism data collection pages are designed with check-off options rather than asking providers to use text fields to provide information about comorbidities, symptoms, and other pertinent information. It is the only registry in the country that includes children up to the age of 22 and refers them to their local county case management services. We serve as a model registry and continue to provide technical assistance to other states considering a registry. The Autism Registry provides quality prevalence information for the entire state and information about any population differences. Current national studies such as the Autism and Developmental Disabilities Network estimate that the rate of autism in NJ is 1 in 34 (based on review of records of a cohort of 8-year-old children in four counties who meet criteria for autism). The National Child Health Survey also reports that 3.4% of families reported that their child current has ASD.

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

The Autism Registry interfaces with developmental pediatricians, pediatric neurologists, psychologists and psychiatrists and other licensed providers who diagnose autism. NJ also has several large multi-disciplinary autism diagnostic and treatment specialty centers. While there are many diagnostic opportunities, there continue to be long-wait times for diagnosticians, and areas in the state where there are many fewer resources. Looking within counties, we see that while 61% of children are diagnosed withing their home county, the range is large (15% to 85%.) Facilities and services are clustered in the more urban northeast, in Middlesex, Hunterdon and Monmouth counties which have several hospitals focusing on children's specialty services (Figure 13).

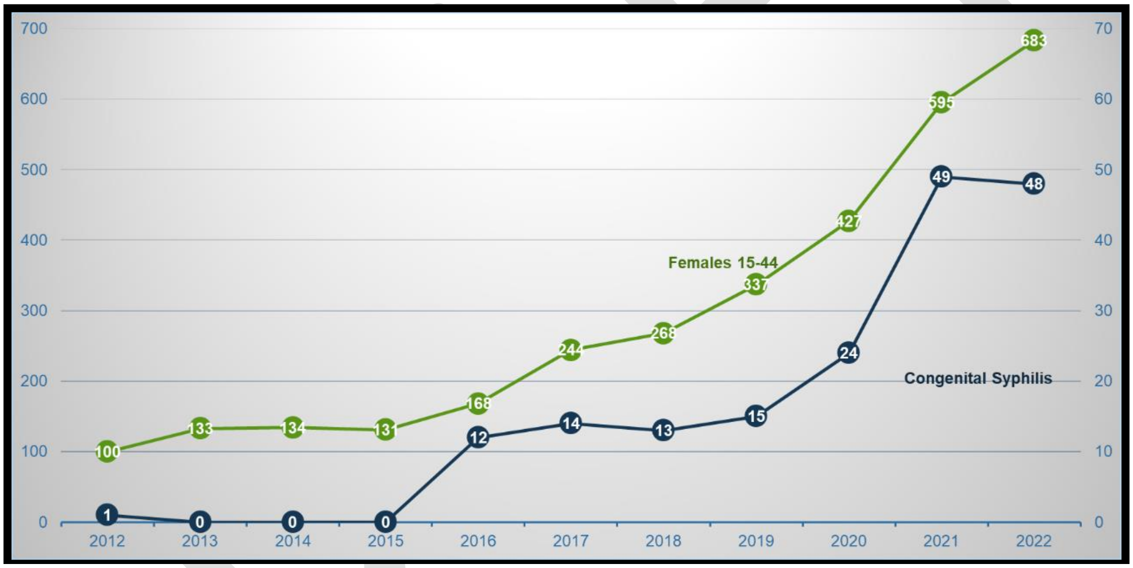
Figure 13. Percent of Children who receive an ASD diagnosis within their County of Residence; year of births 2003-2021



Data Systems and Emerging Threat (DSET) Response

An important function of SCHS is to identify and respond to trends in exposures to pregnant mothers that have the potential to fuel rising rates of children with special health needs, receiving funding from CDC's Surveillance of Emerging Threats to Pregnant People's and Infants Network (SETNET) program. The SCHS work in this area began in 2020, monitoring outcomes of pregnancies complicated by COVID-19 infection from 2020 through 2023. The SETNET project was expanded in 2022 to include surveillance of congenital syphilis and congenital cytomegalovirus (CMV) infections. Syphilis infections during pregnancy and cases of congenital syphilis have been rising significantly in NJ and nationally (Figure 14).

Figure 14. Reported Syphilis Cases among 15-44yr old Females and Congenital Syphilis cases in NJ 2012-2022



The project began by tracking 313 pregnancies with delivery outcomes in 2018-2021 that were complicated by syphilis infection with maternal/newborn chart abstraction and infant follow-up tracked through age two and data was submitted to CDC. During FY24, the project continued with reviewing 145 additional cases with delivery outcomes in 2022 and will begin case ascertainment on 2023 delivery date cases. To date, the CMV project reviewed medical records for 197 pregnancies with deliveries beginning in 2018 to identify 68 cases meeting case definition criteria. Since postnatally acquired CMV infection can be a complication of NICU infants, an initial chart review is required to accurately identify congenitally acquired cases. Those case then receive more detailed review and infant follow-up to age three with data submitted to CDC. The DSET program is looking at strategies to identify additional exposures appropriate to this model.

FCCS

FCCS plays a central role in ensuring that all counties provide robust services and collect key information to establish quality across NJ. FCCS Special Child Health Services Case Management (SCHSCM) oversees and provides approximately four million dollars in funding to 21 county-based CMUs. These funds include Title V funds and state MCH Block, Casino-revenue, and Catastrophic Illness in Children Relief funds (CICRF). Each CMUs also receives funds from their county government. Each county determines the amount of those funds. These units provide resources and referrals to families of children from birth up to their 22nd birthday. Annually, over 19,000 families receive services from SCHSCM.

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

The CMUs remain successful in linking CSHCN to important services. Below is a summary of a child and her family's journey navigating her various needs over the past decade, thus showcasing the role of CMUs working with Title V-CSHCNs.

Reflective Quote:

On a Friday afternoon, FCCS SCHSCM received an urgent email from a Federally Qualified Health Center (FQHC) seeking assistance in obtaining a specialty formula for a six-year-old tube-fed child who had only two days of nutrition remaining. The child's family was waiting for their Medicaid application to be renewed. FCCS SCHSCM staff immediately contacted a SCHS Case Manager in the family's county of residence. Throughout the weekend, the Case Manager persistently reached out to the family, leaving multiple voice messages. Simultaneously, she connected with a local foundation for assistance and reached out to other families on her caseload, whom she knew had unopened specialty formula they no longer needed. The Case Manager went to the family's home on a Saturday to gather the vital formula. It was later discovered that the family spoke Haitian-Creole, which explained the unanswered calls. With the help of an interpreter, the family provided consent to participate in the SCHSCM program and allowed the Case Manager to deliver the nutrition directly to their home. The Case Manager personally delivered the needed formula to the grateful family on a Sunday. SCHSCM continues to support the family with their insurance renewal process and other related needs.

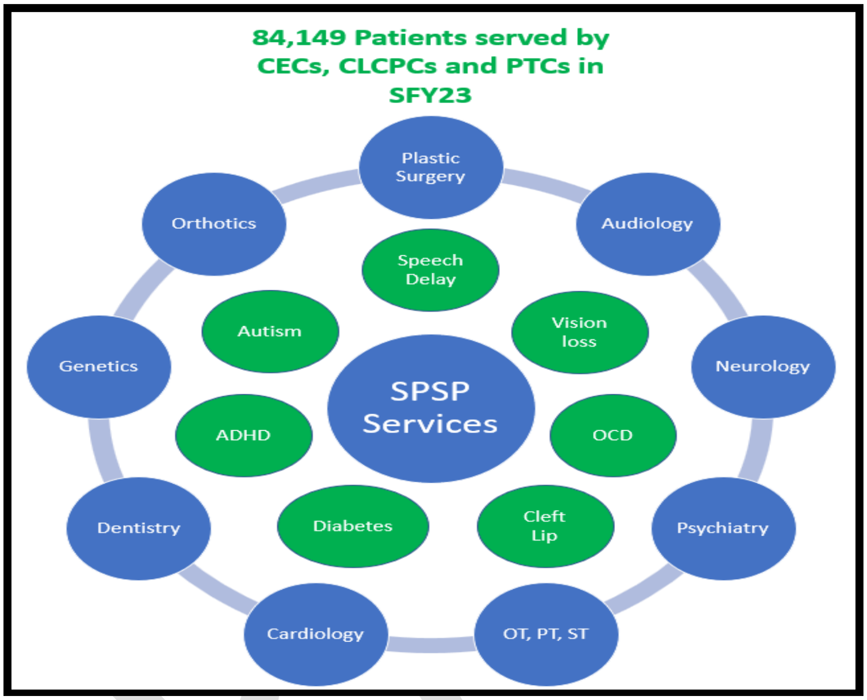
One key factor that FCCS focuses on for SCHSCM is the level of engagement with children referred to CMRS from the BDARS. The level of family engagement within SCHSCM, special needs population encompasses a wide range of needs. For example, a child born with hypospadias, which can be surgically corrected and require no further SCHSCM assistance, may require little to no continued engagement. In contrast, a child with a diagnosis of moderate hearing loss, may have more extensive and prolonged needs, resulting in a greater level of engagement. These different levels of need, along with families that SCHSCM is unable to contact, help explain why CMUs successfully link a large proportion of children and families released from BDARS. However, children with more complex or comprehensive conditions, such as autism, are more likely to successfully link initially and remain engaged with SCHSCM for a greater amount of time after their initial linkage to SCHSCM.

Additionally, FCCS manages a Fee-for-Service program that assists eligible NJ families to purchase hearing aids, ear molds, orthotics, or prostheses through a State approved vendor system. Family cost participation is calculated using a sliding scale based on family size and income, and the SCHSCM case managers support families in completing the application process. Since Grace’s Law was passed in 2008, requiring NJ insurance companies to cover medically necessary expenses incurred in the purchase of hearing aids for children under the age of fifteen (15), most children served by this program are NJ children who do not have NJ-based health insurance plans or any health insurance coverage at all.

SPSP

The SPSP aims to provide access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services to families with CSHCN that are 21 years old or younger (Figure 15). With support from the State and Title V funds, health service grants are distributed to multiple agencies throughout NJ. The SPSP consists of eight Child Evaluation Centers (CECs), of which four CECs house Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder (FAS/FASD) Centers, and three CECs provide Newborn Hearing Screening (NBHS) follow-up. Additionally, there are three Pediatric Tertiary Care (PTC) Centers and five Cleft Lip Cleft Palate-Craniofacial (CLCPC) Centers. All centers provide services statewide across the 21 counties in NJ and are partially funded via the health service grants. Patients receiving services at these locations may not be captured by BDARS due to their non-mandated diagnoses (i.e., ADHD, Speech delay) and/or parent/caregiver choice to decline participation in SCHSCM. Approximately 63% of the children served are uninsured or are covered via Medicaid/Medicare programs. In SFY24, $2,205,025 was awarded to CEC grantees, while $769,748 was distributed to CLCPCs and $933,033 to PTCs.

Figure 15. Specialized Pediatric Centers



The SPSP has been negatively impacted by the national pediatric subspecialty shortage. According to the American Academy of Pediatrics, there are approximately 1.5 million children with ASD, but only about 700 practicing board-certified Developmental-Behavioral Pediatricians (DBP), Pediatric Subspecialty Shortages Fact Sheets. This national shortage is reflected in NJ by the Child Evaluation Centers' new patient DBP waitlist that ranges from 4 – 12 months. Feedback gathered from site visits indicate that some CECs have spearheaded their efforts to train psychiatry fellows, implement Generalist as Specialist programs, and send nursing staff to receive ADOS training. Additional stressors are the low Medicaid reimbursement rates for specialized services making some specialized facilities not continue their Medicaid contracts. For instance, Cooper Hospital, a CEC in southern NJ, had their agreement with Nemours Hospital for cardiology, endocrinology, and pulmonology services terminated on 7/2/24. The CEC was able to secure staff to address this shortage, but this termination has placed further burden on the system. Statewide issues of insurance authorizations holding up services, and thus delaying treatment, are reported.

III.B.3.c Relationship with Medicaid

The continued collaboration of Medicaid with the TVP consists of a number of formal and coordinated efforts, which are outlined in our Memorandum of Understanding/Interagency Agreement; below a non-exhaustive list of ways in which Medicaid and the TVP work or will work together:

a. Create purposeful, standardized meetings to discuss existent and emergent issues that overlap with Medicaid and TVP.
b. Have designated liaisons in each state system who consistently notify one another of changes to any regulations/policies, collaborating on the development of performance measures and improving data linkage for ultimate program administrative and outcomes improvements.
c. Share relevant, aggregate data related to populations served by TVP.
d. Focus on “Identification, Outreach and Referral”, which contains language on collaborative work in the space of health promotion, including developing and implementing activities and outreach materials.
e. Implement fiscal policies to detect and prevent fraud.
f. Collaborate on policies that directly impact the maternal and child health populations.

III.B.4 MCH Emergency Planning and Preparedness

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

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

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

Table 1: Levels of emergency and impact

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

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

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

The Newborn Screening and Genetic Services (NSGS), Follow-Up program, has plans for how to continue operations when staff is not able to report to a given worksite, when the Laboratory Information Management System (LIMS) is not available, and for when the DOH network is down. These plans are coordinated with the NJ NBS Laboratory. The NJ Public

Health and Environmental Laboratories (NJPHEL), NBS Laboratory, has a laboratory coverage agreement for backup services to ensure continuity of operations.

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

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

The NJTVP has learned from the disruption the COVID pandemic created in health care. As of January 2025, many health care providers continue to offer a telehealth option for residents of the state who need connection to care, but have mobility issues, or are too sick to come to an appointment in person. Moreover, hospitals and long-term care facilities are enhancing their COVID-pandemic provoked services to ensure that people’s needs are addressed, especially under difficult circumstances that relate to CHF.

III.C. Needs Assessment

III.C.1.a. Process Description

As part of the Title V MCH Block Grant Program, every five years New Jersey (NJ) is required to complete a comprehensive, state-wide needs assessment on the health and well-being of mothers, children, and youth, including children with special healthcare needs (CSHCN). The T5NA team has worked to collect data, consult residents and professionals with lived experience, as well as evidence-based literature, and review current practices to inform and improve MCH outcomes. Moreover, to strengthen partnerships for ensuring the effective implementation of strategies designed to address the needs of the MCH population.

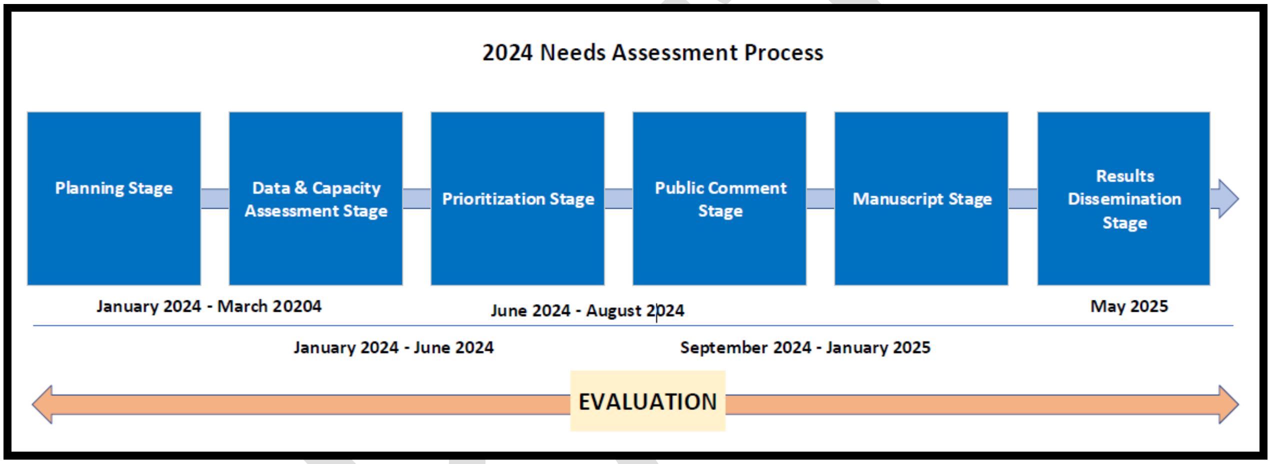
The NJ Title V MCH Block Grant aimed to answer the following questions:

- What are the needs of each target population?

- What are the needs of the target population that are not being addressed with current programming?
    - Which groups within the target populations have these needs, and where are they located?
- What is currently being done and how effective are those interventions?

The T5NA was a systematic process to collect information about the state's public health system. The information collected during the needs assessment process was used to guide planning efforts to address the varied needs of pregnant women, mothers, infants (up to age one), children, adolescents, and CSHCN. Below, the original steps of the 18-month process are delineated in Figure 16.

Figure 16: Title V Block Grant Needs Assessment Process



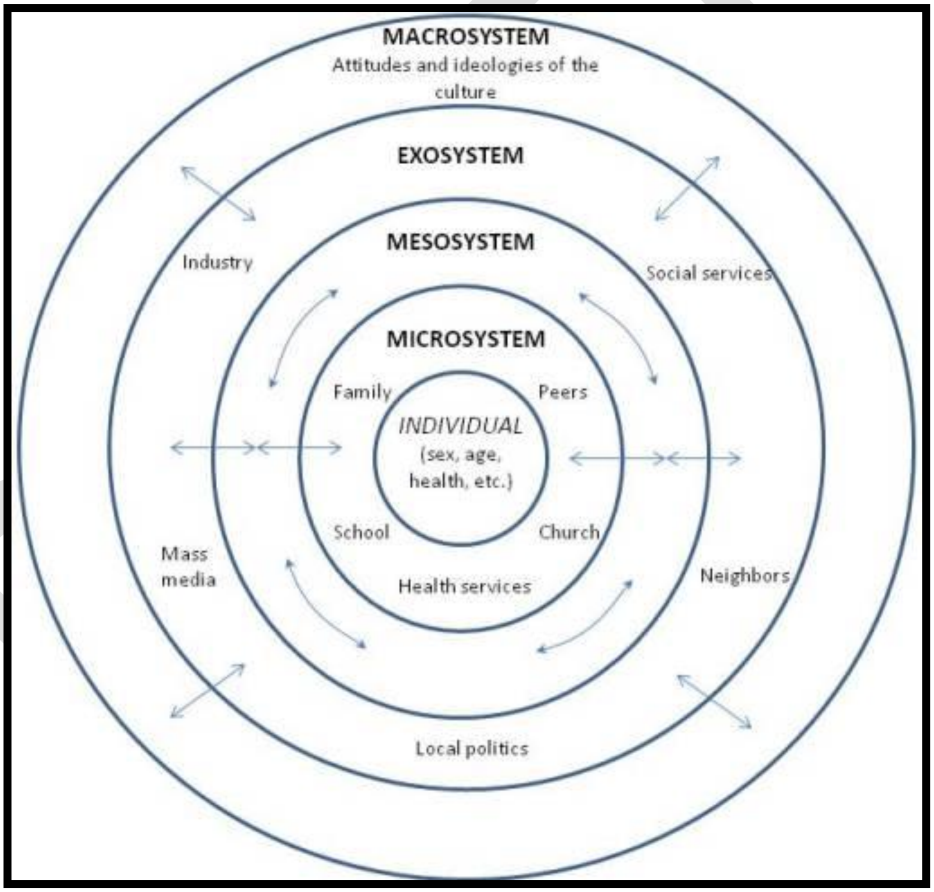
Guiding Principles of the NJ T5NA Process

- Health Equity
- Trauma-informed
- Community Engagement
- Transparency
- Data-driven Decisions
- Evidence-based and Informed Practices
- Adaptability
- Collaboration with Systems/Consumers/Community
- Quality Improvement

Framework & Methodology Guided by our Principles

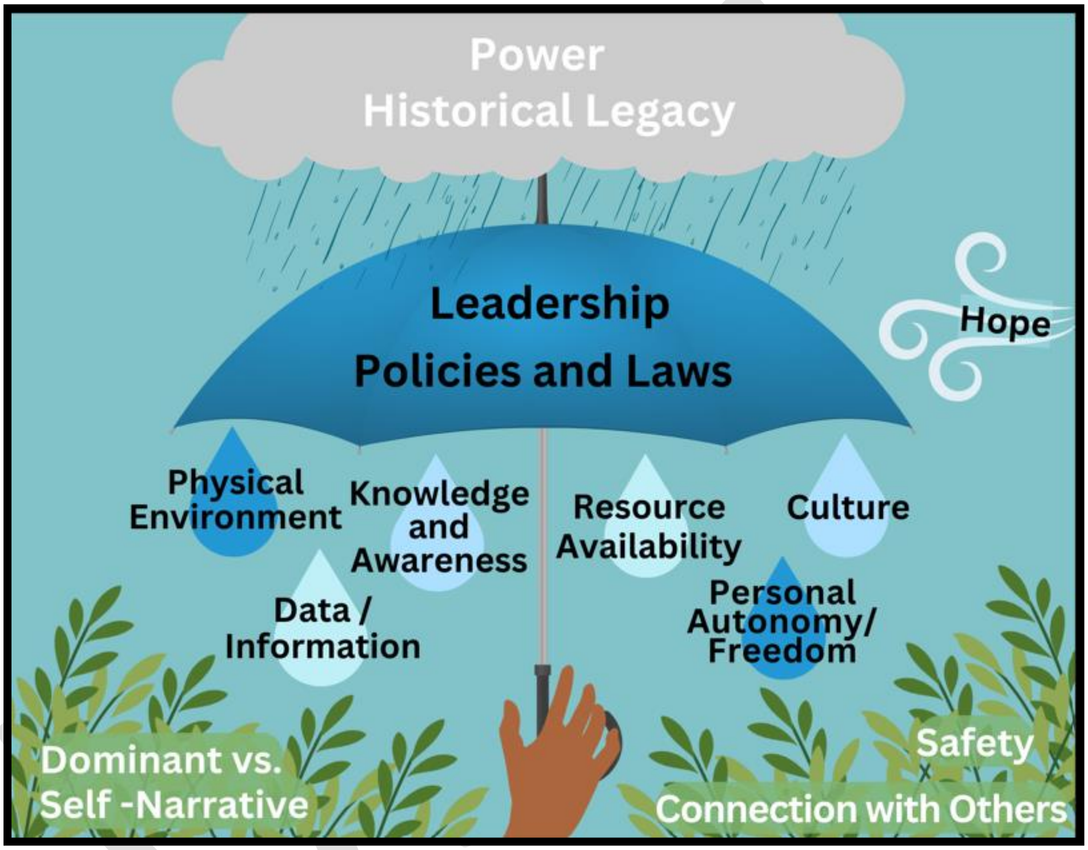
The T5NA team within the Family Health Systems (FHS) Division at the New Jersey Department of Health (NJDOH) used a mixed methods approach during the process, informed by best practices and evidence-based research while elevating the voices and experiences of the individual and family service recipients in NJ as well as the professionals working with these priority populations. In conducting the needs assessment, the T5NA recognizes the interplay of micro, mezzo, and macro forces that impact people's lives. For this reason, the needs assessment is influenced by the theoretical framework of the Socio-Ecological Model (SEM; Figure 17). The SEM is a tool used to define the complex interplay of individual, interpersonal, organizational, societal and community factors that influence health behaviors and health outcomes.

Figure 17: Bronfenbrenner's Socio-Ecological Model:



The NJDOH staff recognize the impacts of various systems, including strengths and limitations which are state-specific, and have profound significance for the MCH populations in NJ. These additional factors that are considered in the work of FHS in NJ include assessments of power and historical legacy, which contemporarily influences regulations and legislation, ultimately benefiting or harming the residents across the life course. Concomitantly, the FHS staff recognize the buffering impact of knowledge, resource availability and anti-racist and trauma-informed service delivery in the state on health behaviors and health outcomes. Below, a visual representation of the confluence of factors which impact an individual and community's health and well-being in NJ (Figure 18):

Figure 18: NJ's Socio-Ecological Model



Stakeholder Involvement

Throughout the T5NA, various stakeholders were invited to provide input and collaborate on the process from start to finish. The T5NA team was intentional to invite and involve a broad spectrum of stakeholders, which included our state's family-led organizations, our MCH Consortia (MCHC), organizations that work with our CSHCN populations, academic partners, other state departments such as the Department of Education (DOE) and the Department of Children and Families (DCF). Additionally, service recipients and community members were invited to engage in the T5NA process at various junctures.

To begin the process, a NJDOH Leadership Work Group was formed to include people who, a) worked with populations that received Title V funding, and/or b) oversaw programs that distributed goods or services to MCH populations throughout the state. The leadership team is included below (Table 2).

The primary aim of the Title V Work Group was to provide feedback and guidance related to data collection, analysis of themes and prioritization throughout the needs assessment process. A secondary aim of the work group was to create a criteria-based ranking system which would help guide the prioritization process.

Needs Assessment Leadership Teams

Table 2. Title V Block Grant Work Group

DOH Internal Work Group	
ROLE	**NAME**
Director of Special Projects and Quality Improvement/Title V Coordinator	Rebecca Shoaf Kozak, PhD, LICSW, MPH
Executive Director of Children & Youth with Special Health Care Needs	Sandra Howell, PhD
Executive Director of MCH and Title V Director	Nancy Scotto-Rosato, PhD
Lead MCH Epidemiologist/State System Development Initiative (SSDI) Director	Genevieve Lalanne-Raymond, RN, MPH
Program Manager of Child and Adolescent Health	Jennie Blakney, MA
Program Manager of SNAP-ED	Payal Arora, MS, RD
Research Scientist 2/NJ Pregnancy Risk Assessment Monitoring System Coordinator	Sharon Cooley, MPH
Research Scientist 1 of Early Identification and Monitoring, CSHCN	Elena Napravnik, MA
Executive Director, Performance and Grant Management Unit	Omolola Taiwo, PhD
State Dental Hygienist, Oral Health Services Unit	Becky Parnian, DHSc, RDH, MPH, CDA
Program Coordinator with Maternal Health Innovations	Millie Melendez, MPH
Program Managers with NJ WIC Services	Cindy Weiss-Fisher, MS, RD

Main purposes of the T5NA Work Group:

1. To collectively evaluate the Title V-funded, state-wide endeavors from the past five years that have been implemented with the broad goal of understanding how state goals have aligned with priorities set out by past Title V Program (TVP), what gaps exist and what programming modifications need to occur to address the contemporary issues revealed
2. To determine members of, collaborate with and guide a Steering Committee made up of community partners, clinics, hospitals and community agencies to assess the work that has been done with Title V funds and act as a sounding board for ideas shared by community partners

A Steering Committee was formed, comprised of grantees and service providers (Table 3). The main purpose of the Steering Committee was to offer feedback on the needs assessment process and cultivate relationships with MCH colleagues in the state.

Table 3. Title V Block Grant Steering Committee

Steering Committee Invitees	
ROLE	**NAME**
Partnership for Maternal and Child Health of Northern New Jersey	Mariekarl Vilceus-Talty, MA, BSN President & CEO Marie Kinsella, MS, MCHES, Director of Community Programs Virginia Middlemiss, MSW, LSW, CLC. Senior Mgr. Community Programs
Central Jersey Family Health Consortia	Laura Taylor, MSW, LSW Chief Program Officer
Southern New Jersey Perinatal Cooperative "The Cooperative"	Helen Hannigan, MGA, CEO Denise Bouyer, MS, Director of Family Support/Community Services
SPAN	Carolyn Hayer, Executive Director Jeanne McMahon, MPH, Senior Program Director Deepa Srinivasavaradan, BS, IMH-E®, AMCHP Family Delegate and Director of Early Childhood Initiatives
Autism NJ	Jon Gottlieb, Esq., Director of Information Services at Autism New Jersey

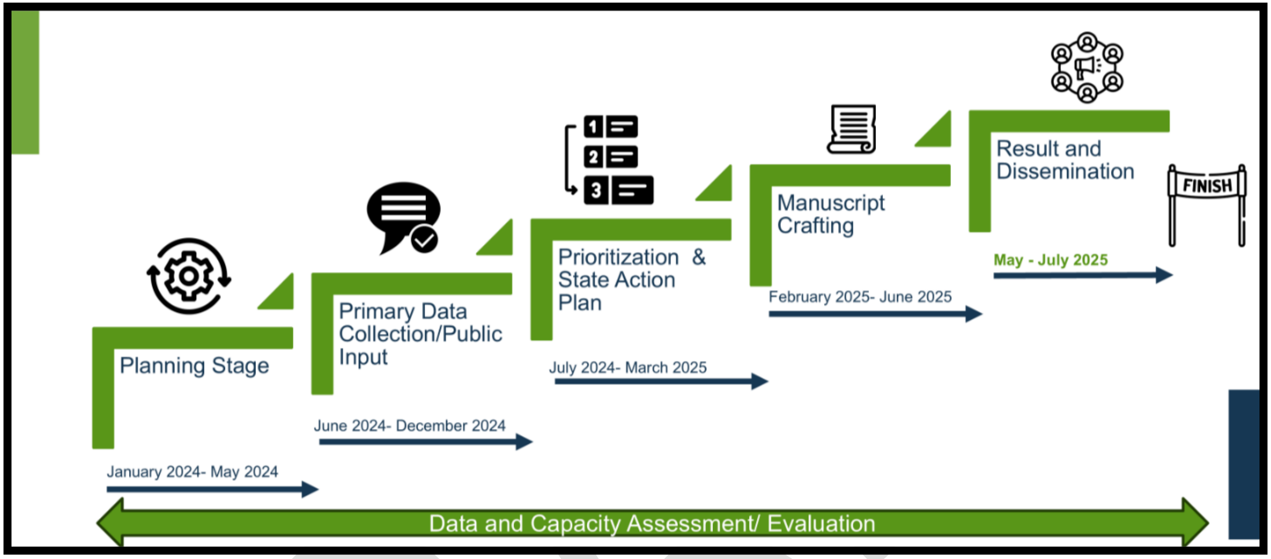
New Jersey's Statewide Ombudsmen for Individuals with Intellectual or Developmental Disabilities and their families	Paul Aronsohn
Medicaid Policy Partner	Shin-Yi Lin, PhD (Deputy Director of Policy, Division of Medical Assistance and Health Services), NJ Department of Human Services
Head Start	Antoinette Harrison, Head Start Collaboration Office Coordinator
NJ Healthcare Quality Institute	Armonie Pierre-Jacques, MPH, Program Officer
Rutgers -School of Public Health	Christina Dogbey-Smith, Reproductive and Maternal Health Program Director
Rutgers- LEND (Developmental Center)	Caroline Coffield, PhD, Assistant Professor of Pediatrics, Rutgers Robert Wood Johnson Medical School; Director, NJLEND
ACENDA	Christina Reiss, BSW, Director of Infant and Early Childhood Health
Children's Specialized Hospital	Jill Harris, PhD, Director of Research development and Coordinator of Autism Services
DOE	Luiz Pereira, M.Ed., Director of the Office of Student Support Services
DOE	Kimberly Murray, Director of the NJDOE Office of Special Education
DCF	Lenore Scott, LSW, Assistant Director, Office of Early Childhood Services
NJ Breastfeeding Strategic Plan	Ellen Maughan, JD, IBCLC, New Jersey State Breastfeeding Coordinator Videsha Joshi, MPH, NJ Breastfeeding Strategic Plan Associate
Youth Leads	Jasmin Langomas, Youth Development Specialist Sabih Hasan, Youth Development Specialist

Stages of the Needs Assessment Process

In addition to examining recent evidence-based scholarship on conducting needs assessments in health and health related fields, the T5NA team consulted the book, *Needs Assessment in Public Health* by Donna Peterson and Greg Alexander (2001) to develop and strategize on our process.

The needs assessment process began in earnest in December of 2023, with five, distinct stages identified as part of the following 18-month trajectory: Planning, Prioritization and Crafting of the State Action Plan, Public Comment, Manuscript Crafting and Results and Dissemination. While we had originally planned for a sixth, distinct step in the process regarding Data Capacity and Assessment, we quickly realized during the planning stage that Data Capacity and Assessment is an ongoing stage that threads throughout the entire process. Therefore, this phase of the work was removed and considered ongoing (Figure 19).

Figure 19. 2025 Needs Assessment Process, and Timeline



Planning Stage

As we prepared for the T5NA, the team came together to identify the basic structure of the needs assessment. The following action steps were delineated, and questions were answered, during that initial phase of planning:

Start-Up Planning

1. Establish the structure of the needs assessment and its process.
    a. Who is directing the activities in each phase?
    b. Who is on the leadership committee?
2. Identify the types of needs to be assessed and the potential use of the needs assessment.
3. Identify the stakeholders and target population of the needs assessment.
4. Create a Community Engagement Plan that specifically outlines how families and individuals will be represented throughout the needs assessment process
5. Meet with the Steering Committee to vet the timeline and plan
6. Work with NJDOH Executive Leadership and FHS Assistant Commissioner to determine how data and information will be shared with stakeholders throughout the process.

Operational Planning

1. Establish which team members will help determine the indicators and data sources to support prioritization
2. Determine methodology to be used to prioritize needs in terms of importance
3. Determine strategies for facilitating meetings, managing conflict, and reaching consensus
4. Determine a strategy for ongoing needs assessment work and maintaining relationships formed during the needs assessment process

Data and Capacity Gathering and Assessment Stage

1) Sources of data were collected and reviewed; and
2) Data were assessed
3) Two questions were asked:
    a. Are the data meeting the objective of collecting information we need?
    b. How do the data inform us about the needs of the communities that we serve?

Secondary Data Review

The Title V Staff (TVS) began this stage of the process by reviewing information and data already collected in the state, including health reports, local county needs assessments, evidence-based scholarship and data systems. These data and documents were consulted to gain an understanding of the unmet needs, disparities, voids in service provision and strengths of the MCH populations in the state. Below are some of the secondary data sources the state utilizes, and how different data are collected and contribute to our understanding of the MCH health outcome landscape. Additionally, analysis included an examination of moderators which impact the health trajectory of NJ populations.

MCH Epidemiology Unit (MCH Epi) and the Maternal Data Center

The MCH Epi Unit engages in numerous data collection and analysis activities to inform public health intervention and program improvement throughout NJ. For instance, the NJ Pregnancy Risk Assessment Monitoring System (PRAMS) is a joint research project of the NJDOH and the Centers for Disease Control and Prevention (CDC). The PRAMS survey, which collects quantitative data, is administered to one out of every 50 women giving birth in NJ each month, and who are randomly selected for the PRAMS survey while representing the various racial and ethnic populations in the state. Information from PRAMS has been used to design the NJ Healthy Women, Healthy Families program, which provides Doula care, Community Health Worker (CHW) services, and more services with the potential to impact MCH policy and practice throughout the state.

Secondly, the MCH Epi Unit houses the Fetal-Infant Mortality Reviews (FIMR) program, through which the NJDOH has agreements in place with three MCHC to conduct FIMR at the regional level across all counties within their respective catchment areas. After reviewing the cases, the region-based FIMR programs identify ways to strengthen the systems of care and resources available to families to prevent future deaths. The FIMR team utilized death data and made recommendations to the Action Teams, which in turn will implement the recommendations aimed at preventing other infant and fetal deaths in NJ.

Thirdly, the MCH Epi Unit houses the Maternal Mortality Review Committee (MMRC) to view all maternal deaths in the state and disseminates findings via reports to stakeholders including hospitals, clinics and community-based organizations. The team engages thematic analyses of the interviews conducted with family members who have experienced a maternal death. Through the maternal reviews and the interviews, the team synthesizes their findings into a list of recommendations that can potentially aid in implementing multiple quality improvement initiatives to improve the safety of pregnant women throughout the state.

The MCH Epi team is consulted for any data-related inquiry or assessment. The data collection efforts of our epidemiologists are informed and increased based on the contemporary needs of the programs. Working in conjunction with this unit is the NJDOH Maternal Data Center (MDC), which produces a legislatively mandated Hospital Report Card, housing the following data for each hospital in the state:

1. the number of vaginal deliveries performed;
2. the number of cesarean deliveries performed; and
3. the rate of complications experienced by a patient receiving maternity care:
    a. for a vaginal delivery, which shall include the rate of maternal hemorrhage, laceration, infection, or other complication as prescribed by the Commissioner of Health; and
    b. for a cesarean delivery, which shall include the rate of maternal hemorrhage, infection, operative complication, or other complication as prescribed by the Commissioner of Health.

The NJDOH MDC also aims to assure data regarding maternal health and related outcomes are transparent to policy makers, consumers, and relevant stakeholders in NJ, through dissemination of data visualizations focused on the maternal health ecosystem and CHF.

Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

The MIECHV nurse home-visiting program assesses the program's strengths and needs through various quantitative data points that align with the six required benchmark areas. These include monitoring improvements in **maternal and newborn health** (e.g., tracking the percentage of mothers receiving postpartum care within 8 weeks and breastfeeding rates at 6 months), **child injuries and maltreatment** (such as monitoring safe sleep practices and injury-related emergency department visits), and **school readiness** (including the percentage of children screened for developmental delays and early language activities). Additionally, MIECHV monitors **family economic self-sufficiency** through data on primary caregiver education completion and continuity of health insurance coverage, focusing on **coordination and referrals**, measuring the completion of referrals for depression, developmental delays, intimate partner violence, and substance use. These data points help the program staff evaluate how effectively the program meets the needs of families, supports positive outcomes, and identifies areas where we need to increase our efforts. Regularly reviewing these metrics ensures continuous improvement in at least four of the six benchmark areas, as HRSA requires.

Children and Adolescent Health Program (CAHP)

Currently, the CAHP uses quantitative and qualitative data to measure overall program impact, individual program impact and trends in public health issues such as mental health, suicide, adolescent pregnancy and adolescent and young adult sexually transmitted infections (STI) rates. To measure overall public health program impact, multiple surveys capture individual level unmatched responses of participant demographics, satisfaction with programs and responses to behaviors such as engaging in sexual activity, exposure to sexual violence, parent/caregiver involvement and access to supportive adults other than parents/guardians. To measure individual impact, some evidence-based models use matched pre- and post-surveys that capture participant demographics, safety and belonging, protective factors, academic status, sexual activity and other health behaviors; through an online database the CAHP can see both the aggregate and individual impact of program delivery on participants. Finally, the CAHP uses trend data from multiple sources including The Youth Risk Behavioral Surveillance (YRBS) Survey, the NJ Municipal Revitalization Index (NJ MRI) and NJ State Health Assessment Data (NJ SHAD) to observe data related to adolescent pregnancy, suicide and STI rates among adolescents and young adults. These data are used primarily to identify locations, populations and geographic areas where adolescents and young adults are at higher risk for poor health outcomes due to multiple factors. Combining these metrics with program impact and individual impact data, the CAHP can identify which programs, and their precise geographic areas, will provide the most impact to NJ adolescents and young adults. These data also help determine changes to RFA’s that are released to the public for funding.

Postpartum Resources and Support Network Program (PRSN)

The primary goal of the PRSN is to enhance postpartum resources and service delivery through a statewide approach. This includes administering education and training for community providers to improve Perinatal Mood and Anxiety Disorder (PMAD) screening and ensure appropriate referrals to support services. A secondary goal is for grantees to educate and engage birthing individuals and their families on the signs and symptoms of PMADs, the importance of screening, and connecting to care—ultimately reducing the stigma associated with perinatal mental health conditions and improving maternal health outcomes. NJPRSN grantees support the maternal health population by providing free access to support groups and connecting individuals in need to MCH mental health providers.

The MCH programs use quantitative data methods and analysis to determine the strengths and needs of our program. The NJ PRSN grantees have relationships with hospitals, clinics, and community health centers to gather information on birthing individuals. Hospital discharge information is used to track at-risk of postpartum depression. In addition, peer support data are collected to ensure birthing individuals engaged and connected with resources. Behavioral risk factors surveillance help identify trends, and high-risk populations.

The Doula Learning Collaborative (NJDLC)

To assess training needs, NJDLC relies on quantitative NJ FamilyCare (NJFC) claims data, which maintains the number of doulas currently enrolled as NJFC Community Doula Providers, the number of Doula-only Agencies, and the number of doula-assisted births. There are over 2.2 million children, adults, and pregnant women currently receiving Medicaid benefits in NJ. There are approximately 100,000 births per year in NJ, and NJFC covers approximately 30,000 births each year, or about 30% of the births in the state. To date, there are 112 doulas enrolled as NJFC Community Doula Providers and serve doula-only organizations providing doula care services in NJ.

Healthy Women/Healthy Families

For the Healthy Women, Healthy Families program, quantitative data on the number of women enrolled in the CHW and postpartum doula programs are collected at the municipality, county, regional, and state levels. Data on referrals and successful referrals to needed resources are accessible for the women enrolled in the program and is analyzed by service type/resource need as well. In addition, quantitative data collection through various health, pregnancy, and postpartum assessments offers information on our clientele and the MCH population, shedding light on indicators like number of clients who utilize Medicaid and public benefits and other maternal health indicators like breastfeeding status.

ConnectingNJ

The ConnectingNJ system has been created as a network of partners and agencies dedicated to helping NJ families get connected to the resources and information needed to raise healthy children. Connecting NJ utilizes a county-based, single point-of-entry system that simplifies and streamlines the referral process for obstetrical and prenatal care providers, community agencies, and families.

The Connecting NJ data system, CNJ Link, collects information on incoming referrals to the system by county, referring providers, pregnancy status, and race and ethnicity. In addition, the system displays service referrals and program assignments categorized by resource need/service type such as healthcare, family and social support, nutrition, public benefits, etc. These quantitative data allow for analysis of the needs of the MCH populations Title V serves, including targeted analysis by county level, race/ethnicity, and pregnancy status. In addition, data on successful referrals and connections are available to analyze outcomes and determine whether MCH populations are getting connected to the resources they need.

Colette Lamothe-Galette Institute (CLGI)

Our CLGI trains CHWs in the state and tracks the demographics of those recruited and trained to endorse demographic parity with the clients they serve. These characteristics are maintained in a secure database and used for program planning purposes.

SIDS

The Sudden Infant Death Syndrome (SIDS) Center of NJ collects vital statistics, on sudden deaths in the first 12 months of life that remain unexplained, to analyze trends in infant mortality concerning sleep-related deaths falling under the umbrella Sudden Unexpected Infant Death (SUID), which is comprised of SIDS, Ill-defined and Unknown Causes, and Accidental Suffocation and Strangulation in Bed.

CSHCN

NJ’s CSHCN work is housed under the Special Child Health Services Unit and as it includes newborn screening programs and mandated condition-based registries; the prevalence of many health conditions are tracked using our registries. These data are combined with birth and death files and other administrative data sets such as hospital billing data to help us better understand where children are located relative to service sites, how often they utilize emergency services or need in-patient care. Because the unit links children to case management services, additional quality of life measures, population need for services, and outcome data for those children who participate in that voluntary service are limited. While this provides some insight into children's needs over time, the unit is moving to more active, long-term follow for selected conditions. Additionally, the unit examines demographic data for our served population and compare to the overall population data for those locations to those who we are potentially underserving. Moreover, the unit analyzes data to determine the impact of known and suspected risk factors for selected conditions such as autism, birth defects with known teratogens, and environmentally sensitive disorders. In this way, we can support prevention initiatives and support early screening programs.

Beyond the quantitative data resources, the unit engages in direct conversations with service providers, stakeholders, and families. As part of our TVP, the unit provides financial support for specialty providers, while also routinely conducting meetings with grantees; not only to assess their services and use of funds, but also to discuss changes that they see within their clients and the communities they serve. These observations are extremely useful to alerting leadership about potential impact such as services closing or potentially no longer accepting Medicaid. For some providers, they can internally adapt and thereby decrease negative impacts to the children they serve. These conversations also allow the unit to potential shift our funds as populations shift across the state. For instance, in the past several years, housing costs have driven younger families further south in the state as the housing costs in the norther counties has increased. Stakeholder agencies also provide helpful insights about family needs, experience with providers, waiting times for evaluations and other needs which the unit might be able to assist with. Most importantly, we routinely hear from families via our case management system in two ways; family input to the case managers and direct family input via surveys and focus groups us shape services so that they are more accessible and more closely fit the needs of the family.

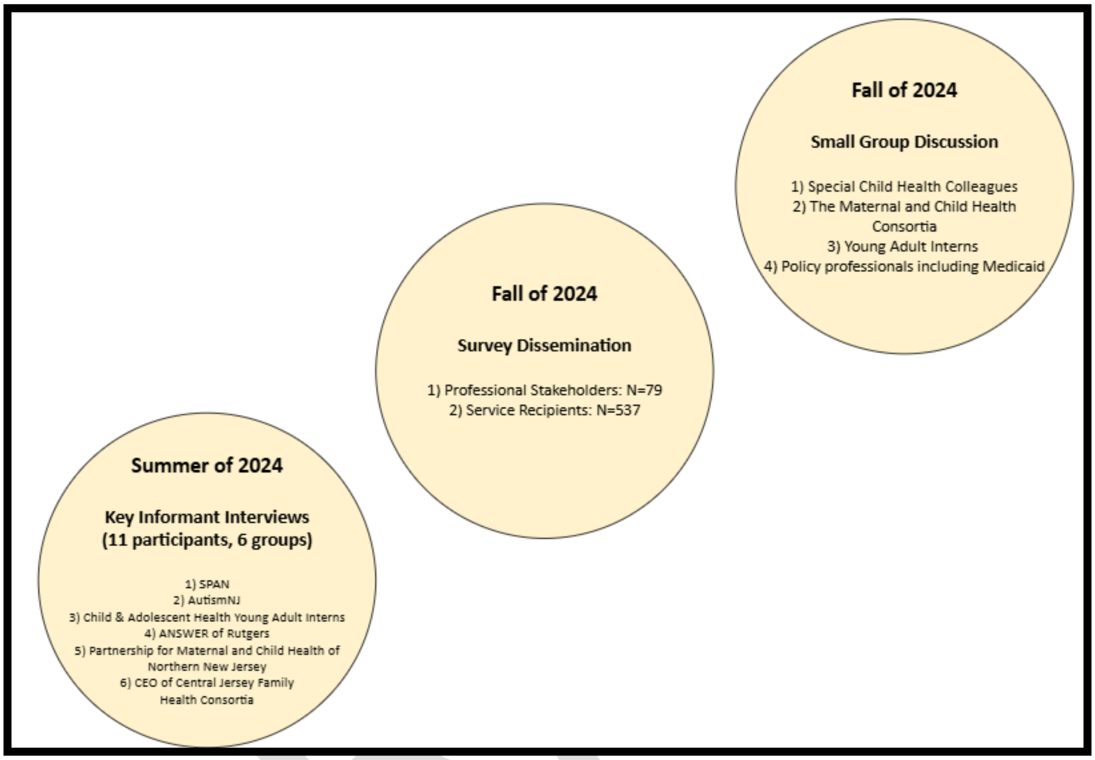
Primary Data Collection

Engaging Stakeholders including Professionals and Service Recipients

As the needs assessment process initiated and the T5NA team solidified a timeline and strategic plan, one of the primary aims was to solicit feedback from both professional stakeholders and service recipients. The feedback process was deliberately planned to involve stakeholder involvement throughout all the phases of needs assessment process. This process was guided by the NJDOH Work Group and supported by the Steering Committee.

There were three, distinct phases of feedback during the T5NA process. The first process engaged key informants from the community who typically engage with service recipients in a variety of roles. The second process of engagement was marked by the release of our Title V Needs Assessment Discovery Surveys; one draft crafted for professional stakeholders and one draft crafted for service recipients and in English and Spanish. These surveys were disseminated to service recipients vis-à-vis work group staff, steering committee participants and posted on the WIC shopper website. During this second phase, the T5NA Lead met with all the CSHCN Case Managers of the Family Centered Care Program (FCCP) during their quarterly meeting, to gather feedback regarding their work managing caseloads of children engaging with the special child health programs. This second phase of the process overlaid with the third phase of the process, during which five small group discussions were facilitated with professional stakeholders representing each of the five population health domains. The primary data collection process began in June of 2024 and completed in December of 2024 (Figure 20).

Figure 20. Primary Data Collection & Information Gathering for the Needs Assessment



Qualitative Data Analysis

Thematic content analysis was done via an inductive approach for all the interviews conducted. For the Discovery Surveys, the open-ended questions were also analyzed and categorized using an inductive approach. The Title V MCH summer interns input the transcripts into word document and excel forms for review. The lead of the MCH Needs Assessment conducted the initial review of qualitative data and initially tagged themes throughout the content narrative. The interns then re-reviewed the themes to ensure thematic saturation and discussed the findings with the T5NA team.

Key informant interviews

The key informant interviews consisted of five groups of professionals, with representatives from each population health domain including Women/Maternal Health, Perinatal/Infant, Child Health, Adolescent Health, CSHCN & Cross-Cutting/Systems Building; see below table (Table 4) for related positions and organizations.

Table 4: Key informant interview participants

Position/Organization
COO of Partnership for MCH in Northern NJ
CHES Training & Technical Assistance Manager at ANSWER
Director of Information Services at Autism NJ
Project Director for Family-to-Family Health & Parent-to-Parent NJ Affiliate, SPAN
State Coordinator at Family Voices NJ, SPAN
Project Director at Early Health and Detection Intervention, SPAN
Project Director at Family WRAP/Special Child Health Services Case Management, SPAN
Community Health Worker/Doula & Project Director for Family Leave, SPAN
CEO of Central Jersey Family Health Consortium
NJDOH Youth Lead Intern
NJDOH Youth Lead Intern

The questions asked during these interviews focused on professional experiences of working within the MCH realm in NJ. Specific questions included, “What do you think is going well for women, children, CSHCN and families in the state?” and “Over the past five years, what was missing but could have potentially improved the quality of services you delivered to the community?”

Responses ranged, but some key themes emerged. When asked, “What do you think is going well for women, children, CSHCN and families in the state?”, each group of professionals repeated the themes of **service area increase *and* additional support for families in the state.** A **s**econdary theme that emerged, and specifically in the group of professionals who work with and alongside CSHCN, included a **strong affirmation of the funding** and a **need for continued fiscal support** that is received from Title V to do the work in the community, which additionally helps to mobilize families across the state.

When asked, “Over the past five years, what was missing but could have potentially improved the quality of services you delivered to the community?”, a thread of themes emerged between all groups interviewed, including **possibility for virtual engagement of providers, increased awareness of MCH services, and overall expansion of services.** A secondary theme that was cited a few times was that of a need for **increased mental health support for families in the state**, and, most importantly, the ones that experience the worse health outcomes including those who are uninsured or underinsured, people of color and CSHCN.

FCCP Quarterly Meeting Feedback

Each of NJ’s 21 counties maintains a Special Child Health Services (SCHS) Case Management Unit (CMU). These programs are funded by the NJDOH and each county’s Board of

Commissioners. Their mission is to promote access to preventative and primary care for CSHCN from birth up until their 22nd birthday. During the fall of 2024, the T5NA lead attended a quarterly meeting to review Title V funding and gather feedback from the state's FCCP Case Managers.

The goal of SCHS-CMU is to provide comprehensive, coordinated, culturally competent case management services for families with CSHCN. These case managers are either Nurse professionals or Social Work professionals and are situated in all 21 counties of the state.

With parental consent, SCHS-CMU works with the child's parents, physician, and/or specialists to evaluate the strengths and needs of the affected child and develop and individual service plan (ISP) for the child and family. The ISP targets the medical, educational, rehabilitative, developmental, social, emotional, and economic needs of the child and family.

All NJ residents with Special Health Care Needs or at risk for Developmental Delay and are age 21 and younger are eligible for SCHS Case Management. Many of these children will have been/need to be registered with the New Jersey Birth Defects or Autism registries. Registrations can be completed by hospitals, physicians, dentists, audiologists, certified nurse midwives, advance practice nurses, cytogenetic laboratories, and directors of clinical laboratories.

Several important themes emerged during the small group discussion and subsequent share-out of the FCC Case Managers. In response to the question, "What are the most prevalent and contemporary needs of CSHCN in NJ", the following themes were most-often cited:

- Access to specialty providers (Ot/PT/psychotherapist)
    - Mental Health
- Need for clinical, diagnostic and developmental providers
    - Waiting over a year for Autism Dx
- Lack of insurance coverage
- Transition: dealing with multiple systems with different levels of engagement/expectations
- Dearth of outpatient specialists
- Access to Children's System of Care
- Counseling/emotional behaviors. Therapists who work with developmental disabilities are needed.
- Translation services are high need. Immigrant families are in a liminal space between needing and acquiring services.
    - Transportation and waitlists for providers are longer for immigrants
- Transition: having to deal with multiple systems; lacking cohesion
- Different Medicaid MCOs- navigating them. Provider network/lack of providers, continuity if care (ex; transferred to another hospital)

Discovery Survey Dissemination

The final phase of the primary data collection efforts included the dissemination of a Discovery Surveys. A Discovery Survey is a general survey disseminated to gather the needs or desires of a a population. There are two main purposes of a Discovery Survey: one, to solicit feedback from the community directly and, secondly, to use as a tool to evaluate reach and inclusivity. Two versions of the Discovery Survey were available for approximately eight weeks in the fall of 2024; one directed toward Professional Stakeholders, and one directed toward Service Recipients. The Service Recipient survey was translated into English and Spanish for respondents.

Professional Stakeholder Responses

First, the survey was distributed to Professional Stakeholders in the state, with 79 professional stakeholders responding. The distribution of professional representation was quite large, with professionals from healthcare organizations and community based or non-profit organizations representing most of the respondents. Concomitantly, the professionals surveyed engage with all populations in the five health domains, although the more than half of respondents worked with CSHCN and/or identified as parents, caregivers or guardians.

Service Recipient Responses

The Service Recipient survey was aimed at gathering feedback from community members and those that receive services or access programming from Title V-funded programs. The Service Recipient survey was made available in English and Spanish, with a total of 551 respondents. Of those, 347 respondents recorded answers in English and 204 respondents recorded answers in Spanish. Important to note is that the language is which respondents input information in the survey is not a proxy for an ethnic or racial group identification.

Survey respondents were represented across the three most prevalent racial categories in NJ, although not equally representative of the entire NJ population: non-Hispanic Black, Hispanic or Latin/a/x, and non-Hispanic White. However, the racial group with the highest response rate was that of Hispanic or Latin/a/x (~30%), followed by non-Hispanic Black (23%) and non-Hispanic White (11%). The survey recipients were not representative by sex, with ~90% of all respondents identifying as a woman. Most respondents were between the ages of 25 and 44 years old.

The demographic questions included in the survey were entirely optional and to provoke comfortability while engaging with the survey, resulting in skewed understanding of respondent demographics.

Discovery Survey Results and Analysis

Thematic threads exist in the narratives that were offered both by Professional Stakeholders and Service Recipients. These primary threads included the following:

- Increasing access to transportation/mobility help

- Improving accessibility and communication/linguistic capabilities of providers
- Improving training/education and support opportunities for professionals (clinical to allied)
- Greater telehealth accessibility
- Eliminating discrimination in service provision
- Diversifying the workforce to enhance competencies and increase provider/client parity
- Streamline application processes
- Improved health and mental health services
- More education and awareness about services in the state

Plan for Continued Service Recipient Engagement

To maintain engagement with community members, all service recipients were invited to de-identify themselves by providing their contact information to receive continued communication about the process, and to engage as a part of the Service Recipient Steering Committee. In total, 62 people responded, and have been contacted for an initial meeting to discuss ongoing engagement regarding the MCH Title V Block Grant.

Small Group Discussion

During the small group discussions with professional stakeholders, several themes emerged. When asked, “What do you think is going well for birthing people, children, children with special needs, and families in the state?”, **support** and **service area increase** were the two main themes that emerged. When asked, “Over the past 5 years, what was missing but could have potentially improved the quality of the services you delivered to the community?”, **addressing gaps in health outcomes, connecting patients to quality and appropriate care providers and increased collaboration amongst private and public partnerships** were the main themes that emerged. When asked, “What improvements would you like to see in MCH programming in the next five years?”, the primary themes that emerged included **more funding, communication, and accessible technology.**

When asked, “What feedback have you heard from the population you serve about the quality of care they receive from their providers?”, the professional stakeholders reported on three consistent themes in their reports; **inappropriate/sub-par communication, systemic discrimination and mistrust in providers.**

Prioritization Stage (Figure 21 & Figure 22)

Once data were collected, the TVP discussed ways to thematically organize and ultimately prioritize the themes that emerged in the data capacity stage. Our stakeholders and TVP leadership helped guide the prioritization work and determine methodology. The initial questions asked included:

- How can we engage families, communities, and stakeholders in prioritization?
- What criteria will we use for criteria-based ranking? How will the criteria be decided on?
- Who will manage the collection of data?
- What materials will need to be created for each prioritization activity?

Figure 21. Prioritization Stage

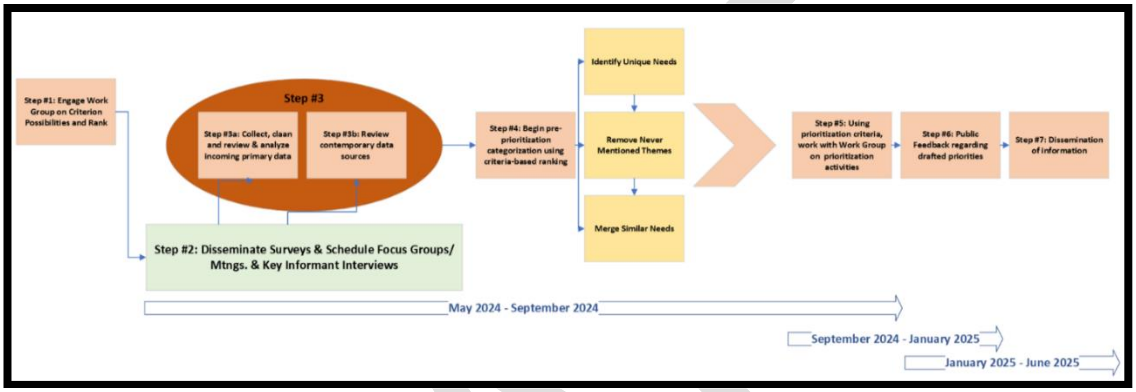
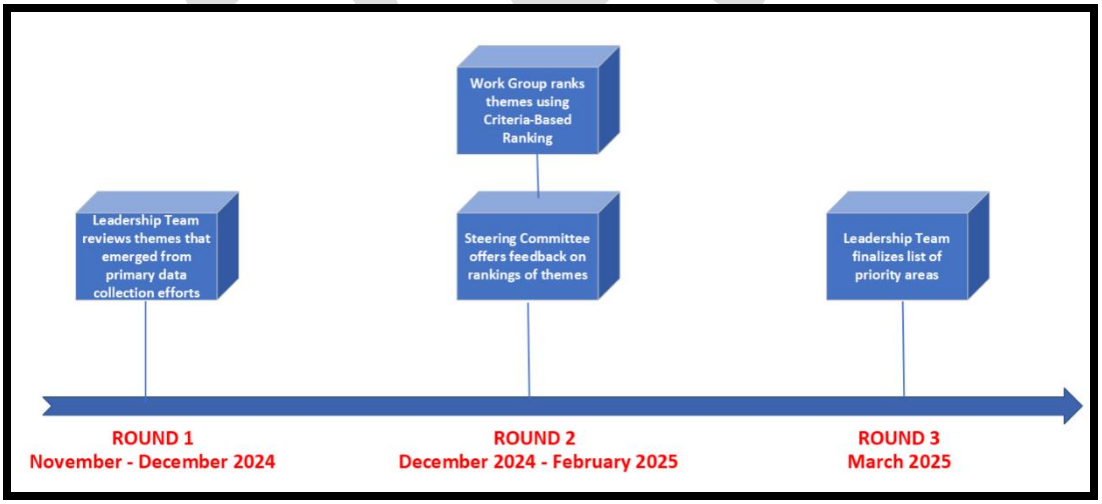


Figure 22. Timeline of Prioritization Activities for NJ



Criteria-Based Ranking Approach

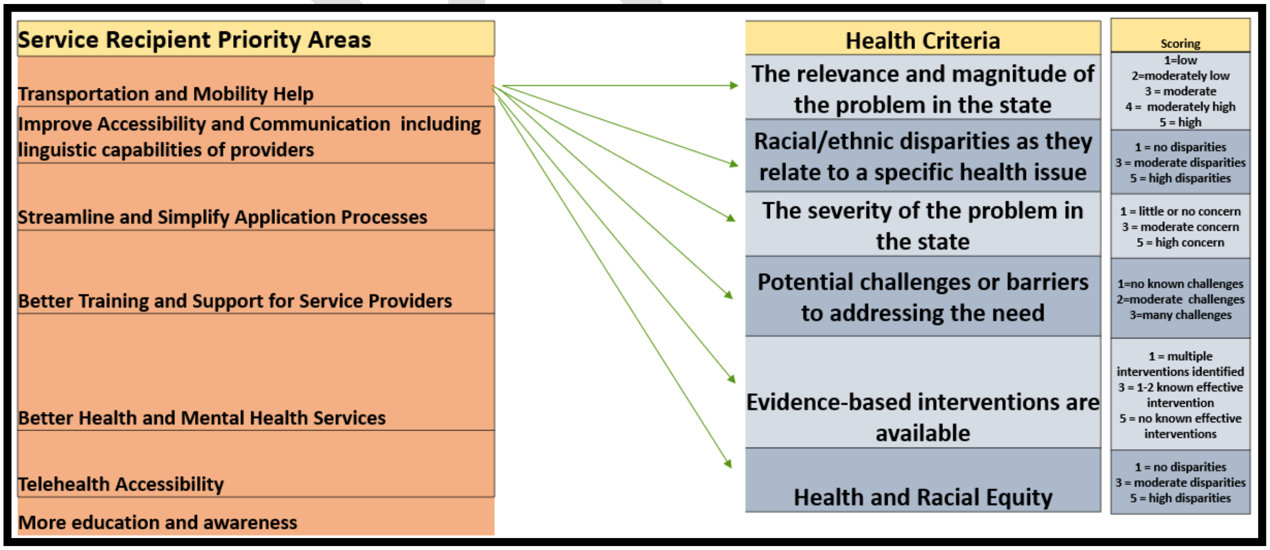
Each member of the Needs Assessment Leadership Team scored each potential Title V priority area from 1 (low priority) to 5 (high priority) and included two types of prioritization criteria: that of *Health Need* (Figure 23) and that of *Structural/Political* (Figure 24) factors that can support or impede change. The TVP decided to further develop prioritization criteria after a meeting where prioritization themes were discussed, and challenges associated with broad themes emerged. Primarily, the recognition by the TVP that a need can be high in any given area of the state, but, if political will and resource allocation is limited or non-existent, the priority will likely not be addressed; at least, not in a timely way.

Criteria-Based Ranking Prioritization Criteria included:

Health Need:

1) Population differences as they related to a specific health issue
2) The relevance and magnitude of the problem in the State (the number of people who are impacted and a top issue for communities in the state)
3) The severity of the problem in the State (the level of concern related to the issue at hand)
4) Consequences of not intervening
5) Potential challenges or barriers to addressing the needs (what may get in "the way" of completion)
6) The severity of the problem in the State (the level of concern related to the issue at hand)
7) Unexpected outcome of intervention

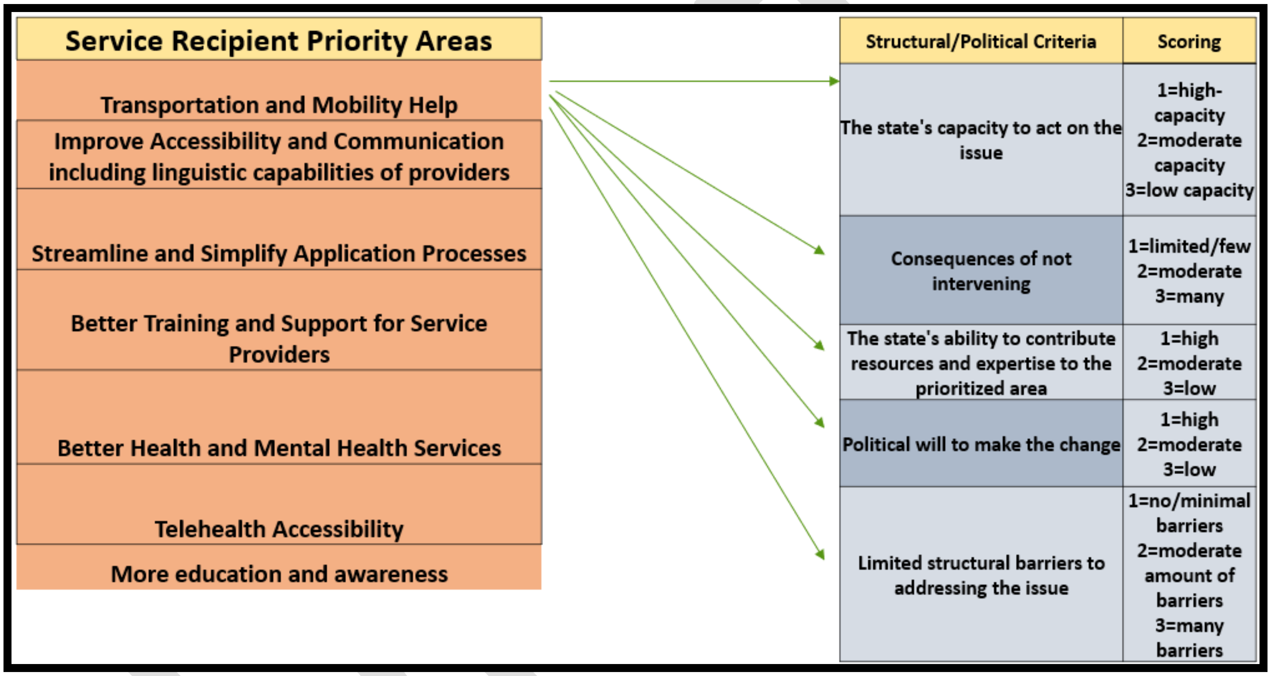
Figure 23. Example of Prioritization Process of Priority Areas using Health Criteria



Structural/Political:

1) The State's capacity to act on the issue (the resources, financial and person power + time to address the issue)
2) Consequences of not intervening (short, medium and long-term)
3) The State's ability to contribute resources and expertise to address the prioritized area (ability for multiple stakeholders to dedicate resources to the intervention)
4) Limited structural barriers in addressing the issue (approval processes as barriers, little or no legislative backing for the issue, etc.)
5) Political will to make the change (current political landscape regarding this theme)

Figure 24. Example of Prioritization Process of Priority Areas using Structural/Political Criteria



Service Recipient Priority Areas
Transportation and Mobility Help
Improve Accessibility and Communication including linguistic capabilities of providers
Streamline and Simplify Application Processes
Better Training and Support for Service Providers
Better Health and Mental Health Services
Telehealth Accessibility
More education and awareness

Structural/Political Criteria	Scoring
The state's capacity to act on the issue	1=high-capacity 2=moderate capacity 3=low capacity
Consequences of not intervening	1=limited/few 2=moderate 3=many
The state's ability to contribute resources and expertise to the prioritized area	1=high 2=moderate 3=low
Political will to make the change	1=high 2=moderate 3=low
Limited structural barriers to addressing the issue	1=no/minimal barriers 2=moderate amount of barriers 3=many barriers

III.C.1.ii.e. Consultation with other Needs Assessments & Data Capacity Efforts Aimed at Improving MCH

Limitations exist to the information we have gathered during this specific T5NA process, chiefly, the skewed demographic representation of survey respondents, including lack of participation from key segments of the populations, such as fathers/partners of pregnant and parenting women. However, NJ has engaged in both local needs assessment efforts and a larger strategic planning process focused on improving outcomes for birthing people and their families in the recent past, of which the results help to enhance our understanding of the needs of the Title V populations in NJ.

Local Needs Assessments

The NJ DCF partners with human services organizations in each county to undertake an assessment of local strengths and needs. The goal of these assessments was to collect the information needed to make sure the right mix of services and activities are available in every county in NJ to support families. In a coordinated effort to understand the needs of families in each county, DCF funded county Human Services Advisory Councils (HSACs) to undertake an assessment of local needs. Counties are charged with gathering information related to local basic and service needs, social connections and community networks, and gauging the impact of those needs on subpopulations, trends in needs over time, key barriers to service delivery and considerations for action. Data from all 21 County HSAC Needs Assessment Reports were analyzed and consolidated into a synthesis report by the Institute for Families at Rutgers School of Social Work. The most recent data available are from FY2025.

County HSACs conducted these needs assessment that consisted of three components: a standardized survey of need areas provided by DCF, focus groups conducted with specific sub-populations, and key informant interviews conducted with need area experts. DCF provided each HSAC with a county data profile and needs assessment guidance and instruments (i.e., surveys, focus group and key informant interview protocols, etc., as well as technical assistance.)

As a starting point, DCF and human services leadership defined 13 total need areas, which were felt to be the pressing needs at the time. The six basic need areas identified were housing, food, health care, community safety, employment, and career services, childcare. The seven specialized service need areas were services for families caring for a child of a relative, behavioral/mental health services for children, behavioral/mental health services for adults, substance use disorder and prevention services, domestic violence services, parenting skills, legal and advocacy skills. From these, the County HSACs identified two priority basic need areas and two priority specialized need areas.

Participants involved in this process made several important recommendations to improve services, and ones which emerged in our T5NA process. These themes included increasing awareness of local services, increasing cross-sector collaboration. Finally, participants recommended tailoring services to meet the needs of diverse populations, including expanding service delivery to underserved areas and increasing cultural competence and multilingual services.

NurtureNJ

On Maternal Health Awareness Day 2019, Nurture NJ, a statewide awareness campaign committed to both reducing maternal and infant mortality and morbidity and ensuring equitable care among women and children of all races and ethnicities, was launched. This campaign has focused on improving collaboration and programming between all departments, agencies and stakeholders to achieve our goal of making NJ the safest and most equitable place in the country to give birth and raise a baby.

The Nurture NJ Strategic Plan is the culmination of over a year of in-person and virtual meetings with our departments and agencies, health systems, physicians, doulas, community organizations, and most importantly, mothers and their families.

NurtureNJ is a statewide awareness campaign committed to both reducing maternal and infant mortality and morbidity while ensuring equitable care among women and children of all races and ethnicities. This campaign has focused on improving collaboration and programming between all departments, agencies and stakeholders to achieve the goal of making NJ the safest and most equitable place in the country to give birth and raise a baby.

Nine Action Areas for the Nurture NJ Strategic Plan include:

1. Build racial infrastructure and capacity
2. Support community infrastructures for power-building and consistent engagement in decision-making
3. Engage multiple sectors to achieve collective impact on health
4. Shift ideology and mindsets to increase support for transformative action
5. Strengthen and expand public policy to support conditions for health in NJ
6. Generate and more widely disseminate data and information for improved decision-making
7. Change institutional structured to accommodate innovation and transformative action
8. Address the social determinant of health
9. Improve the quality of care and service delivery to individuals

NJ's Breastfeeding Strategic Plan

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

Recognizing breastfeeding as an important prevention effort for a multitude of health issues, the NJDOH and FHS have committed to working alongside partners throughout the state to bring this strategic plan to fruition. A few of the notable successes of the program include:

- Increased WIC lactation support positions to two full-time staff members and expanded the role of the statewide WIC Breastfeeding Coordinator to include greater outreach to state healthcare provider organizations and nutrition programs and other maternal child health partners.
- Developed a WIC emergency plan that ensures seamless transition of WIC nutrition and breastfeeding support services to remote services during public health crises.
- Fully transitioned WIC benefits to Electronic Benefits Transfer (EBT) cards.
- Expanded texting capabilities to enhance delivery of nutrition and administrative communications and breastfeeding counseling with WIC clients.

NJ’s 2025 Priority Needs

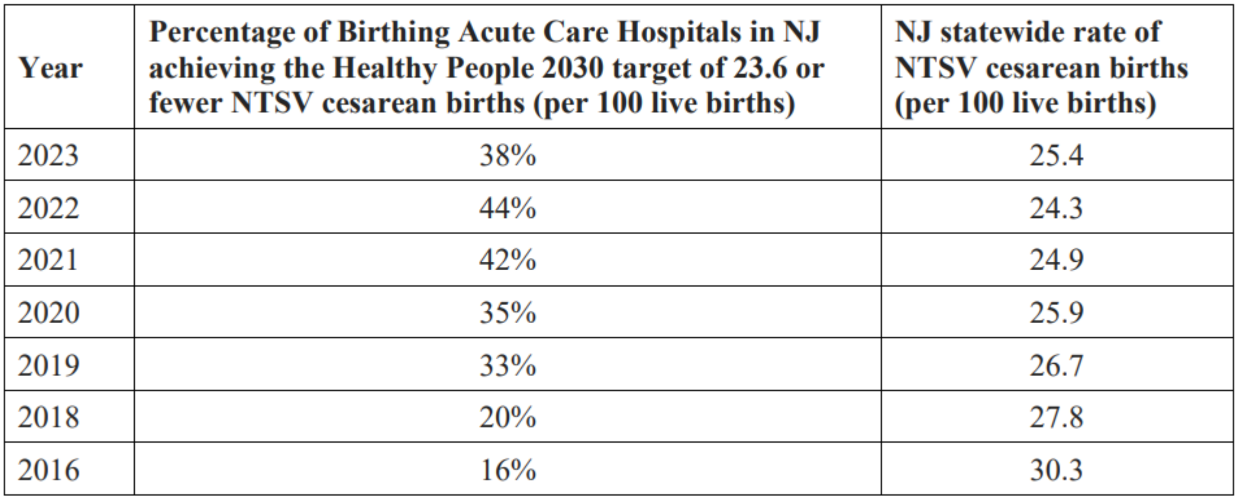
Quantitative Overview

The health of a state is directly related to the health of its mothers and babies. Some primary markers of MCH include rates of obstetric hemorrhage, post-admission infections, and SMM with transfusion at the hospital level. According to our MDC 2023 report, the racial and ethnic profile of NJ mothers is changing, whereas in 2000, approximately 46% of all births were to women of color, as of 2023, approximately 55% of all births were to women of color in the State. Several markers of postpartum health shifted from 2022; obstetric hemorrhage rates increased from 58 to 52 per 1,000 delivery hospitalizations in 2022; post-admission infections to 22 from 21 per 1,000 delivery hospitalizations in 2022; and severe maternal morbidity (SMM) with transfusion to 25 from 23 per 1,000 delivery hospitalizations in 2022. Additionally, delivery complication rates by race/ethnicity in 2023 impacted non-Hispanic Black and Hispanic mothers more so than their non-Hispanic White counterparts, as non-Hispanic White mothers had the lowest rate of severe maternal morbidity (SMM) at 17.7 per 1,000 delivery hospitalizations.

Non-Hispanic Black birthing people had the highest rate of obstetric hemorrhage (68.2 per 1,000 delivery hospitalizations, an increase from 64.9 per 1,000 delivery hospitalizations in 2022). Hispanic birthing people had the second highest rate of 57.2 per 1,000 delivery hospitalizations). The lowest rate was among Other/Multi-race birthing people at 50.2 per 1,000 delivery hospitalizations.

The rate of cesarean births among nulliparous (first time birthing people), with a term (37 or more completed weeks of gestation), singleton (one fetus), in a vertex position (headfirst presentation of the fetus), or NTSV cesarean births, slightly increased to 25% in 2023 from 24% in 2022. The percentage of birthing acute care hospitals in NJ that achieved the U.S. Department of Health and Human Services Healthy People 2030 target of 24% or fewer NTSV cesarean births decreased to 38% in 2023 from 44% in 2022. Please see Table 5 below for additional details.

Table 5. Longitudinal hospital achievement toward Healthy People 2030 cesarean section rates



Year	Percentage of Birthing Acute Care Hospitals in NJ achieving the Healthy People 2030 target of 23.6 or fewer NTSV cesarean births (per 100 live births)	NJ statewide rate of NTSV cesarean births (per 100 live births)
2023	38%	25.4
2022	44%	24.3
2021	42%	24.9
2020	35%	25.9
2019	33%	26.7
2018	20%	27.8
2016	16%	30.3

Qualitative Overview

According to the 2021-2022 National Child Health Survey data, 82.3% of families with a CSHCN reported having FCC and 79.1% had a usual source of sick care; however, only a third felt they had a medical home.

Only a third of families said they have no difficulty getting referrals, and only 43% said they have the care coordination that they need. Although NJ has many providers, unfortunately only 11% felt the state have a well-functioning system. Consistent with national results, only 36.1% of families met all the “flourishing” criteria.

The State’s ability to surveil newborns, register any birth defects and autism diagnoses as well as track follow-up connections makes NJ a unique state regarding the robustness of services provided to the CSHCN population. The Birth Defects Registry mandates that all NJ residents’, birth through the age of five who have a congenital birth defect, are registered with the NJDOH. Concomitantly, a law was passed in 2007 to require all children through the age of 21 with an autism spectrum disorder to be registered. The SCHS staff work with all of licensed health care providers and facilities about their role and responsibility in this process.

Nine Title V 2026-2030 priority areas were identified during the prioritization process. Unsurprisingly, many of the priority needs reported during this needs assessment overlay with priority needs from the past five-year grant cycle. Nevertheless, the themes elevated through the primary data collection process reiterated the need for a focus on expansion of services, health equity and CHF.

The nine priorities are:

- **Access to Transportation and Mobility Services:** Supporting families in mobilizing on their activities of daily living
- **Access to Translation/Interpretation Services:** Supporting the diverse, non-English heritage speakers of our state in receiving and understanding critical information about their health
- **Improving the Accessibility of Services:** By improving application processes and facilitating connection to care
- **Better Training and Support for Service Providers:** Chiefly, for CSHCN
- **Improved health and mental health services:** Ensuring all people living in NJ have the opportunity to reach their full health potential
- **Diversify the Workforce to Enhance Cultural Competency of Providers:** Related to the second priority, ensuring provider parity may help to sustain patients in care
- **Telehealth Accessibility:** Ensuring comprehensive, quality care is available for all to access
- **Increased Education and Awareness of Services:** Ensure available services are marketed and in various languages

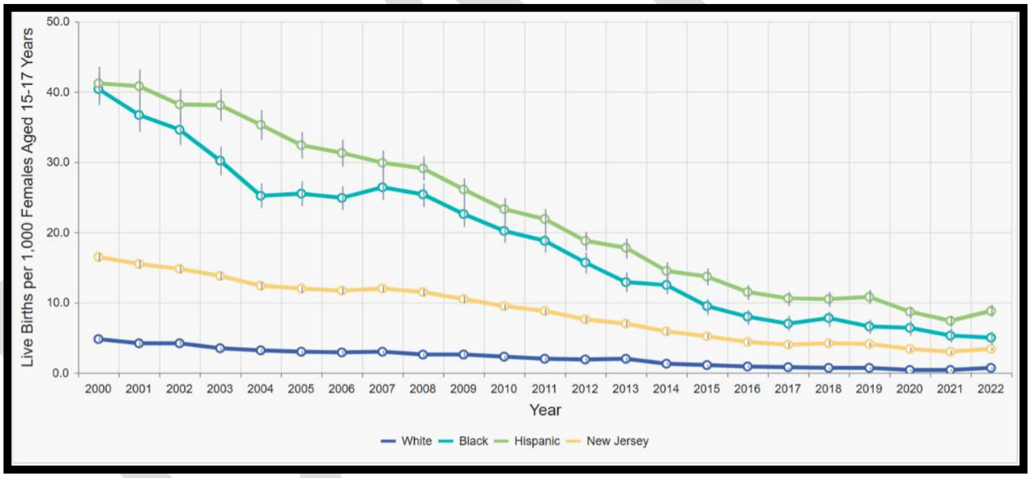
Interface between the collection of the Needs Assessment data, the finalization of the state's Title V priority needs, and the development of the State's Action Plan

The Needs Assessment data further informed NJ's ongoing efforts to bolster the MCH service landscape of the state. Many of the state priority needs (SPNs) remained the same from last grant cycle due to the continued efforts of many of our programs, strategized on in past years and with a longitudinal aim of decreasing rates of negative health outcomes and increasing positive health outcomes for the five population health domains. In other words, the needs assessment reiterated the state's continued mandate to address major health outcomes in our state for women, infants, children, CSHCN and adolescents.

For example, *Increasing Healthy Births*, and *Reduce Black Maternal and Infant Mortality by Expanding & Strengthening Evidence-Based Programs Addressing Black Infant Mortality* remain high on our state's priorities as the outcomes between populations in both categories continue to persist, leaving women of color at higher risk for negative health outcomes during pregnancy and after delivery as compared to their White non-Hispanic counterparts. Additionally, *Promoting Healthy Youth Development over the course of Childhood, Adolescence and Young Adulthood (AYA)* remains a focus for our state as we have seen the positive impact of early education related to sexual health, emotional health and physical well-being pay dividends in producing well-developed and integrated young adults. Similarly, the SPN of *Improving Nutrition, Food Security & Increasing Physical Activity* aligns with the SPN of *Promoting Healthy Youth Development from Childhood Through Adolescence & Young Adulthood (AYA)* insofar that supporting early nutritional and physical development buffers against negative health outcomes over the course of life.

While Teen Pregnancy Rates in NJ have declined significantly overall over the last twenty years, rates have plateaued for young women of color and non-Hispanic White mothers in the recent years and have increased for Hispanic-identifying mothers between 2021-2022, the years we have the most recent data. Maintaining a focus on the SPN of *Promoting Healthy Youth Development by Reducing Teen Pregnancy & Sexually Transmitted Infections (STIs)* is paramount to continuing the decrease of teen pregnancy in the state and further diminishing the pregnancy and health disparities between different racial categories, affecting women of color at higher rates than their non-Hispanic, White counterparts (Figure 25).

Figure 25. Teen Birth by Race/Ethnicity, Ages 15-17 Years, NJ, 2000-2022



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

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

- Insufficient or excessive weight gain during pregnancy
- Mental health challenges, such as depression and anxiety

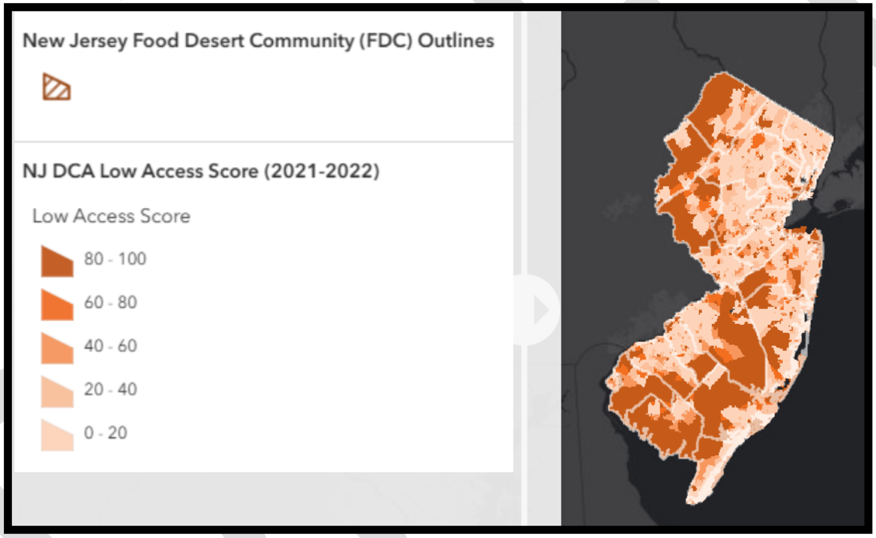
- Obesity
- Pregnancy complications, such as high blood pressure, anemia, or gestational diabetes
- Delaying or forgoing medical care due to competing financial demands, such as the need for food

For infants and children, food insecurity can contribute to:

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

Low Access Scores indicate the extent to which residents are underserved by supermarkets due to the lower income profile of their neighborhoods. [6]Residents of a block group with a higher Low Access Score typically travel longer distances to access a major supermarket than residents of a block group with a lower Low Access Score (Figure 26).

Figure 26. New Jersey Food Desert Map, 2021-2022



Source: Maternal Data Center website; February 2025

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

Evaluation of the T5NA Process

In the spring of 2025, the T5NA process lead conducted a process evaluation of the T5NA, with a specific focus on the use of a trauma-informed and intersectional lens during the process. This evaluation aimed to review the process of the needs assessment and gather information from work group members and steering committee members on ways in which the process could have strengthened.

Evaluation questions included:

- What are best or recommended practices for understanding community needs using a trauma-informed intersectional lens?
- In what ways did the needs assessment successfully apply a trauma-informed intersectional lens?
- In what ways could the needs assessment have been more trauma-informed, and intersectional in nature?

While some results varied, a few themes transcended the feedback. Respondents widely reported the importance of creating safe spaces, transparency, and trustworthiness in any feedback-gathering stage, and while simultaneously adhering to a trauma-informed, intersectional approach to the work. When asked ways in which the needs assessment successfully applied a trauma informed lens, respondents reported one way in which this happened when by facilitating a group with “diverse participants” at the table who, “represented various categories of professionals and points of view”. Moreover, some respondents stated that the space to discuss Title V was, “empowering” as it “provided different ways for people to feel comfortable sharing.” Respondents also reported that the lead facilitator’s ability to explain the process clearly helped to foster a safe space in which to share. One respondent reported that the collaboration and involvement of Cross-sector partners (e.g., public health, behavioral health, social services) were included to understand trauma holistically.

Some respondents reported that involving participants with lived experience in the design and facilitation process and providing follow-up support or resources would have made the process more trauma informed. Moreover, some respondents reported that the process could have been more intersectional by “more deeply analyzing how overlapping identities (e.g., race, gender, disability, immigration status) impacted access and outcomes”, and by “engaging a broader range of marginalized voices in data collection and interpretation.”

Continuous Quality Improvement

Working alongside the Steering Committee and T5NA Work Group, assets of the state, protective factors of various populations, challenges and opportunities were identified every step of the needs assessment process. This continuous process evaluation was complimented by the quality improvement expertise offered from members of the Work Group, the Steering Committee, TVS and Family Health Services (FHS) Leadership. During meetings, questions were asked, in both larger groups and smaller groups, such as, “How is the process moving along?” and “What can we be doing better during this stage of the process?” Additionally, with the T5NA Work Group, constituted by state-employed professionals working in the arena of

MCH, the list of questions also included, “What questions should we be asking service recipients to ensure we gather the information that would be most helpful?” For this reason, the Discovery Survey creation process took approximately four months, moving through a formal approval period and receiving feedback from various professionals at the NJDOH.

Lessons Learned

Planning and executing a needs assessment was elucidating and challenging. The amount of feedback given by both professional stakeholders and service recipients was overwhelming as many themes emerged during the conversations and meetings that were conducted between December of 2023 and December of 2024. The inductive approach to qualitative data analysis was utilized to gather most oft-repeated themes, however, secondary and tertiary themes emerged which required attention but did not meet the saturation level of key themes that formed the priorities listed above. Naturally, this process can eliminate the prioritization possibility of themes that are situated immediately outside of the most oft-repeated themes, but still may be identified frequently enough to provoke attention to their genesis. This liminal space between the “priority themes” and “secondary theme” is quite small and, thus, can limit the possibility of further consideration of important themes.

Additionally, the engagement of service recipients was of utmost importance throughout the process. Professional stakeholders were asked what they hear “from the field” regarding stakeholder feedback, and how they believe services can be improved based on this feedback. Moreover, service recipients were engaged vis-à-vis the Discovery Survey Process, and in the formation of the Service Recipient Steering Committee. However, no incentives were offered for participation in the process and so limited events were planned to engage a representative sample of service recipients from the state. The T5NA Team recognizes this as a major limitation in the needs assessment process and plans to budget for participant incentives when engaging the Service Recipient Steering Committee in an ongoing way.

Also, a natural outcome of such a process produces individual-level feedback, as most of the information collected comes from individuals; both the secondary data and the primary data collected. In engaging in this individual way, we unwillingly attribute health problems and limitations to the individual person rather than seeing them as being impacted, and impacting, the multi-level systems of which they exist. The use of the HEM and the SEM as the foundational framework for this process were to offer a buffer to the natural implications of individual-level analyses. But we recognize the “person in environment" approach must be endorsed when thinking and talking about health outcomes and related policies to address such outcomes. The role of the systems surrounding an individual have a greater influence on a person’s ability to access the services and healthcare needed to be fully actualized than their own autonomous decision-making process.

Like any assessment and research process led by individuals, bias is inherent in their work. The TVP staff and T5NA Team recognize that the collective knowledge and expertise they bring to the work, including their backgrounds and lived experiences, impact the work being done. While the T5NA process involved professionals and service recipients, the work was conducted by MCH staff whose positions within NJDOH do not preclude them from bias related to the endeavors previously listed. The TVP and T5NA actively mitigated against the effect of their positionality by engaging the Work Group, the Steering Committee and HRSA TVS to reflect on the process and remain as objective in the process as possible. Nevertheless, the buffering efforts to limit bias did not eliminate the possibility of bias being infused in the process unconsciously. To further limit this bias, additional service recipient and NJ resident voices will be integrated in the process, from start to finish, during the next needs assessment period.

Limitations

Voluntary response bias was present in each step of the research process. Voluntary response bias is when a person self-selects to participate in a survey, rather than being randomly selected. This type of response bias can lead to a non-representative sample of participants, which was the case in NJ's Discovery Survey process. Additionally, no funding was provided to service recipient participants for their engagement; this likely limited the depth at which people offered feedback throughout the process, thus ultimately limiting generalizability of the findings.

III.C.1.b. Findings

III.C.1.b.i. MCH Population Health and Wellbeing

Strengths and Needs

During the T5NA Process, several MCH population health strengths and needs were noted during primary and secondary data collection efforts. The overall strengths included some of the aforementioned themes, while population health domain-specific themes are delineated below.

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

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

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

- Workplace flexibility
- Appointment flexibility
- Breastfeeding education and resources

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

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

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

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

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

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

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

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

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

Over the past year, a few leadership changes have occurred at the FHS Division level. For one, our previous Executive Director of the MCH Unit transitioned out of her role. Two different MCH staff have taken on the role of Acting Executive Director in the months that followed and have worked closely with the previous Assistant Commissioner and current Title V Director to manage the budget and ensure programming continues with no interruption. On the FHS fiscal team, an Assistant Director joined the team and will play an important role in managing the Title V fiscal processes alongside our Fiscal Analyst.

Strengths, Opportunities, and Challenges

With the TVP situated in FHS, a diverse and varied group of state program staff support MCH initiatives. Within FHS, a rich tapestry of programming is created and endorsed. For example, while the WIC and Early Intervention programs do not receive Title V funding as they are supported by federal funds primarily, the TVP is able to leverage the program's client base to give and gather information and feedback on new or modified programs and resources throughout the state. Furthermore, the staff that work on related, yet distinct, MCH programming offer unique perspective and expertise on the engagement of the MCH populations throughout the state. In addition to programmatic collaboration, the TVP is situated within the Public Health Services branch of the NJDOH. The main service of the Public Health Branch comes from local and county health departments. This collaboration between the state and local health officials facilitates the transfer of health communication and information. This, in turn, promotes timely transfer of information to address the most immediate needs of the residents of NJ.

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

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

While NJDOH leadership promotes internal collaboration on projects and grants, there remain additional opportunities for more robust partnerships to form within the NJDOH branches and with other state entities. One of the opportunities that is emerging is between the NJDOH and the newly legislated Maternal and Infant Health Innovation Authority (MIHIA). In July 2023, Governor Murphy signed S3864, also known as the “New Jersey Maternal and Infant Health Innovation Center Act”, which created the NJ MIHIA. The Authority is tasked with overseeing the NJ Maternal and Infant Health Innovation Center based in Trenton and will be the government entity that continues the vital work of Nurture NJ for years to come. Nurture NJ is the statewide program that was launched by First Lady Tammy Murphy in 2019 to reduce the maternal and infant mortality epidemic in NJ and ensure equitable care among women and children of all races and ethnicities.

The one-of-a-kind Authority is governed by a 15-member Board and employs an appointed President and Chief Executive Officer who is in the process of hire accompanying staff. The Board will adopt recommendations for action to reduce maternal mortality, morbidity, and disparities from the NJ Maternal Care Quality Collaborative (NJMCQC). The Board also will be required to coordinate with a Community Advisory Committee to support and inform the work of the Authority. The 11-member community advisory committee will represent diverse community groups with relevant experience as providers or recipients of maternal, infant, and child health services. MIHIA is an incubator for research and development, an academic and perinatal workforce training center, and a data collaborative. The trauma-informed and patient-centered authority will offer comprehensive clinical services to serve moms before, during, and after pregnancy, while hosting research and wrap around community services to residents.

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

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

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

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

While the objective of this program is laudable, the resource availability does not yet meet the demand as the program gains traction. The promoting of the program, and subsequent hiring and training of nurse home visitors takes time and is in the early stage of gaining traction. Therefore, the state is working hard to meet the demand as the program grows simultaneously.

Additional partnerships that have affected Title V capacity to provide and assure services for MCH populations include the Technical Assistance Partnership that occurred between the National Center on Substance Abuse and Child Welfare (NCSACW) and NJDOH, along with colleagues from DCF and DHS. This interdepartmental collaboration focused on re-defining substance exposed newborn and helping pregnant women with Substance Use Disorder get connected to services when there is a need. Lastly, the group worked on a statewide Plan of Safe Care (PoSC) to ensure pregnant women receive timely and appropriate services when in need immediately after delivery. Also, a deeper partnership has occurred within state departments and related to ConnectingNJ resource referral. The two agencies have expanded services throughout every county, working more closely and strategically to attend to the varied and complex needs of pregnant women and children in the State.

Strengths, Opportunities and Challenges

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

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

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

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

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

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

The opportunities that NJDOH must create for additional impact in the state are numerous. For one, the Title V agency has been consulting with other states on innovative ways to address some of the CHF as service respondents reports things such as lack of transportation and childcare as voids which prevent connection to care. For this reason, the NJDOH is working closely with partners to identify ways to improve service accessibility. One such programs is Project MyRide. One of the consortia partners, the Southern New Jersey Perinatal Cooperative, has begun an initiative to offer free medical and social service-related rides to service recipients in the Southern region of the state. This is one initiative that has been created in response to voices in the state.

Although work is being conducted to create, initiate, modify and sustain various programs by our Title V agency, challenges remain. In the past year, vital COVID funding, which helped to propel our agency through tumultuous moments, ended. The agency has made every effort to sustain NJDOH staff hired with those funds to remain positions with the state. However, the need has grown as COVID-related issues have not completely diminished.

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

<u>CSHCN</u>

Within our TV CSHCN program, we support services for children through grants to specialty providers and facilities. These service grants support infrastructure, staff and/or direct services. These specialized centers and providers can flex these funds and use them where the need is highest. While Medicaid provides a significant source of funding, there are still gaps in coverage by Medicaid or other insurance programs. Regional gaps in service access also exist because two major specialized care providers in the southern region of our state discontinued their participation with Medicaid. Low reimbursement rates were cited as a major cause. While our TV funds cannot replace the Medicaid funds, our grants can provide the agencies with support for other facilities who are growing their capacity to serve this population. Although we strive to eliminate disparities of all kinds within our state, we do have regional differences in access to providers. Specialized services and facilities tend to be in more urban areas, creating access and transportation issues. While NJ is a geographically small state, travel from the more rural areas can be a significant barrier. Our case management units work closely with families to ensure that they can access services and other programs such as Catastrophic Health Insurance for major treatment costs which are not covered by insurance.

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

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

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

The Maternal and Child Health Epidemiology (MCH Epi) team promotes the health of pregnant women, infants, and children through the analysis of trends in MCH data and facilitates efforts aimed at developing strategies to improve MCH outcomes through the provision of data and execution of applied research projects. Moreover, the MCH Epi program provides MCH surveillance and evaluation support to Maternal and Child Health Services while advancing data-driven MCH programming. The State Systems Development Initiative (SSDI) project, which resides in the MCH Epidemiology TVP, focuses on enhancing and expanding the NJ TVP data capacity by improving data exchange for linkages within the department and between other agencies. The NJ SSDI project focuses on integrating information systems that are deemed necessary to ensure the availability of timely information for decision-making in all priority areas. The NJ SSDI project seeks to build, strengthen, and expand NJ's MCH data capacity to support Title V MCHBG program activities. During the five-year needs assessment process, NJ SSDI staff contribute to data-driven decision-making in MCH programs, including assessment, planning, implementation, selection of state priority needs, and the development of the five-year State Action Plan. To ensure the continued effectiveness and readiness of data to inform Title V needs assessment, NJ SSDI staff within TVP established a robust data structure that includes data linkages using 'provisional' real-time data. By improving the MCH data structure, NJ is better able to support informed decision-making, provide effective and efficient resource allocation, and improve the quality of programming for NJ's MCH population.

NJ TVP staff utilized the linked datasets to conduct analyses and produce reports (e.g., data briefs and topic reports). These reports are available on the MCH Epi webpage and the New Jersey Department of Health's State Health Assessment Data (NJSHAD) system. Thus far, TVP has demonstrated success in accessing and linking data across several data sources. Progress in completing the SSDI work plan for the budget period 12/1/24 to 11/30/25 and future plans are depicted below.

Accomplishments

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

1) Continued implementation of the PRAMS Phase 9 survey and opioid supplement
2) Completed 2024 birth year data collection (January to September births) for NJ PRAMS with an approximate 50% response rate for expired batches
3) Posted 2023 PRAMS data on NJSHAD
4) Shared annual birth file via STEVE with the Centers for Disease Control and Prevention (CDC) to support the PRAMS data-weighting process
5) Completed the 2024 PAHS opt-out process with the 2024 PRAMS survey; data collection is expected to start in spring 2025
6) Continued to assist with start-up of the NJ Fatherhood Survey (fatherhood data will be linked to PRAMS data)
7) Received approval for the data briefs, “Assessing Unintended Pregnancy in NJ Birthing Persons, PRAMS 2018-2022,” and “Physical Abuse as a Risk Factor for Adverse Mental and Behavioral Maternal Outcomes,” and the topic report, “Health Care Services,” and posted them on the NJ PRAMS webpage
8) Submitted two PRAMS Data-to-Action/Success Stories to the CDC
9) Developed a manuscript on the impact of maternal health education/support on select postpartum behaviors, PRAMS 2018-2022, for submission to the journal Public Health Reports
10) Developed a topic report on postpartum checkups (2019-2023) (pending internal approval)
11) Provided MCH data for MCH Block Grant report/application, developed an infographic for each domain, which will be used as part of the needs assessment, and provided data-related input in the process of selecting state priorities
12) NJ Fetal Infant Mortality Review (FIMR) teams continued entering data into the National Fatality Review Case Reporting System (NFR-CRS)
13) Completion of Phases 1 and 2 of the Perinatal Periods of Risk (PPOR) analysis
14) Launched the PPOR workgroup composed of a multidisciplinary group of stakeholders and people with lived experience who will partake in developing a strategic action plan to strengthen existing and/ or launch of new prevention strategies
15) Managed the NJ Maternal Mortality Review Committee (MMRC), which reviews all pregnancy-associated deaths of persons with an indication of pregnancy up to 365 days, regardless of cause

16) Developed the 2019-2021 NJ Maternal Mortality Report (pending internal approval)
17) Participated in the 2025 Harvard T.H. Chan School of Public Health and CDC Program Evaluation Practicum and developed two evaluation plans, one for the NJDOH's Postpartum Resources and Support Network and the other for MMRC
18) Developed longitudinal data collection in REDCap for public health initiatives (e.g., Healthy Women, Healthy Families) within the unit to track and evaluate key indicators

Goals and Objectives

Table 6: SSDI/NJ MCH Epi alignment

Goals and Objectives	Progress for Reporting Period
GOAL 1 - Build and expand NJ's MCH data capacity to support Title V MCH Block Grant program activities and contribute to data-driven decision-making in MCH programs, including assessment, planning, implementation, and evaluation.	
Objective 1.1 - Continue data support to the 2025 NJ Title V MCH Block Grant Report.	• provided data support to the 2025 State Title V MCH Block Grant Report and Needs Assessment. • developed an infographic for each domain which will be used as part of the needs assessment. • provided data analysis to inform Title V MCH Block application/ annual report and the selection of state priorities.
Objective 1.2 - Improve linked birth and infant death certificates annually.	• used key identifiers and linked birth certificates to infant death data. • linked birth and death certificates to PRAMS monthly sample to identify mothers who have lost their infant so they can be approached with a sympathy note instead of a congratulations note. • linked birth certificate and Special Supplemental Nutritional Program for Women, Infants, and Children (WIC) eligibility files to complement PRAMS data with important information on a large segment of the low-income "at-risk" MCH population. • used birth certificate and fetal death certificate data to conduct PPOR analysis. PPOR is a community-driven data approach to identifying key periods between the pregnancy and infancy period to drive recommendations and policy. • used birth and fetal death certificate data to identify maternal deaths, which are reviewed

	by a multidisciplinary committee and confirm false positive pregnancy statuses.
Objective 1.3 - Continue the linkage of Perinatal files for the latest months available to provide current data for annual reporting and analysis.	• pulled PRAMS sample monthly from birth certificate data. • pulled 2024 death certificate records based on pregnancy status to be reviewed by the MMRC.

Objective 1.4 – Secure the Perinatal Risk Assessment (PRA) and Connecting NJ files.	• MCH Epi has access to the PRA. The PRA is part of the dataset used to conduct maternal mortality reviews. Additional data sources used for MMR are:
	  • Birth/Fetal death certificate
	  • Maternal death certificate
	  • Universal billing/hospital discharge data
	  • COVID-19 testing database
	  • COVID-19 vaccine database
	  • Department of Child Permanency and Protection (DCPP/child welfare) records
	  • Emergency Medical Services records
	  • Perinatal Risk Assessment
	  • Key informant interviews (family/support persons identified in medical record)
	  • Autopsy, toxicology, report of investigation by medical examiner (RIME) reports
	  • Prenatal care records
	  • CDC community vital signs dashboard
	• FIMR grantees have access to the PRA

GOAL 2 - Advance the development, access, and utilization of linked information systems between key MCH datasets in the state.	
Objective 2.1 – Implement the annual PRAMS survey and link data for use in Title V reporting and other collaborative activities.	• implemented the annual PRAMS survey with opioid supplemental questions • completed the 2024 PAHS opt-out process with the 2024 PRAMS survey • submitted two PRAMS Data-to-Action/Success Stories to the CDC and identified topics to be further developed for upcoming Data-to-Actions • continued assisting with start-up activities for the NJ Fatherhood Survey project (data will be linked to PRAMS)

Objective 2.2 – Obtain access to the latest hospital discharge data annually.	• obtained access to hospital discharge data annually • continued to advance the utilization of the minimum/core indicators data sets for Title V MCH programs • use hospital discharge data for maternal mortality reviews
Objective 2.3 – Establish new and renew existing Memorandums of Understanding (MOU) with partners/organizations as needed to support MMR-related work	• continued to renew MOUs as needed for the MMR project as their expiration date approaches • the NJMMRC established a MOU/DUA with the NJ Department of Law and Public Safety's Fatal Accident Investigation Unit to obtain records of fatal motor vehicle incidents involving women who died within one year of the end of their pregnancy. • the NJMMRC is currently working with the NJ Department of Law and Public Safety's Office of Drug Monitoring and Analysis to obtain overdose-related records involving women who also died within one year of the end of their pregnancy.
Objective 2.4 – Continue to advance the utilization of the minimum/core indicators data sets for Title V MCH programs.	• continued to advance the utilization of the vital records data sets (e.g., birth certificate, death certificate, universal billing) for Title V MCH programs
GOAL 3 – Assist and provide program evaluation and data supports to inform NJDOH’s public interventions/ initiatives that align with the Nurture NJ Strategic Plan, which focuses on reducing maternal mortality and eliminating racial disparities in birth outcomes	
Objective 3.1 – Clean, analyze collected survey data and synthesize the evaluation results into a set of recommendations to inform leadership’s decision on how to improve MCH outcomes.	• developed evaluation plans for the NJDOH’s Postpartum Resources and Support Network and the MMR project in collaboration with CDC and the Harvard T.H. Chan School of Public Health to enhance dissemination activities
GOAL 4- Improve data collection, analysis, and visualization to inform public health policies as they relate to emerging issues	
Objective 4.1- Continue to work on standardizing the NJ FIMR case identification process.	• continued working on standardizing the NJ FIMR case identification process • conducted site visits with FIMR grantees. • established the PPOR Committee (a multidisciplinary team that includes someone with lived experience)

Objective 4.2 – Continue to support FIMR committees in the process of uploading data to the NFR-CRS.	• renewed IRB approval for the FIMR protocol. • continued to support FIMR committees in the process of uploading data to the NFR-CRS
Objective 4.3 - Continue to develop a dashboard and publish MCH Indicator reports for data visualization and utilization.	• analyzed 2023 PRAMS data and posted on NJSHAD • developed data reports (e.g., data briefs, manuscripts) on 1) physical abuse and adverse mental and behavioral maternal outcomes and 2) the impact of maternal health education/support on select postpartum behaviors • drafted the maternal mortality report for deaths that have a temporal relationship to pregnancy (within 365 days) between 2019-2021. This report will be released for public consumption in coming months (pending approval).

Plans for the Upcoming Budget Year

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

Objective 1.1

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

Objective 1.2

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

Objective 1.3 - Update the SAS program when necessary and utilize SAS to pull

1. PRAMS sample monthly from birth certificate data.

2. Maternal Mortality sample from death certificate data.

Objective 2.1

1. Support all activities related to implementing the PRAMS survey.
2. Complete data collection for the 2024 PAHS, link PAHS data to the 2024 PRAMS dataset (if available) and send the linked dataset to Columbia University for weighting and analysis.
3. Continue implementing the NJ Fatherhood Survey, submit the 2025 birth year data to Lurie Children's Hospital for weighting, analysis, and dissemination.
4. Develop two PRAMS Data-to-Action examples.

Objective 2.2 - Continue to initiate key data sharing agreements as needed for access to files for analysis.
Objective 2.3 - Keep track of and renew, when necessary, any Memorandums of Understanding with all relevant partners.
Objective 2.4 - Provide data support for the needs assessment and grant reporting.
Objective 3.1 - Conduct evaluations and generate reports to inform the development of new or the revision of current RFAs, as needed.
Objective 4.1 - Continue to convene a multidisciplinary team to aid in the implementation of PPOR in NJ.
Objective 4.2 - Continue to support staff at the grantee organizations to utilize the NFR-CRS.
Objective 4.3

1. Develop data reports to inform MCH programs that can potentially impact policy and practice.
2. Submit abstracts for session and/or poster presentations at 2026 national conferences.
3. Draft the upcoming MMR report for deaths that have a temporal relationship to pregnancy between 2021-2023, tentatively.

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

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

Title V data capacity efforts that are funded by sources other than SSDI include updating the annual MCH Block Grant performance measures, providing data for the Five-Year Needs Assessment, and providing customized data to internal and external partners for program planning and evaluation. In addition, the CDC provides funding to NJDOH to implement the NJ PRAMS. NJPRAMS is housed within the MCH Epi program and is a crucial surveillance tool necessary to improve the health of NJ mothers and infants.

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

Moreover, to increase the NJ data capacity, MCH Epi staff entered multiple other agreements not funded by the SSDI or Title V grants. The table below (Table 7) depicts two of MCH Epi's agreements in this grant cycle.

Table 7. MCH Epi's Agreements and Contracts

Agreement(s) and Contract(s)				
Type of Agreement	**Project(s)**	**Between**		**Description**
Data Use Agreement	Fetal and Infant Mortality Review	New Jersey Department of Health-MCH Epi	Michigan Public Health Institute (MPHI)	The purpose of this agreement is to establish the terms and conditions for the collection, storage, and use of data obtained from the fatality case reviews submitted by Fatality Review (FR) teams in the State of New Jersey and entrusted to the National Fatality Review Case Reporting System (NFR-CRS).
Data Use Agreement	Postpartum Assessment of		Columbia University in	This agreement aims to enable researchers at Columbia to

	Health Survey (PAHS) study formerly known as Postpartum Assessment of Women Study (PAWS).		the City of New York	use 2020 NJ PRAMS survey data to conduct the PAWS observational cross-sectional study and to return the link dataset to MCH Epi TVP for analysis.

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

Adolescent Health

CAHP uses three separate databases/dashboards to collect program performance measures and program fidelity information for the Personal Responsibility Education Program (PREP) and Sexual Risk Avoidance Education (SRAE) Programs. In addition to these databases, the New Jersey Readiness to Stand (R2S) challenge actively evaluates all aspects of program delivery. The NJ School Health (NJSH) recently released a competitive RFA which included the collection of program level outcome data, NJSH will be determining how to best collect and disseminate data in the first year of the grant funding cycle.

CSHCN

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

The Early Hearing Detection and Intervention program received inpatient hearing screening data via VERI, and outpatient hearing evaluations are reported in a module in the NJ

Immunization Information System (NJIIS). Data from those sources are merged in an EHDI database and used to generate multiple reports to meet program needs. These include a monthly data reconciliation report and annual reports to hospitals, midwives, and audiologists.

The Birth Defects and Autism Registry System (BDARS) and the Case Management Referral System (CMRS) are developed and maintained via funding through a Memorandum of Agreement with Rutgers University. The CMRS system is undergoing a major overhaul to improve the system's ability to be flexible in responding to new situations, such as future pandemics and natural disasters that will impact the service needs of CSHCN. Furthermore, the system redesign helps improve the quality of data reporting, improve the user experience, and implement an acuity measurement. The acuity measurement will be developed through a weighted scale that utilizes pivotal information from CMRS, such as diagnosis, linkage to services, insurance information, medical home, transition to adulthood, and other key data to determine each child's level of acuity in a format that is easily understood and utilized by stakeholders. These data elements allow FCCP staff to evaluate staffing of Case Management Units at County level to respond to communities of greater need and determine each child's real-time level of need at-a-glance.

As part of a cooperative agreement, SCHS programs provide CDC with de-identified hearing screening and follow-up data on all NJ occurrent births, case data for certain congenital disabilities, critical congenital heart defect screening results, and both maternal and newborn data, including infant outcomes up to six months of age for cases with pregnancy complicated by syphilis or cytomegalovirus infection.

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

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

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

The NJDOH prioritizes partnership over singular work as we recognize the work is enhanced when in collaboration with others. We work closely with various entities across the state that engage the MCH populations. Our internal collaborations include with Women, Infants and Children (WIC) unit, and our SNAP-Ed Unit on breastfeeding initiatives and coordinating on a

Nutrition Coalition. Interdepartmentally, NJ endorses cross-collaboration with the Youth Mental Health initiative between programs, led by our CAHP Program, and the Governor's Council, participated in by our CSHCN Executive Director.

Moreover, the newly received MHI grant will bolster the important, evidence-based work we have been engaging. This work will continue to be cross-collaborative, engaging state professionals and clinical professionals to meet the shared aims of educating and training service recipients and professional stakeholders. Furthermore, the initiatives of the MHI grant link to are borne out of our ongoing Maternal Mortality Review (MMR) work and the recommendations made by the committee. The data produced in our MDC also inform the initiatives crafted and modified by our MHI.

III.C.1.c. Identifying Priority Needs

In engaging in a review of our state's current priority areas and related programming, alongside the outputs from the primary and secondary data collection efforts that occurred during the needs assessment process, new priority areas emerged while some remained. Concomitantly, some priority areas morphed into more precise areas of focus.

For one, the previous SPN of "Increasing Equity in Healthy Births" was strengthened by adding language that implies our state's more global focus, "Increase healthy births and bridge gaps in birth outcomes." The same rationale was applied to our state's previous SPN of, "Reducing Black Maternal and Infant Mortality", and modified to capture more concisely the plan to, "Reduce Black Maternal and Infant Mortality by Expanding and Strengthening Evidence-based programs Addressing Black Infant Mortality." The continued cultivation and reliance on evidence-based programming has been seen as a priority in meeting the SPNs listed here.

The previous SPN of, "Improve Nutrition and Physical Activity" was modified to, "Improving Nutrition, Food Security and Increasing Physical Activity", a combination of overlapping needs that the State has been addressing, with a renewed focus on food security. The SPN of "Food Security" has been added to this SPN as NJ sees the correlation between food security and adverse birth outcomes for mothers and babies and wants to precisely focus on this pathway to mitigate against the effects of food insecurity. This modified SPN augments the efforts of our state's varied programs in addressing this concerning issue.

The SPN of, "Promoting Healthy Development from Childhood, Adolescence & Young Adulthood (AYA)" & "Reducing Teen Pregnancy and Sexually Transmitted Infections" ultimately was combined as teen pregnancy and STI's are situated within an AYA's overall health status, and, therefore, should be considered simultaneously. Furthermore, this SPN relates to the newly added and universal NPM of Bullying.

The new SPN of, "Promoting Healthy Youth Development for CSHCN over the course of Childhood, Adolescence and Young Adulthood" has been added as it relates directly to the universal National Performance Measure (NPM) of Medical Home.

The addition of the SPN, “Improve exclusive breastfeeding rates for the first six months after birth” coincides with the State’s commitment to increasing breastfeeding rates to improve health outcomes for mothers and babies. NJ has a Breastfeeding Strategic Plan that has been implemented by a State Breastfeeding Coordinator, and for which the aims coincide with NJ’s Title V endeavors. Moreover, breastfeeding support is one area of interest that emerged during the needs assessment process.

The addition of SPN, “Reducing Differential Outcomes in Maternal Healthcare for Specific Populations” came directly from the Needs Assessment process and relates to ongoing work of the NJDOH to address gaps in health outcomes. Furthermore, this SPN situates itself within the larger NPM of, “Perinatal Care Discrimination”.

On November 1, 2021, NJ Statute 26:2H-12.108 was adopted. This statute mandates that every NJ hospital that provides inpatient maternity services and every birthing center licensed in the State, pursuant to P.L. 1971, c.136 (C.26:2H-1 et seq.,) shall implement an evidenced-based explicit and implicit bias training program.

In August 2023 the NJDOH released a training series, titled “The Reproductive Justice Project for Equitable Maternal Health.” The training is designed for all physicians, nurses, and other clinicians as well as non-clinical hospital staff who interact with pregnant patients at NJ’s hospitals and birthing centers.

This two-hour evidence-based training with six modules utilizes an e-learning webinar format to discuss the explicit and implicit biases, institutional racism, and historical events that have contributed to the disparate health outcomes of Black pregnant women in the United States and NJ. The training aims to improve clinical decision-making, patient-provider communication, and trust, and to encourage culturally competent, patient-centered, and evidence-based care.

Following the completion of this course, participants will be able to better:

- Recognize the public health crisis in maternal health outcomes in the United States;
- Discuss NJ-specific racial differences in maternal health outcomes;
- Identify implicit and explicit biases and their potential impact on maternal health;
- Apply strategies to mitigate bias when providing obstetric care; and
- Identify techniques to advocate for reproductive justice.

Secondary priorities emerged during the needs assessment process and included “increasing cash assistance programming” and “loosening of stringent benefit requirements”. While these priorities were mentioned by service recipients during the needs assessment process, the Title V Work Group recognized the limitation of the state to acutely and feasibly enact change on these two issues. While laudable, both overarching secondary themes would take concomitant political will and massive structural change to enact. The TVS at NJDOH, in conjunction with Title V leadership, thus prioritized the themes most often cited in the needs assessment, and for which activities are ongoing or will be facilitated by both financial commitment and political and structural will.

Public Comment Stage

Scheduled for July 9th, 2025. Final written comment due by July 11th, 2025.

Results Dissemination Stage

To be determined, and based on the finalization of the manuscript, integration of public comments and submission of full documents in July of 2025.

Workforce Development and Cross-Collaboration

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

Most FHS staff recognized the need for incorporating the perspectives of families and family representatives into the MCH workforce under the broader umbrella of systems integration. Continued family involvement in health transformation is essential for effective program and policy development related to newly aligned systems. As a result, NJDOH collaborated with community partners through advisory boards and steering committees.

FHS implemented the development of succession planning to ensure essential functions were considered in long-term planning. During this past fiscal year, cross-training of staff was implemented to provide the ability to maintain key roles in the event of short-term staffing shortages. Changes in the workforce funded by Title V reflect staff's long-standing MCH priorities and core functions.

TVS also pursues other training opportunities offered at national conferences, including AMCHP, the MCH Epidemiology Conference, and the MCH Public Health Leadership Institute. Departmental trainings have been offered on ethics, grant writing, and grants management. Opportunities to supplement staffing through student internships, special temporary assignments, fellowship programs, and state assignees have also been successful. Recruitment and Retention of qualified TVP staff are ongoing goals of NJ TVP.

A focus on filling key positions and building the public health infrastructure is a key focus of NJDOH. The recently awarded CDC grant (CDC-OE22-2203), which created an Office of Workforce and Professional Development, gained traction in 2024, posting and hiring for positions vital to reach the mission of the office, engaged primary data collection efforts to understand challenges of the current workforce, and began crafting plans to address retention issues to invest in a more comprehensive future talent pipeline. In January of 2025, a survey was disseminated to all DOH employees inquiring about what workplace efforts help create a healthy and sustainable workplace. The survey was designed to gather information on what staff find appealing about working at the NJDOH, with an aim of implementing retention measures for staff. The new Director of this office who is leading this valuable research effort was selected from the MCH Unit, Division of FHS.

MCH Workforce & Training

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

The recruitment and retention of Title V staff is an ongoing effort by the leaders of the FHS Division at NJDOH. MCH leadership has been working closely with academic institutions and the MCH Workforce Development Center to continue to cultivate relationships and to offer training opportunities for those clinical and macros professionals interested in working in the public health and social service sectors. The FHS Division of NJDOH has an ongoing relationship with the Rutgers School of Medicine, to host resident interns who have an interest in MCH initiatives. This collaborative relationship has borne fruit as the NJDOH has hosted two residents in the past year. Both residents worked to support efforts of the Title V Needs Assessment Process, by conducting a literature review and offering support to the Title V process by offering clinical insights into some of the outreach work being done throughout the division.

Additionally, during the summer of 2024, two master's level public health students joined our TVP to support ongoing Title V Block Grant Needs Assessment efforts, primarily facilitating key informant interviews with professional stakeholders in the state. In January 2025, staff within the MCH Unit attended an evaluation practicum that was hosted by the Centers for Disease Control (CDC) in partnership with Harvard University. The practicum was a two-week immersive experience that allowed an opportunity for MCH Services staff to brainstorm and draft targeted approaches to evaluating two programs within the unit: the MMRC and the Postpartum Mood Disorder project. With the collaboration of the CDC Division of Reproductive Health and the T.H. Harvard School of Public Health, staff engaged in MCH-specific evaluation learning sessions and discussed the intervention of community-based programming and evaluation. As a deliverable of the practicum, the teams drafted a data-evaluation plan for each program. The practicum served as a valuable and compelling experience to enhance the program’s aims, with both experiences creating new and innovative partnerships with academic institutions: Drexel University, Emory University and Harvard University.

In January of 2025, another master's level public health student has begun her final year practicum with our FHS division, supporting both the Title V Block Grant Needs Assessment process as well as manuscript drafting with the MCH Epi Unit. The connections formed with these young professionals has created a mutually beneficial relationship over the course of the past year, enhancing program endeavors while offering mentorship to enhance skills sets of these young public health professionals.

Adolescent Health

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

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

Current assessments of the adolescent workforce participating in NJDOH programs suggest that some providers/professionals working with adolescents lack essential skills and knowledge needed to serve this vulnerable population effectively. As an example, self-reported data on perceptions of professional competencies related to youth mental health collected via surveys of staff at fifteen school districts prior to the implementation of Lifelines Trilogy suggested that members of the crisis team were unaware of or had misinterpretations of school policies regarding mental health and suicidality. This lack of knowledge included which tools to use for screenings, where to refer for services and when to include parents/caregivers. In addition, self-reported data from pre- and post-survey trainings provided to NJDOH grantees indicated a similar lack of knowledge and skills related to subjects such as birth control and other contraceptives, STIs, and social and emotional learning, prior to training.

In November of 2024, the CAHP was accepted to the MCHB Workforce Development Center 2025 Learning Journey to develop a strategic plan. The team has been working with their assigned coach, reviewing existing child and adolescent health strategic plans and will attend the WDC learning event in May in Chapel Hill, North Carolina. The CAHP strategic plan will be developed with the guidance of the WDC and will be submitted for approval by December of 2025.

In our survey of adolescents, over 85% indicated they do not feel understood or supported by the adults in their lives (professionals, parents, and caregivers). Given the current landscape of adolescent health education, support, and service needs, continued training and education of adolescent health professionals and providers is an important goal for the CAHP and the professionals/providers who work with the adolescent population. To this end, NJDOH has added a professional engagement and training component to the Statewide Parent and Professional Engagement Program (S-PEP). Motivational Interviewing Training for Empowering Youth Toward Change (MITEY Change), a self-paced training series, will be provided free to early career youth serving professionals in NJ and will help assist providers in acquiring the skills needed to effectively serve children, youth and young people in NJ. There is an application process for training and a limited number of spots will be made available while the program assesses both need and capacity. In 2025, 75 professionals will receive free MITEY

Change training, and as the first cohort of trainees.

Children with Special Health Care Needs

Within the SCHS unit, we have been focusing on workforce development in several ways. We envision what our organizational chart needs to look like in the future and build the positions to get to that vision. This year, we developed a group of staff known as the Data Systems and Emerging Threat Response program. Within this program are data staff, who sit within our other programs but report to a single data coordinator who ensures that the data work across the programs is met. By cross-training and having staff work on multiple data systems, they can ensure that we can meet our data demands even when staff is out, leaving, or retiring. Additionally, the Coordinator runs a monthly data group across the division to bring staff from MCH, WIC, EIS, and SCHS together. These training meetings expose staff to new ideas and information.

Meeting the needs of emerging threats such as COVID, ZIKA, and natural disasters has often happened in an ad hoc manner. This team is designed to look at ways more prospectively to address developing issues. The focus has been on bringing in different types of staff that are able to write and execute funding opportunities, work with medical records, and organize and manage projects with quick turnaround times. Having the staff means we can be more strategic and timelier in collecting data and producing results and recommendations for changes. Along with bringing in new staff, we are looking for more opportunities to capitalize on existing staff expertise. We conducted a survey asking staff about needs for training, desired areas they want to expand, and hidden “talents.” One staff person let us know that she had learned SAS in her master's program and would be interested in more data work. We were able to reallocate data tasks to her and paired her with a colleague who was struggling with her data tasks.

Another area of workforce development is hiring more early-career staff and exposing them to meetings, stakeholders, and project management. As in medicine’s “see one, do one, teach one” philosophy, we have started a grant group that exposes junior staff to the grant writing process, including having staff conduct “Grant 101” training, linking staff with mentors, and allowing staff to take the lead on grants with the more experienced staff acting as mentors and reviewers. Our philosophy is “see a few, do work on some, write one.” Additionally, we are bringing junior staff to board meetings, workgroups, and stakeholder meetings and letting them take on these roles over time.

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III.D. Financial Narrative

III.D.1 Expenditures

III.D.2 Budget

*Financial and Budget Narrative Section to be completed by July 2025 submission date

III.E. Five-Year State Action Plan

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

State Priority Needs	Strategies	Objectives	National & State Performance Measures	Evidence-Based or Informed Strategy Measures	National & State Outcome Measures
Improving Women/Maternal Health					
Increase Healthy Births and Bridge gaps in birth outcomes	**Increase access to preventive medical visits for women (ages 18–44) through evidence-based programs**, such as: - The Community Health Worker Model - The Healthy Women, Healthy Families Initiative - The Maternal, Infant, and Early Childhood Home Visiting Program	**Increase the percentage of women (ages 18–44) who had a preventive medical visit in the past year by 1% by 2030.** *(Baseline 2022 BRFSS: 73.2%)* **Increase the percentage of Black, non-Hispanic women (ages 18–44) who had a preventive medical visit in the past year by 1% per year by 2030.** *(Baseline 2022 BRFSS: 76.7%)*	**NPM:** Perinatal Care Discrimination	**ESM:** Percentage of women (ages 18–44) who report receiving a preventive medical visit in the past year **ESM:** Rate of Black, non-Hispanic preterm births per 1,000 live births in NJ **ESM:** First trimester prenatal visit rate **ESM:** Number of births supported by community doulas	**NOM 2:** Severe maternal morbidity per 10,000 delivery hospitalizations **NOM 3:** Maternal mortality rate per 100,000 live births **NOM 4:** Percent of low-birth-weight deliveries (<2,500g) **NOM 5:** Percent of preterm births (<37 weeks)

	Increase postpartum medical visits for women (ages 18–44) through evidence-based programs, such as: - The Community Health Worker Model - The Healthy Women, Healthy Families Initiative - The Maternal, Infant, and Early Childhood Home Visiting Program	**Increase the percentage of women (ages 18–44) who attended a postpartum medical visit within the past year by 1% by 2030.** *(Baseline 2023 NJ PRAMS: 92.4%)*	**NPM:** Postpartum Visit - **(A)** Percent of women who attended a postpartum checkup within 12 weeks after birth - **(B)** Percent of women who attended a postpartum checkup and received all recommended care components **NPM:** Postpartum Mental Health Screening - Percent of women screened for depression or anxiety following a recent birth **NPM:** Perinatal Discrimination - Percent of women with a recent birth who experienced racial/ethnic discrimination during pregnancy, delivery, or postpartum care	ESM: Percentage of women who attend a postpartum visit within the first four to six weeks after birth.	**NOM 6:** Percent of early-term births (37–38 weeks) **NOM 8:** Perinatal mortality rate per 1,000 live births + fetal deaths **NOM 9.1:** Infant mortality rate per 1,000 live births **NOM 9.2:** Neonatal mortality rate per 1,000 live births **NOM 9.3:** Post-neonatal mortality rate per 1,000 live births **NOM 9.4:** Preterm-related mortality rate per 100,000 live births **NOM 10:** Percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

State Priority Needs	**Strategies**	**Objectives**	**National & State Performance Measures**	Evidence-Based or Informed Strategy Measures	**National & State Outcome Measures**
Perinatal/Infant Health					
Reduce Black Maternal and Infant Mortality and Expand & Strengthen Evidence-Based Programs Addressing Black Infant Mortality	**Increase Infant Safe Sleep Practices** - Educate caregivers on safe sleep (no co-sleeping, back sleeping, no soft bedding). - Conduct public health campaigns on safe sleep practices. -Continue and expand the **Healthy Women Healthy Families** initiative. - Strengthen existing Black Infant Mortality reduction programs. - Implement and evaluate evidence-based interventions targeting disparities. - Provide training, mentorship, and technical assistance to doulas. - Ensure sustainability	Increase the percentage of infants placed in a safe sleep environment by 1 percentage point by 2030 (Baseline PRAMS 2021: 19.49%, Updated Baseline PRAMS 2023: 28.2%). Increase the percentage of women trained as community doulas and enrolled as NJ NJFamilyCare (Medicaid) providers by 100% (112) by 2030.	**NPM: Safe Sleep** A) % of infants placed on their backs B) % of infants placed on a separate, approved sleep surface C) % of infants placed without soft objects or loose bedding **NPM: Improve Breastfeeding Rates** A) % of infants ever breastfed B) % of infants exclusively breastfed through 6 months	**ESM 5.1:** % of women reporting safe sleep practices in PRAMS (no co-sleeping, back sleeping, no soft bedding). **ESM 4.2:** % of trained community doulas enrolled in Medicaid.	**NOM 9.1:** Infant mortality rate per 1,000 live births **NOM 9.3:** Post-neonatal mortality rate per 1,000 live births **NOM 9.5:** Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

	through direct billing under Medicaid.				
	Decrease Black Non-Hispanic Preterm Births - Expand access to prenatal care. - Increase the number of trained community doulas enrolled in Medicaid.	Reduce Black non-Hispanic preterm birth rate by 1 percentage point by 2030 *(Baseline 2022: 13.3%).*	**NPM: Perinatal Care Discrimination** - Percent of women with a recent birth who experienced racial/ethnic discrimination during pregnancy, delivery, or postpartum care -% of Black, NH pregnant women who started prenatal care in their first trimester	**ESM 4.2:** % of trained community doulas enrolled as NJ FamilyCare (Medicaid) providers.	**NOM 9.1:** Infant mortality rate per 1,000 live births **NOM 9.3:** Post-neonatal mortality rate per 1,000 live births **NOM 9.5:** Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
	Increase Births in Baby-Friendly Hospitals - Encourage hospitals to obtain Baby-Friendly designation. - Promote hospital participation in breastfeeding initiatives.	Increase the number of Baby-Friendly hospitals by 2% by 2030 *(Baseline 20254: 15 hospitals).*	**NPM: Breastfeeding** A) % of infants ever breastfed B) % of infants exclusively breastfed through 6 months	**ESM 4.1:** % of births in Baby-Friendly hospitals	**NOM 9.1:** Infant mortality rate per 1,000 live births **NOM 9.3:** Post-neonatal mortality rate per 1,000 live births **NOM 9.5:** Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Reduce Differential Outcomes in Maternal Healthcare for Specific Populations	- Provide education to the allied professional workforce on bias	Decrease the percentage of women reporting racial/ethnic discrimination in healthcare (by 5% in 2030)	**NPM: Perinatal Care Discrimination** - Percent of women with a recent birth who experienced	ESM: # of trained allied professionals who complete bias training	NOM 1: Early Prenatal Care NOM 2: Severe Maternal Morbidity

		(Baseline 2023 PRAMS: 7.85%). Increase number of professionals who have taken Implicit Bias Training by 15% by 2030)	racial/ethnic discrimination during pregnancy, delivery, or postpartum care		
Improve Nutrition, Food Security & Increase Physical Activity	- Increase access to nutrition and physical activity programs for pregnant and postpartum women. - Promote smoking cessation efforts as part of maternal health education and prenatal wellness initiatives. - - Expand participation in **food assistance programs** and increase awareness of community food resources. - Promote partnerships with schools and local organizations to increase access to **nutritious food options**.	Improve maternal health by increasing engagement in evidence-based nutrition, physical activity, and smoking cessation resources. - Increase household food sufficiency for children ages 0–11 by expanding access to healthy and affordable food options (Baseline:73.4%, National Survey of Children's, 2022-2023)	**NPM: Food Sufficiency** % of children (ages 0–11) in food-sufficient households.	**ESM 14.1.1:** Number of women engaged in maternal health programs that include nutrition, physical activity, and smoking cessation resources.	**NOM 16.1:** Adolescent Mortality Rate (Ages 10–19 per 100,000).

	- Encourage integration of **nutrition education** into pediatric and early childhood services.				
Improve Exclusive Breastfeeding Rates for the first six months after birth	- Leverage the Doula Learning Collaborative (DLC) for workforce training. - Promote hospital breastfeeding policies using birth certificate and mPINC data.	Increase the percentage of infants breastfed and exclusively breastfed for 6 months. *(Baseline:20.3%, National Survey of Children's, 2022-2023)*	**NPM: Improve Breastfeeding Rates** A) % of infants ever breastfed B) % of infants exclusively breastfed through 6 months	**ESM 4.1:** % of births in Baby-Friendly hospitals **ESM 4.2:** % of trained community doulas enrolled as NJ FamilyCare (Medicaid) providers	**NOM 9.1:** Infant mortality rate per 1,000 live births **NOM 9.3:** Post-neonatal mortality rate per 1,000 live births **NOM 9.5:** Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
State Priority Needs	Strategies	Objectives	**National & State Performance Measures**	**Evidence-Based or Informed Strategy Measures**	**National & State Outcome Measures**
Child Health					
Promote Healthy Youth Development from Childhood Through Adolescence & Young Adulthood (AYA)	- Expand access to **Ages & Stages Questionnaire (ASQ)** developmental screenings through online platforms as part of the **ECCS Impact Program**. - Increase parent engagement in early childhood screening efforts. - Strengthen partnerships with pediatric providers to promote	Increase the percentage of children (ages 9–35 months) receiving developmental screenings by 5 percentage points by 2030. *(Baseline: 34.4, National Survey of Children's Health, 2022-2023.*	**NPM: Developmental Screening** % of children (ages 9–35 months) who received a developmental screening using a parent-completed tool in the past year. **NPM: Medical Home** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	**ESM 6.1:** Promote parent-completed early childhood developmental screenings via an online **ASQ screening tool**. **ESM:** Number of preventive dental visits in the past year for children ages 1-17 years old	**NOM:** % of children meeting criteria for **school readiness**. **NOM:** % of children (ages 0–17) reported to be in **excellent or very good health - CHS** **NOM 16.1:** Adolescent Mortality Rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

	developmental screenings.		**NPM: Preventive Dental Visit Child/ Adolescent** Percent of children, ages 1 through 17, who had a preventive dental visit in the past year		
State Priority Needs	Strategies	Objectives	**National & State Performance Measures**	**Evidence-Based or Informed Strategy Measures**	**National & State Outcome Measures**
Adolescent Health					
Promote Healthy Youth Development & Reducing Teen Pregnancy & Sexually Transmitted Infections (STIs)	- Increase bullying and suicide prevention presentations delivered by or supported by **NJDOH Title V**. - Implement school-based programs to raise bullying awareness and prevention. - Promote **Social and Emotional Learning (SEL)** programs to help youth build resilience, decision-making, and social skills.	Increase the number of adolescents participating in a bullying awareness and prevention program.	**NPM: Bullying** % of adolescents (>17) who report being bullied or bullying others.	**ESM 9.1:** % of students completing a bullying/suicide prevention program delivered by or supported by **NJDOH Title V**.	**NOM 16.1:** Adolescent Mortality Rate (Ages 10–19 per 100,000). **NOM 16.3:** Adolescent Suicide Rate (Ages 15–19 per 100,000). **NOM ??:** % of high school students who report being bullied on school property or electronically (via texting, social media, etc.). *(Youth Risk Behavioral Surveillance Survey)*
	- Expand evidence-based SEL programs such as **Teen Outreach Program® (TOP), Teen Connection Project®, and Teen PEP** to increase youth resilience and self-awareness.	Increase the percentage of students completing an evidence-based SEL program by 5% per year by 2030. *(Baseline:*	**NPM: Bullying** % of adolescents (>17) who report being bullied or bullying others.	**ESM 9.2:** % of program participants reporting protective factors related to bullying, including speaking to a	**NOM 16.1:** Adolescent Mortality Rate (Ages 10–19 per 100,000).

		2021 program completion data).		trusted adult and resiliency skills.	
	- Adopt evidence-based youth engagement strategies to improve participation in **Teen Pregnancy Prevention (TPP) programs**. - Expand access to programs such as **Teen Outreach Program® (TOP), Love Notes®, Reducing the Risk®, Get Real®, FLASH, and Teen PEP** in high-risk counties/municipalities.	Increase the percentage of students completing at least 75% of an evidence-based teen pregnancy prevention program by 5% per year by 2030. *(Baseline: 2021 program completion data).*	**SPM: Reducing Teen Pregnancy** Teen birth rate for females **aged 15–19 in NJ**.	**ESM 9.3:** Number of students (male and female) who completed at least 75% of an evidence-based **Teen Pregnancy Prevention Model**.	**NOM: National Teen Birth Rate** *(CDC.gov)* Reduction in births to youth **>20 nationally**. **2022 U.S. teen birth rate: 13.6 per 1,000 females (ages 15–19)** *(a 4% decline from 2021)*.
	- Increase **mentorship programs** delivered through the **Child and Adolescent Health Program (CAHP)**. - Survey youth to assess **non-parent/guardian mentorship** as a protective factor for mental health and well-being.	Increase the number of youth (ages 10–24) **in CAHP-sponsored programs** who report having a non-parent/guardian mentor that they can talk to. *(Baseline to be collected in 2025).*		**ESM:** Require mentor training for professionals engaging youth in **CAHP-supported programs**. Require all **CAHP sub awardees** to include a survey question assessing mentorship support.	**NOM:** Improved adolescent mental health and reduced rates of depression/anxiety due to mentorship support
State Priority Needs	Strategies	Objectives	National & State Performance Measures	**Evidence-Based or Informed Strategy Measures**	National & State Outcome Measures
Children with Special Healthcare Needs					
Improve Access to Quality Care for CSHCN	Identify and monitor transition to adulthood needs for CYSHCN and their families served through the Case Management Units (CMUs).	Increase the percentage of CYSHCN ages 12- 17 years served by Special Child Health Services Case Management Units (SCHS	**NPM: Transition** Percent of adolescents with and without special health care needs, ages 12 through 17, who received	ESM 12.1: Percent of CYSHCN ages 12-17 years served by SCHS CMUs with at least one transition to adulthood service.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 17.2: Percent of children with

		CMUs) with at least one transition to adulthood service by 3 percentage points by 2030 *(Baseline New Jersey Special Child Health Services, Family Care Center Services 2021: 33.5%).*	services to prepare for the transition to adult health care		special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
	Explore youth and their parents' needs to facilitate transition with insurance, education, employment, and housing, and link them to community-based partners.	Increase the percentage of children and children with special health care needs, aged 0 – 17 years old, who have a medical home by 4 percentage points by 2030 *(Baseline The New Jersey Special Child Health Services, Family Care Center Services 2024: 28.8%)*	**NPM: Medical Home** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care	**ESM 11.1**: Percent of CYSHCN ages 0-18 years served by SCHS CMUs with a primary care physician and/or Shared Plan of Care (SpoC).	
	Provide comprehensive care with physicians and allied health professionals, by partnering with patients and their families.	Improve coordination of care by increasing referrals and engagement with primary care providers.	**SPM 3**: Percentage of newborns discharged from NJ hospitals who did not pass their newborn hearing		

			screening and have documented outpatient audiological follow-up.		
	Special Child Health Services Unit Coordinators ensure timely case management assignment for BDARS referrals to facilitate early intervention (within 14 days)	Increase the percentage of live children registered with BDARS and referred to SCHS CMUs who are receiving services by 0.5% by 2030 *(Baseline: 95.2%, 2024).*	**SPM:** Percent of live children registered with the BDARS who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.	Improved early intervention services for children with birth defects and autism.	
	Improve BDARS to reduce the time from referral to autism diagnosis.	Decrease the age of autism diagnosis by 1 year by 2030 *(Baseline NJ Autism Registry 2024:* 5.1 *years old).*	**SPM:** Average age (in years) of initial diagnosis for children with an Autism Spectrum Disorder	Earlier diagnosis and intervention for children with Autism Spectrum Disorder (ASD).	
	Identify families who are in Case Management whose children have been bullied or who bullied via surveys.	Assess the baseline of the percent of children who have been bullied or who have bullying others. Provide support to families via education and resources to the CMUs.	**NPM: Bullying** Percent of adolescents with and without special health care needs, ages 12 through 17, who are bullied or who bully others	Increased awareness and support systems for bullied children and families.	
Promote Healthy Youth Development for CSHCN over the course of Childhood, Adolescence	Strengthen medical home access for all children, including CYSHCN, through provider partnerships and policy improvements.	Increase access to comprehensive and coordinated healthcare services for children and adolescents.	**NPM: Medical Home** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	**ESM 11.1**: Percent of CYSHCN ages 0-18 years served by SCHS CMUs with a primary care physician and/or Shared Plan of Care (SpoC). For	

and Young Adulthood			-Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care	2024, 35.7% of children in Case Management had a primary physician and/or Shared Plan of Care (SpoC)	

III.E.2. State Action Plan Narrative Overview

NJ has remained committed to several of the SPNs from the last cycle as the contemporary efforts to address maternal morbidities and mortality, special child health medial home, adolescent health bulling, and overall gaps in health outcomes continue to improve the lives of many families in NJ. Based on an assessment of the past Title V funded efforts, and data gathered during the Title V Block Grant Needs Assessment process, a few new SPNs were added and integrated into the next five-year grant cycle's State Action Plan. The new needs included integrating two SPNs into one, Increasing Healthy Births and Bridging Gaps in Birth Outcomes. This need gets to the dual and overlapping mandates of ensuring healthy births while also ensuring that all populations across the state have healthy prenatal and postpartum outcomes, including delivery healthy babies.

Moreover, the addition to the SPN, Reduce Black Maternal and Infant Mortality is, Expansion and Strengthening of Evidence-Based Programs to Address Black Infant Mortality. Evidence-based programs addressing infant mortality directly connects to the reduction of black maternal and infant mortality; therefore, the two SPNs were combined.

Improving Exclusive Breastfeeding Rates as an SPN were added due to the state's increased focus on breastfeeding, evidenced by a Breastfeeding Strategic Plan (BSP) that was initiated in 2022, and of which the work is ongoing.

The SPNs of Promoting Healthy Youth Development, Improving Access to Quality Care for CSHCN and Promoting Healthy Youth Development and Reducing Teen Pregnancy and Sexually Transmitted Infections (STIs) remain as SPNs due to the ongoing growth of the related programs and the positive outcomes from the endeavors.

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

Women/Maternal Health Annual Report

The selection of the NPMs during the Five-Year Needs Assessment process recognizes the impact the life course approach will have on increasing healthy births and improving women's health across their life span. The Life Course Perspective helps to conceptualize health care needs and services for various populations, and which evolved from research documenting early life events' important role in shaping an individual’s health trajectory. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one’s lifetime. NJ has prioritized improving women's health and has utilized several evidence-based strategies to increase the NPM of Postpartum Visit including the HWHF, MIECHV, FIMR, and Maternal Mortality Review. The Murphy Administration has placed additional emphasis on reducing maternal mortality and morbidity through the NurtureNJ Initiative.

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

In 2022, the overall percentage of adequate prenatal care based on the Kotelchuck Prenatal Care was 69.7%. However, more needs to be done to improve care. This aligns with the need for TVP to improve SPN Increase Healthy Births and Bridge Gaps in Health Outcomes by focusing on preconception care and early prenatal care. Improving access to prenatal care is essential to promoting the health of NJ mothers, infants, and families. Early and adequate prenatal care is an important component of a healthy pregnancy and birth outcome because it offers the best opportunity for risk assessment, health education, and the management of pregnancy-related complications and conditions. Prenatal care is also an opportunity to establish contacts with the health care system and to provide general preventive visits.

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

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

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

TVP staff on the project team have access to data collected on this secure system. Connecting NJ is designed to simplify the referral process, improve care coordination, provide developmental screening, and ensure an integrated maternal, infant, and early childhood care system. From July 1, 2018, to January 1, 2025, more than 152,489 pregnant individuals were referred to CNJ and there have been over 104,024 service referrals given to these individuals. To better align the ESM with our current initiatives, ESM 1.2 (Number of individuals trained to become community-based doulas) was selected for its positive impact on NPM Postpartum Visit and Perinatal Care Discrimination, and the SPN of Increasing Healthy Births and Bridging Gaps in Health Outcomes.

In 2021, a Request for Application (RFA) was issued to create a NJ DLC, which was awarded to Health Connect One. The DLC has focused on reducing maternal and infant mortality and eliminating any differences in health outcomes by providing training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to grow the community doula workforce.

To date, approximately 344 individuals have been trained to become community doulas, and as of December 2024, 767 births have been supported by NJ's trained community doulas. To ensure the sustainability of community doula services in NJ, TVP staff worked collaboratively with Medicaid to offer community doula services to women through NJ FamilyCare benefits. NJ FamilyCare Medicaid benefits have been expanded to cover community doula services. Presently, a doula can now serve pregnant women whom NJ FamilyCare covers as a covered benefit. As of December 2024, 105 individual doulas and 7 doula group agencies have enrolled as fee-for-service community doula providers.

A mixed-methods outcome evaluation was conducted to examine the outcomes and benefits of the Doula Pilot Program as measured by quantitative data (i.e., program data from the Maternity Neighborhood database) and qualitative data (i.e., interviews with program stakeholders). Program outcomes and benefits were observed at three stakeholder levels: 1) client, 2) doula and grantee agency, and 3) NJDOH and state system levels (Figure 26).

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

Thus far, the CLG-CHWI has successfully trained and integrated over 800 CHWs into NJ health systems, and endeavors to expand its programs through state funding to include apprenticeships for perinatal CHWs and increased recruitment of Peer Mentors and Certified Nurse Assistants (CNAs; Figure 27).

Figure 26. Program Outcomes Across Clients, Doula and Grantees Agencies, NJDOH, and State Systems

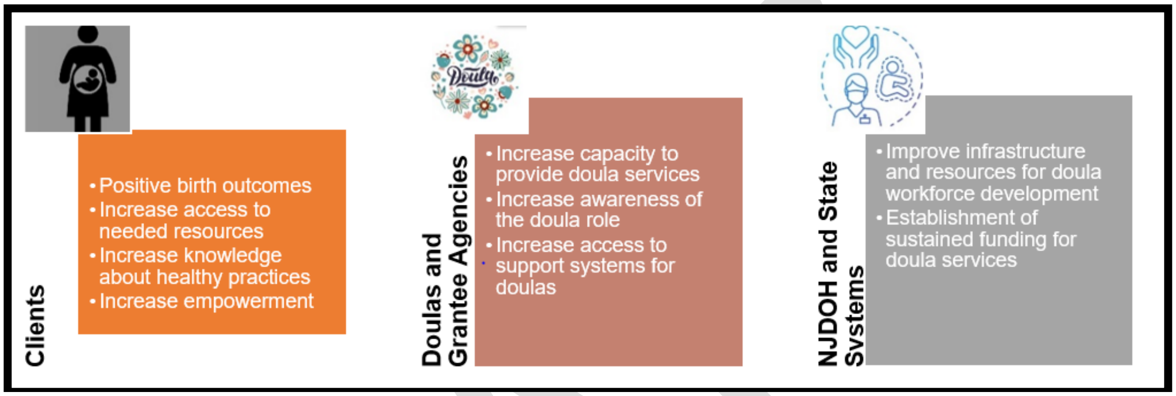
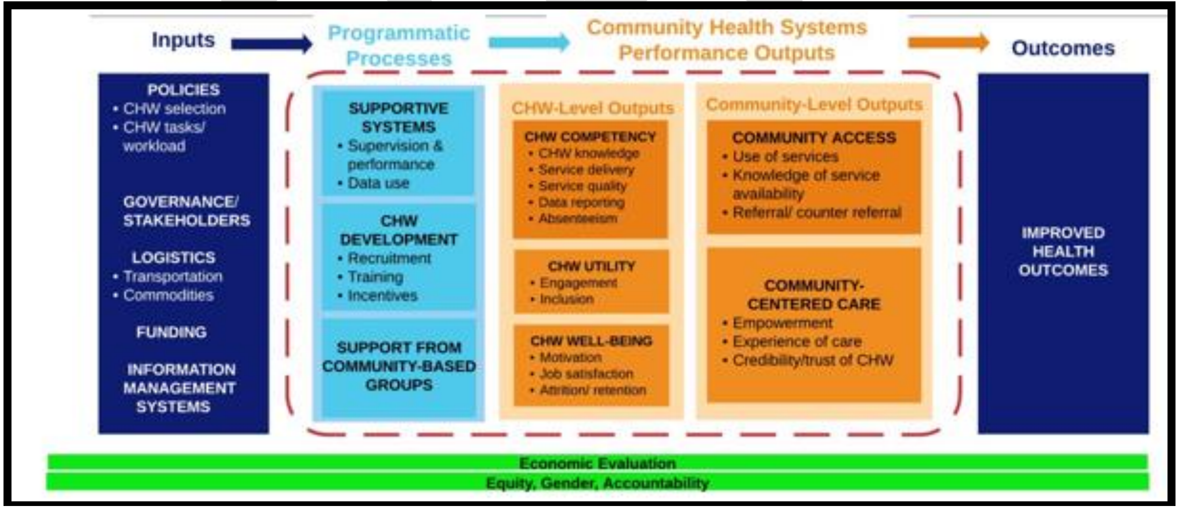


Figure 27. Overview of NJ Community Health Worker Workforce and Expected Outcomes



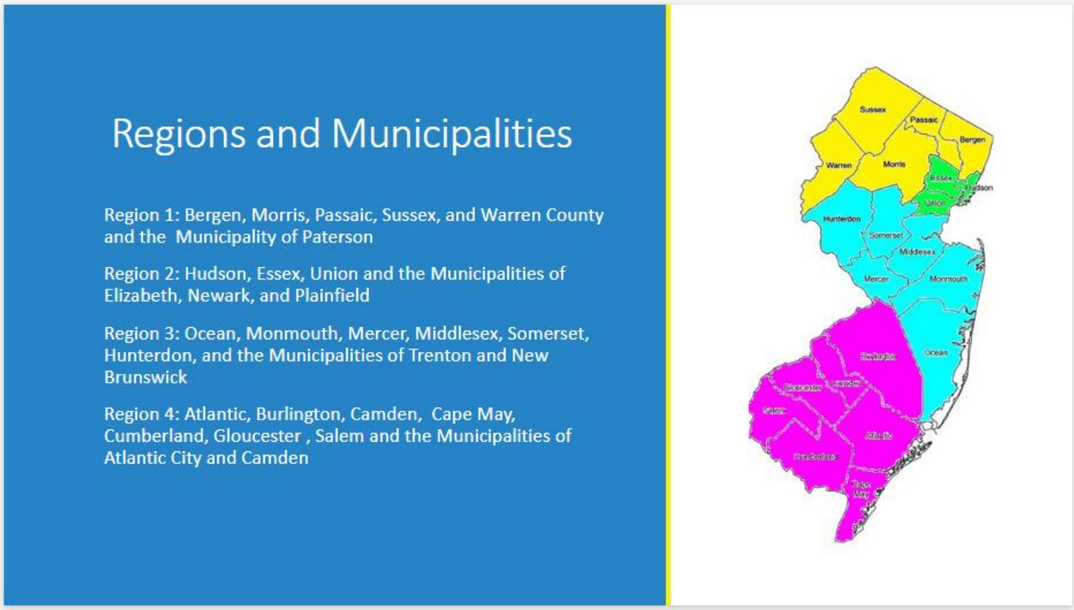
Moreover, TVP established the Colette Lamothe Galette-Community Health Worker Institute (CLG-CHWI) through a NJ Department of Labor (DOL) Apprenticeship to infuse additional services in the communities. TVP collaborates with community colleges throughout the state to create a standardized community health worker training and certification program, resulting in a robust CHW workforce. This apprenticeship opportunity has allowed the state to educate an emerging and critical component of its workforce – creating a needed infrastructure to support CHWs, enhance CHW skill sets, and lead sustainable efforts to support this indispensable workforce. Graduation of the initial cohorts has already begun, with new cohorts continuously being enrolled.

CHWs and their supervisors, through Title V grantees, have received and continue to receive breastfeeding education. Currently, the CLG-I and the DOH HWHF team are collaborating with the NJ State Breastfeeding Coordinator to develop a statewide standardized breastfeeding training and curriculum for HWHF CHWs and doulas to be delivered in 2025. These grantees have been implementing breastfeeding education and support for lactating individuals and their families through educational sessions with local community partners including community-based organizations, churches, community colleges, and local high schools, Breastfeeding-support is also being provided to participants by International Board-Certified Lactation Consultants (IBCLC), CLCs, and breastfeeding peer counselors either in groups or in one-to-one sessions.

The programs being implemented in the communities through the HWHF initiative allow TVP to implement specific activities to support communities with limited public health resources and the highest need where impacts will be greatest to improve population health outcomes and reduce health gaps. The HWHF Initiative addresses these gaps in birth outcomes through case management and assures that appropriate referrals are made and tracked including medical care referrals to promote healthy births (Figure 18). In addition, the Postpartum Doula Program is addressing postpartum care in specific municipalities with high Black and Hispanic Infant and Maternal Mortality rates to ensure that clients are attending postpartum visits and receiving adequate postpartum care, relating to the NPM of Postpartum Visit.

To ensure that the HWHF initiative is successful, NJ TVP collaborates with the NJDOH Office of Population Health and the Population Health in Action Teams. Through this collaboration, TVP established linkages with sister agencies DOL, Department of Education (DOE), Department of Transportation (DOT) etc.) and sought to address some of the barriers that exist in the scope of CHF. Additionally, efforts to reduce maternal mortality and morbidity have been and continue to be developed under First Lady Tammy Murphy's NurtureNJ Initiative, whose goal is to "make NJ the safest place to give birth in the country." In alignment with this initiative, the Alma Program Expansion Project was established as an evidence-based peer mentoring program created with and for new and expectant mothers experiencing depression, anxiety, and stress. By providing tools that can be locally adapted to meet the needs and elevate expertise within communities, this pilot program has already provided new and expectant parents with knowledge, skills, and support from peer mentors who have faced similar challenges. To date, 15 mentees have completed the six-to-eight-week program.

Figure 28. HWHF Regions for Fiscal Year 2025



Regions and Municipalities

Region 1: Bergen, Morris, Passaic, Sussex, and Warren County and the Municipality of Paterson

Region 2: Hudson, Essex, Union and the Municipalities of Elizabeth, Newark, and Plainfield

Region 3: Ocean, Monmouth, Mercer, Middlesex, Somerset, Hunterdon, and the Municipalities of Trenton and New Brunswick

Region 4: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester , Salem and the Municipalities of Atlantic City and Camden

Annual Report - NPM #14:

A) Percent of women who smoke during pregnancy and
B) Percent of children who live in households where someone smokes

The adverse effects of parental smoking on children have been a clinical and public health concern for decades and were documented in the 1986 U.S. Surgeon General's Report. Unfortunately, millions (more than 60%) of children are exposed to secondhand smoke in their homes. These children have an increased frequency of ear infections, acute respiratory illnesses, and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections leading to 7,500 to 15,000 hospitalizations annually in children under 18 months; and sudden unintended infant death (SUID). As a result of the many health consequences, the health costs of smoking during pregnancy are significant. Excess prenatal care costs and complicated births among pregnant women who smoke exceed $4 billion a year. (See NJ Pregnancy smoking rates in Table 3 below) It has been estimated that a 1% drop-in rate of smoking among pregnant women could result in savings to the US of $21 million in direct medical costs in the first year. Another $572 million in direct costs could be saved if the rates continued to drop by 1% annually over seven years. Secondhand smoke also has significant health effects on an infant.

Pregnant women exposed to secondhand smoke have a 20% increased risk of having an infant born with low birth weight, and secondhand smoke exposure also increases the risk of infections in the infant, and even death from SUID. Children living with smokers are also more likely to have more frequent and acute asthma attacks, ear infections, and serious respiratory illnesses like pneumonia and bronchitis due to second and third-hand smoke exposure (Table 8). The cost to care for childhood illnesses resulting from exposure to second and third-hand smoke is estimated at $8 billion annually. In addition to the effects during the perinatal period, health consequences for older children and adults (whether from direct smoking or second /third-hand exposure) are well documented in the literature and include respiratory infections, cancer, and death.

The adverse effects of parental smoking on children have been a clinical and public health concern for decades, as documented in the 1986 U.S. Surgeon General's Report. According to the 2022-2023 National Survey of Children's Health, it is estimated that over eight million children in the US live in households where someone smokes and an additional 3.2 million are living in households where someone vapes or uses electronic cigarettes (Table 9 & Table 10). These children are at greater risk for experiencing more frequent medical complications including ear infections, acute respiratory illnesses, related hospital admissions, severe asthma and asthma-related problems, lower respiratory tract infections and SUID. According to the literature, secondhand smoke exposure during pregnancy can cause an increased risk of infants born with low birth weight or preterm birth. ACOG Committee Opinion 807 asserts that "an estimated 5-8% of preterm deliveries, 13-19% of term infants with low birth weight, 22-24% of cases of SIDS and 5-7% of preterm related infant deaths have been attributed to prenatal maternal smoking.

According to the CDC, in 2018 it was estimated that cigarette smoking cost the United States more than $600 billion including healthcare spending, lost productivity, and premature death.

Table 8. Smoking rates in pregnant women in NJ 2017-2022

Year	Smoking in the month before you knew you were pregnant (4Ps Q8)	Pregnant Woman 2nd or 3rd Hand Smoke Exposure (PsychSoc Q)
2017	8.8%	7.3%
2018	7.8%	5.6%
2019	7.7%	6.0%
2020	6.0%	3.4%
2021	4.7%	2.1%
2022	4.1%	2.2%

Mom's Quit Connection for Families (MQCF) serves pregnant people and parents and caregivers of children <8 years old, to address not only the individual smoker but all smokers in the home environment. By helping the clients quit smoking, there is significant harm reduction for their children by decreasing second and thirdhand smoke. Referral sources include PRA, Quit for Kids escalation/chat, provider, and self-referrals. Multi-level interventions are standard, including mailing self-help materials, phone calls, texting, and direct individual cessation services. Relapse prevention interventions are an important part of the program to address the high relapse rates post-partum.

MQCF staff offer Orientations about the MQCF and the Quit for Kids (QFK) programs to providers. These Orientations discuss program parameters, referral options and the cessation resources available, to help attendees successfully implement these programs as a resource for Smoking Cessation services in their organizations. From July 2024 to March 2025, 3,845 professionals have been served.

MQCF's presence on social media remains strong. From July to December 2024, there was a total of 1,172 users to the MQCF website, with 1,152 of them unique/new users. The website continues to be a source of referral to the program, with 13 online self and provider referrals from July 2024 to March 2025. In addition, through the connection with FindHelp.org, 11 individuals received information on MQCF services and website. Every effort is being made to continue social media, which is the least expensive media venue. MQCF information and website are also now included on the Tobacco Free for a Healthy NJ (TFHNJ) monthly infographic. Viewers can click on the MQCF/QFK information, and the link will take them to the website. MQCF program information and tobacco use during pregnancy information are also included on the Prematurity Prevention Initiative (PPI) website and Facebook pages. Staff work closely with PPI staff to post information as well as referral options to MQCF. From July to December 2024, there were a total of 1,073 users to the PPI website, with 663 new users. 1,751 pages were viewed on the PPI website. The PPI Facebook page had a post reach of 545.

MQCF staff discuss the tobacco resources available on The Cooperative Resource Webpage frequently. This site provides an order form to select tobacco resources, and these are then mailed to the provider. Materials have been updated to include a QR code to the MQCF website. From July 2024 to March 2025, MQCF had 2,009 completed client contacts, including phone, text or in-person session, counseling introductions, intakes, providing materials and referrals to Quit for Kids. MQCF continues to offer Client Education in-person and virtually. From July 2024 to March 2025, MQCF staff conducted 14 Formal Client Education programs with 203 participants and four Informal Client Education programs with 62 participants. MQCF attended 38 Health Fair/Community Partner Events with 2,235 participants.

The Rinsey the Raccoon Rides Tobacco Free is a campaign to increase awareness of secondhand and thirdhand smoke as well as the general impacts of tobacco. Through story time events targeted to children ages 3-10 years old, as well as educational materials for parents and caregivers, families learn about the dangers of tobacco use and secondhand and thirdhand smoke exposure. To reach a wider audience via social media platforms, seven videos have been developed featuring Rinsey the Raccoon discussing various tobacco related information to inform children and families of the impact of tobacco. The team promotes the story time offerings and train the trainer curriculums through meetings, tabling events, and direct outreach to organizations. Upon completion of the train the trainers, organizations receive coloring books, presentation books, Rinsey handwashing posters, crayons, and handouts for parents including information on secondhand smoke and asthma, thirdhand smoke, and SUIDS. The team is continuing to reach out to groups working with youth (ages 11-17) to conduct train the trainers so that youth are empowered to read Rinsey for children ages 3-10. From July 2024 to March 2025, 350 Rinsey coloring books have been distributed. Staff have completed three story time events with 135 participants and collaborated with Cape Assist to train peer leaders, who conducted story times with 22 classrooms in the Lower Township Elementary School District and Lower Cape May Regional schools.

Table 9: Percent of women who smoke during pregnancy (last 3 months)

	2017	2018	2019	2020	2021	2022	2023
14 A. Percent of women who smoke during pregnancy	3.5	3.1	2.9	2.7	2.2	1.4	1.9

Data is from the NJ PRAMS Survey

Table 10: Percent of children who live in households where someone smokes

Annual Objective and Performance Data	2017	2018-2019	2020-2021	2022-2023
14B. Percent of children who live in households where someone smokes	n/a	9.7	9.7	8.5%

Data Source: National Survey of Children's Health (NSCH)-SCH 2022-23: Children who live in households where someone smokes. NSCH 2022-23: Children who live in households where someone smokes. someone smokes, Nationwide vs. New Jersey (nschdata.org)

Women/Maternal Health Application Year

Improving the domain of Women's/Maternal Health continues to be an area of focus for our TVS in NJ. For this reason, the SPNs of Increasing Healthy Births and Bridging Gaps in Birth Outcomes, Reducing Black Maternal and Infant Mortality and Expand & Strengthen Evidence-Based Programs Addressing Black Infant Mortality, and Reducing Differential Outcomes in Maternal Healthcare for Specific Populations are areas of focus for our MCH Unit.

Plans for the coming year to address the NPMs of Perinatal Care Discrimination, Postpartum Mental Health Screening, Postpartum Visit as well as Breastfeeding, will involve the enhancement of HWHF and collaboration with families, partners, and stakeholders in the newly implemented State MHI Program. The goal of HWHF continues to be to improve maternal and infant health outcomes for women of childbearing age (as defined by CDC as 15-44 years of age) and their families, especially Black, non-Hispanic and Hispanic women, through a collaborative and coordinated community-driven approach. The HWHF Initiative will continue to develop partnerships with community-based MCH providers/agencies with proven capabilities in implementing activities/interventions within a targeted community, chiefly, reproductive-age women and their families. The HWHF initiative focuses on implementing breastfeeding education and postpartum support, including connecting women in the acute postpartum period to clinical, follow-up care. Support programs for breastfeeding include 1:1 and group sessions by IBCLCs and peer counselors and the establishment of culturally and linguistically appropriate support groups. Breastfeeding educational sessions targeted to non-traditional groups such as fathers, support persons, teenagers, and grandparents have continued with collaborations with fatherhood programs, local community colleges and high schools. To support the continued increase in breastfeeding initiation at birth, a statewide BSP was created. The BSP was launched in 2022 and is currently being implemented and strengthened. The BSP workgroup has been established and convened with an array of representatives including TVP staff, DCF, HWHF CHWs, hospital representatives, state and local WIC staff, etc. Currently, the CLG-I and the DOH HWHF team are collaborating with the NJ State Breastfeeding Coordinator to develop a statewide standardized breastfeeding training and curriculum for CHWs and doulas to be launched in 2025.

Simultaneously, county-based consumer-driven advisory boards continue to contribute to the direction and progress of the HWHF initiative, in collaboration with the Connecting NJ Hubs and other early childhood partners who meet quarterly to build partnerships and local referral systems. The HWHF and Connecting NJ staff have been collaborating with NJDCF's funded Universal Home Visitation Program, Family Connects NJ, which began providing universal postpartum home nurse visits to NJ residents in January 2024. Family Connects NJ began servicing five NJ counties in January 2024 and five additional in January 2025 with a yearly rollout plan to include all 21 counties by January 2027. Connecting NJ hubs have served as the main source to refer new families to Family Connects NJ and dedicated Community Alignment Specialists housed at all the CNJ hubs serve as a coordinator for MCH resources and services. Family Connects NJ nurses also serve as a touchpoint in the homes to refer to long term MCH services such as TVP like HWHF CHWs and postpartum doulas and other home visiting services. The MIECHV Programs and Healthy Start Programs will continue to case manage mothers and assure preventive medical visits through the monitoring of benchmarks, including a reproductive life plan, medical home, and well-women visits. These initiatives will support mothers in all stages of their perinatal journey, and with an acute focus on the NPM of Postpartum Visit, which connects to the NPM of Postpartum Mental Health Screening.

The NJDLC will be enhanced this grant cycle, as the NJDOH, NJ FamilyCare and MIHIA programs partner to increase the doula workforce and doula capacity, enrolling those trained into the NJ FamilyCare system. Additionally, the NJDLC will provide training, workforce development, mentoring, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ. The NJDLC provides cultural competency training and education in NJ-specific community-based resources for doulas. The NJDLC is working with Medicaid to ensure that the NJ community doula training curriculum is approved for community doulas to enroll as NJ FamilyCare Community Doula provider to receive Medicaid reimbursement. We hope to continue the momentum we gained in 2024 and continue to enroll doulas and doula groups as fee-for-service community doula providers. The integration of doula care during a woman's perinatal journey will enhance opportunities for support, connection to resources and advocacy. Furthermore, the involvement of community doulas, who the NJDLC actively recruits and trains, come from the same communities which their clients/patients are part of. This characteristic parity between service professional and client/patient will help to decrease the potential for differential health outcomes for mothers from different racial categories, addressing the NPM of Perinatal Care Discrimination.

The CHWI will continue to enhance the professional development of CHWs and allow for a stronger workforce. The CLG-CHWI will continue to expand its programs through state funding and now will include apprenticeships for perinatal CHWs, an initiative to improve maternal-child health outcomes, Peer Mentors, and Certified Nurse Assistants (CNAs).

In the Spring of 2023, NJDOH released a Request for Funding Application (RFA) to establish the CHW Hub. The CHW Hub is intended to build a Community Health Worker (CHW) workforce to be trained and deployed. The RFA was awarded to Acenda, Inc. Acenda Inc. is a non-profit community focused agency based in Gloucester County. The agency is licensed by the NJ Division of Mental Health and Addiction Services to provide outpatient SUD treatment, recovery groups counseling, relapse prevention, and residential treatment. The CHW Hub will lead deployment strategies in integrating CHWs into health and care teams to assist in addressing mental health, substance use disorder, and other chronic conditions found in the community. The CHW Hub will give trained CHWs access to numerous employment opportunities throughout the state.

NJDOH continues to offer Rutgers ECHO training series into and through 2025. This information gives doulas and CHWs the training needed to support the MCH population in service navigation amidst social and economic stressors. NJDOH ECHO sessions included information to address social needs that COVID-19 exacerbated within vulnerable communities. Presently, the Rutgers ECHO series is ongoing in conjunction with our CLGI.

TVP announced a competitive request for application (RFA) to expand the Alma Program in NJ, which was awarded to Family Health Initiatives. Alma is an evidence-based peer mentoring program created with and for new and expectant mothers experiencing depression, anxiety, and stress. Developed by a collaborative team of researchers, mental health providers, community members, and moms, Alma gives new and expectant moms the support and skills they need to navigate this important chapter in their lives.

The Alma Program Expansion Pilot Project has provided new and expectant parents with evidence-based knowledge, skills, and support from peer mentors who have faced similar challenges. By providing tools that can be locally adapted to meet the needs and elevate expertise within communities, the Alma Expansion project aims to improve maternal mental health and eliminate any differences in health outcomes through, program delivery support, an expanded focus on substance use, and a focus on advocacy to sustain the Alma Program in the State of NJ. In 2025, Alma will be further modified and enhanced after learning from the pilot program what works and what needs of the community demand attention.

Additionally, informed by the recommendations made through the Fetal Alcohol Syndrome (FAS) Prevention and Postpartum Depression and Mood Disorders (PPD-MD) evaluation projects, TVP is drafting a new RFP for the aforementioned programs. These RFPs will be released in 2025 and will focus on increasing education, awareness, and access to services for women diagnosed with FAS and/or PPD-MD.

Through HWHF Initiative and the interventions and activities, TVP will continue to develop partnerships with community-based MCH providers/agencies with proven capabilities in implementing activities/interventions within a targeted community and the capability to focus on reproductive-age women and their families.

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

Plan for the Application Year

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

- Promoting Mom's Quit Connection for Families (MQCF) to expand reach to pregnant women, parents, and caregivers of young children in NJ.
- Increasing Capacity for Direct Service in NJ including for mental health screening
- Maintain MQCF's existing services statewide
  - Promote onsite trainings, orientations, and webinars to MCH professionals in Central and Northern NJ.

Preventing relapse after delivery;

- Continue the development of the smoking cessation interactive app using Quit for Kids texting support program that provides customized messaging and interactive activities from the first trimester through the postpartum period. QFK uses a "concierge" concept that tailors messaging to personal, emotional, social, and environmental issues happening in the client's life throughout and beyond her pregnancy.
- Continue to offer Relapse Prevention counseling to all clients.

Perinatal/Infant Health Annual Report

The domain of Perinatal/Infant Health sets the trajectory of the health of a child throughout the Life Course. NJDOH has identified the following SPNs of Reduce Black Maternal and Infant Mortality by Expanding & Strengthening Evidence-Based Programs Addressing Black Infant Mortality and Improving Nutrition, Food Security and Increasing Physical Activity and selected the related NPMs of Breastfeeding and Infant Safe Sleep as a result of the Five- Year Needs Assessment process. NJ has implemented several evidence-based strategies related to these NPMs, which impacts several NOMs.

Annual Report – Previous NPM 4:

A) Percent of infants who are ever breastfed and;

B) Percent of infants breastfed exclusively through 6 months

Promoting breastfeeding has been a long-standing priority for FHS. Breastfeeding is universally accepted as the optimal way to nourish and nurture infants, and it is recommended that infants be exclusively breastfed for the first six months of their life. Breastfeeding is a cost-effective preventive intervention with far-reaching effects for mothers and babies and significant cost savings for families, health providers, employers, and the government. Breastfeeding provides biologically normal, appropriate nutrition and encourages normal infant development; lack of breastfeeding increases the risk of disease and obesity. FHS has developed many strong partnerships to strengthen breastfeeding-related hospital regulations, promoting breastfeeding education, training, and community support in the past grant cycle.

In 2022, in collaboration with TVP, the NJDOH released the BSP. Presently, TVP staff sit on the committee that partakes in the implementation of the BSP. The Title V Director also secured funding from the FY24 Governor’s budget for dedicated staff to lead implementation of the BSP. A statewide coordinator was hired effective March 2024, and a project associate shortly after. For the past two years TVP staff have continued to participate in the BSP Steering Committee meeting monthly with the NJ State Breastfeeding Coordinator and other representatives of NJ’s early childhood and MCH systems.

The ESM of Increase the Percentage of Births in Baby-Friendly Hospitals was selected for its positive impact on the health outcomes of mother and child, and NJ's ongoing efforts to promote the Baby-Friendly Hospital Initiative and its ability to monitor breastfeeding rates from birth certificate data and the mPINC Survey.

According to the Centers for Disease Control and Prevention (CDC) 2021, National Immunization Survey Breastfeeding Rate Report Card, NJ rates for newborns ever breastfed in 2020 was 81.6%. Breastfeeding rates in four categories of interest from 2019 to 2020 are depicted in the table below (Table 11).

Table 11. Breastfeeding rates of Infants in NJ

Categories	2019	2020
Infants who were exclusively breastfed through 3 months	41.2%	43.3%
Infants who were breastfed at 6 months	55.4%	61.1%
Infants who were exclusively breastfed through 6 months	23.4%	25.1%
Infants who were breastfed at 12 months	33.8%	38.7%

While the percentage of infants who were exclusively breastfed through three months increased, the percentage of infants who were breastfed at 6 months decreased, the percentage of infants who were exclusively breastfed through 6 months increased, and the percentage of infants who were breastfed at 12 months decreased.

FHS has supported Baby-Friendly™ designation through training, technical assistance, and mini-grants. The Baby- Friendly Hospital Initiative (BFHI) is a global program launched by the World Health Organization and the United Nations Children's Fund to encourage and recognize hospitals and birthing centers that offer optimal care for infant feeding and mother/baby bonding. BFHI recognizes and awards birthing facilities that implement the Ten Steps to Successful Breastfeeding (i) and follow the International Code of Marketing of Breast-milk Substitutes (ii). Thirteen NJ hospitals have earned the "Baby-Friendly" designation. About 27% of NJ Birthing Facilities achieved Baby-Friendly status

NJ hospitals participate in the Maternity Practices in Infant Nutrition and Care (mPINC) Survey, a national survey of maternity care practices and policies conducted by the CDC every two years, beginning in 2007. In 2020, 40 of 49 (82%) eligible hospitals participated in the mPINC Survey, and the total score was 82 (above the national score of 81).

Existing Breastfeeding-related Programs

Presently, WIC Services provide breastfeeding promotion and support services for WIC participants through grants to all 16 local WIC agencies. International Board-Certified Lactation Consultants (IBCLC) and breastfeeding peer counselors provide direct education counseling and support services, literature, and breastfeeding aids, which include breast pumps, breast shells, and other breastfeeding aids. WIC staff conducts the *Loving Support*© through the Peer Counseling Breastfeeding Program. Moreover, WIC breastfeeding staff conducts professional outreach in their communities and education to healthcare providers who serve WIC participants. Close collaboration between Maternal and Child Health Services (MCHS), WIC Services (WIC), and the Office of Community Health and Wellness is ongoing. All three programs, in addition to the Office of Minority and Multicultural Health, have an interest in breastfeeding protection, promotion, and support and have similar constituencies.

Through the HWHF initiative, TVP implements community-level programs that promote breastfeeding and potentially address persistent population gaps. For instance, one of the target outcomes of HWHF is increasing exclusive breastfeeding. Additionally, to address the differences in breastfeeding rates, implementing breastfeeding support and education to non-traditional audiences as a mechanism to increase support for non-Hispanic Black and Hispanic women is one of the interventions/strategies of HWHF. Considering that breastfeeding is a "family affair," fathers' and other family members' involvement in the process is a puzzle piece that is supported by the HWHF initiative through its focus on non-traditional audiences. Moreover, CHWs, postpartum doulas, and their supervisors receive breastfeeding education through multiple trainings, educational sessions, and professional development opportunities to become CLCs and IBLCs. Currently, the CLG-I and the DOH HWHF team are collaborating with the NJ State Breastfeeding Coordinator to develop a statewide standardized breastfeeding training and curriculum for HWHF CHWs and doulas to be delivered in 2025. Additionally, the state's breastfeeding coordinator is training Family Connects nurses, our state's Home Visiting nurses, to ensure there is an increase in breastfeeding education throughout the various NJDOH programs in the state. Furthermore, the breastfeeding coordinator is working to increase the number of lactation providers involved in the Zipmilk network, to ensure women and families across the state have access to breastfeeding resources and support.

Annual Report NPM: Infant Safe Sleep

NJ TVP utilizes block grant funding to fund the SIDS Center of NJ (SCNJ). SCNJ implements activities that seek to reduce NJ rate of Sudden Unexpected Infant Death (SUID) which is comprised of Sudden Unexpected Infant Death Syndrome (SUIDS), Ill-defined and Unknown Cause, and Accidental Suffocation and Strangulation in Bed. Research by the Rutgers Robert Wood Johnson Medical School faculty of SCNJ contributed to risk reduction guidelines of American Academy of Pediatrics (AAP), and in association with SCNJ's development and provision of educational programs, tools, and methodologies, including community discussion groups, and its outreach to the public and to health care, social service, childcare, and public health providers, institutions and programs, faith- based communities, home visiting programs, doulas, and community organizations, along with other initiatives that interface with caregivers and communities, NJ's rate of SUID in 2022, the most recently released linked birth/infant death data by the Centers for Disease Control and Prevention (CDC), is second lowest of all States meeting CDC statistical standards for confidentiality and reliability. At 0.52 per 1000 live births, NJ's SUID rate is half the national rate of 1.01. Through its many collaborations, SCNJ has developed the access and trust needed to raise not just knowledge but also the practice of safe infant sleep and other risk-reducing behaviors. In addition, SCNJ monitors variations in rates among population subgroups, identifying and raising awareness of potentially actionable adverse social and health determinants, and targeting communities at greater risk with additional bespoke educational interventions. TVP plays a key role in monitoring the activities and ensuring they respond to New Jerseyans' needs.

Promoting safe infant sleep was selected as an NPM during the Five-Year Needs Assessment process for its importance in reducing often preventable infant deaths and its potential impact on improving a number of previous NPMs. Sleep-related SUID includes SIDS, a leading cause of infant death after the first month of life and third leading cause of death overall.

Due to the strong evidence of the heightened risk of SUID when infants are placed to sleep on side or stomach sleep positions, health experts and the American Academy of Pediatrics (AAP) have long recommended the back sleep position (Ostfeld et al. Pediatrics, 2006). The back sleep position has been called one of the seven leading research findings in pediatrics in the last 40 years (Goodstein & Ostfeld, Pediatrics, 2017). As in its prior publications, the AAP's 2022 updates to its evidence-based recommendations to help reduce the risk of these sleep-related deaths advise that a safe sleep environment should include placing infants to sleep on their backs and having the infant share a parent's room in a crib, bassinet, portable crib, or play yard that meets current Consumer Product Safety Commission standards situated close by the parent's bed. AAP recommends that the sleep space should contain a firm and flat mattress of the type intended for the product used and that the sleeping space be free of soft and loose bedding such as bumpers, pillows, and blankets. Additional recommendations include breastfeeding or the provision of human milk and avoiding overheating and nicotine exposure from any source during pregnancy and after birth. These along with other evidence-based recommendations for the first twelve months of life underlie the National Institute of Child Health and Development (NICHD)

Safe to Sleep Campaign and the work of the SIDS Center of NJ, whose research continues to contribute to the safe sleep policies of the AAP. Adverse social and health determinants, including poverty, preterm birth, delayed or absent prenatal care and obesity also increase vulnerability. Populations found to be at highest risk demonstrate a higher percentage of these and other adverse social and health determinants independent of sleep position. And these risk factors are also identified and addressed by the SCNJ.

The selection of ESM to Promote Infant Safe Sleep Environments monitors and focuses on the safe sleep environment (Healthy Sleep), including back to sleep, no co-sleeping, and no soft bedding. Over 10 years, there has been an upward trend in the use of back-to-sleep placement (Table 12).

Table 12. Percent of Infants placed to sleep on their backs

Table NPM #5	2009	2011	2013	2015	2017	2019	2021	2022	2023
Percent of infants placed to sleep on their backs	65.7	68.9	69.5	70.5	75	73.0	75.2	76.2	67.6

Notes - Source – NJ PRAMS.

https://www-doh.state.nj.us/doh-shad/indicator/view/SafeSleep.Trend.html

In 2003, 58% of infants were placed to sleep on their backs. Since then, the trendline has demonstrated a rise in this behavior, with the 2022 percentage of 76.2%, however a dropped was observed in 2023, 67.6%, which fail to surpass the 2020 Healthy NJ target that 74.1% of infants be placed on their backs. These statistics warrant a need for continuous safe sleep practices education for New Jerseyans.

For 2017-2020, the percentage of Black NH, and White NH infants placed on their backs surpassed the individual target goals for each group established by HNJ 2020. For White NH in 2022, 84.8% were placed on the back. However, as with national data, the reported use of back-to-sleep is lower in Black NJ infants. In 2003, 37.8% of Black NH infants were placed to sleep on their backs, rising to 56.3% in 2023, continuing to surpass the 2020 Healthy NJ target of 53.7% but of concern. Poverty, defined here as coverage by Medicaid rather than private insurance, is associated with a higher rate of SUID, as is also evident in NJ Black NH cases (2.49 vs. 0.91, respectively, per 1000 live births). In a comparison of the percent of NJ births (2017-2021) covered by Medicaid/Medicaid + Private insurance, SCNJ determined that 55% of Black NH births (2017-2021) were covered by Medicaid, in contrast to 77% of Black NH SUID cases. To enhance parent education by caregivers working with families covered by Medicaid, SCNJ created a new comprehensive educational initiative involving stakeholders in the Medicaid, Federally Qualified Health Centers, and Division of Child Protection and Permanency (DCP&P) offices that included a novel component involving onesies with back to sleep messaging in several languages. Education on risk reduction content, on methods for providing culturally sensitive and respectful education, and on the provision of supplemental educational materials in multiple languages, including Haitian-Creole, reached individual healthcare providers and case workers. The newly formed Universal Nurse Home Visiting Program (Family Connects) is also now a participant. Supportive leadership underscored to its staff the importance of providing education across the lifespan including grandparents. This targeted approach has continued, with, for example, close to 2,000 cases workers at DCP&P already trained by SCNJ in the first two months of 2025, and recordings being completed to orient future staff. However, there is are disadvantages among certain groups in factors other than supine placement that play a role in SUID rates. For example, with respect to the risk factor of preterm birth, (Ostfeld et al. Pediatrics, 2017) the percent of these births in NJ declined from 8.3 in 2019 to 7.7 in 2020 in White NH, while the percent of Black NH preterm births remained higher and constant at 13.8 and 13.7, respectively. According to the March of Dimes, in NJ, the preterm birth rate among Black women is 55% higher than the rate among all other women. Smoking is a major risk factor, (Ostfeld et al. J Perinatol., 2023), and a higher percentage of Black NH than White NH mothers smoked in the three months before pregnancy (9.4% vs. 6.4%, respectively).

Of concern, Ostfeld et al. (J Perinatology, 2023) found that most women entering pregnancy as smokers continue to do so throughout pregnancy. Similarly, pre-pregnancy obesity, a more recently identified risk factor, was evident in some groups more than others. Given these differences in adverse social and health determinants, SCNJ takes a multifactorial approach, addressing these issues in educational, clinical, and research forums. An example is its new initiative targeting vaping, an alternative delivery system of nicotine, the active agent of concern. Given the rise in this modality, particularly in future parents, and the rise as well, in a new and large body of research documenting adverse outcomes, SCNJ has provided an extensive and broad-reaching education both in the US and abroad as well as to NJ's social service and healthcare providers and to staff in programs that serve higher risk communities. The three examples of adverse social and health determinants provided here can best be addressed ahead of pregnancy as well as during pregnancy. Yet, 20.8% of SUID cases had 5 or fewer prenatal visits in 2021 in contrast to only 7.5% of all births with such low or absent prenatal care. Accordingly, SCNJ participated in forums such as NurtureNJ to promote shared goals related to accessing pre-pregnancy and pre-partum health care.

To promote infant safe sleep, NJDOH has supported the evidence-based strategies of the American Academy of Pediatrics and NICHD's Safe to Sleep Campaign, as actualized in the activities of the SIDS Center of NJ (SCNJ), www.facebook.com/sidscenternj/, and www.rwjms.rutgers.edu/sids, and the work of the SUID Case Review Workgroup which includes representation from the SCNJ. To improve the surveillance of infant safe sleep practices, TVP conducts the PRAMS survey, which includes questions on infant safe sleep, and participates in the SUID-CR Workgroup.

The SCNJ is a program funded by the TVP program to Robert Wood Johnson Medical School (RWJMS), a part of Rutgers, The State University of NJ, New Brunswick, and is based both at RWJMS and the Joseph M. Sanzari Children's Hospital at Hackensack University Medical

Center, Hackensack, NJ. SCNJ was established in 1987 through the SIDS Assistance Act. The SCNJ's missions are to: 1) provide public health education to reduce the risk of SIDS, 2) offer emotional support to bereaved families, and 3) participate in efforts to learn about possible causes of and risk factors associated with SUID, best practices for providing safe sleep education and other risk-reducing messages and identifying and addressing systemic challenges and barriers. Research by SCNJ faculty has contributed to the identification of risk factors and risk-reducing strategies (i.e., Ostfeld et al. Pediatrics 2006; Ostfeld et al. Pediatrics 2010; Ostfeld et al. Pediatrics 2017).

The SCNJ develops novel safe sleep interventions and tools to educate providers and the public including parents, grandparents, physicians, nurses, the childcare community, hospitals, clinics, first responders, high schools, social service agencies, home visiting programs, doulas, and faith-based communities. It works with state, federal, and national organizations to reduce infant mortality, and the adverse antecedent social and health determinants that increase vulnerability to unsafe sleep environments. SCNJ follows the guidelines of the AAP when providing risk reduction education to help families reduce the situational risks that are associated with SUID.

As noted, NJ SUID rates are among the lowest in the US, declining from 1.13 per 1000 live births in 1990- 1992 to 0.52 in 2022, making NJ's rate second lowest of all states meeting the CDC's statistical criteria for confidentiality and reliability. However, NPM#5 persist throughout the US and are addressed in NJ through targeted professional and community education projects by the SCNJ and its many collaborators, including the home visitor staff in DCF and the MIEC Home Visiting Program both of whose staff receive training from SCNJ.

NJ has participated in the Sudden Unexpected Infant Death Case Review (SUID-CR) Registry grant funded by the CDC since 2006. SUID-CR activities have standardized, and improved data collected at infant death scenes and promoted consistent case review, classification, and reporting of SUID cases. NJ TVP and SCNJ are represented on the multi-disciplinary SUID-CR Review Board, which meets monthly as a subcommittee of the Child Fatality and Near Fatality Review Board (CFNFRB). The SUID-CR is staffed by the DCF and is an important statewide surveillance system for unexpected infant deaths. The SUID-CR makes recommendations to the statewide CFNFRB concerning infant safe sleep and promotes SUID prevention activities which are included in the CFNFRB annual report.

In 2018, SCNJ developed a unique and free app, SIDS Info. for iOS and Android devices to enhance the education of parents and providers about safe infant sleep and enable parents and others to have direct access to this information. This novel and interactive tool contains graphics, English and Spanish text, voiceovers to eliminate language and literacy challenges, and additional resources. It gives nurses, physicians, childcare specialists, caseworkers, home visitors, and other providers a new and standardized way of reviewing the information with parents. Providers also help families download the app to their phone. The app can reduce the need for print material, be efficiently updated, and be more accessible and enduring than print material.

Annual Report – SPM: The percentage of Black non-Hispanic preterm births in NJ

The selection of SPM of the percentage of Black non-Hispanic preterm births in NJ during the Five-Year Needs Assessment process recognizes the persisting gaps in healthy birth outcomes in NJ Infants born prematurely. Premature infants are at the highest risk for infant mortality and morbidity. The percentage of Black preterm births was selected to potentially address the underlying causes of Black infant mortality and the differences that exist between preterm birth rates (Table 13)

The selection of ESM: Promote referrals to evidence-based interventions aiming at reducing Black infant mortality was selected for both SPM # 1 and 7.

Table 13. SPM1 Percentage of Black, NH preterm births in NJ from 2009-2022.

	2017	2018	2019	2020	2021	2022
Annual Indicator	13.1	13.5	13.8	13.7	13.1	13.3
Numerator	1,774	1,835	1,803	1,721	1,666	1,660
Denominator	13,530	13,643	13,043	12,587	12,743	12,500

Notes - Source - Birth Certificate data from the SHAD system https://www-doh.state.nj.us/doh-shad/

Improving maternal and infant health and reducing Black, non-Hispanic infant mortality is a priority within the NJDOH/FHS. Key MCH indicators (including low birth weight, preterm births, and infant and maternal mortality) have not improved significantly over the last decade in NJ, and significant differences persist.

In 2023, preterm birth affected about 1 of every 11 infants born in the US. NJ's overall very preterm birth rate decreased from its peak of 1.8% in 2006 to 1.3% in 2021 and, among singletons, the rate declined from 1.4% in 2000 to 1.1% in 2021.NJ's preterm birth rate was 9.3%. However, differences persist. During 2020-2022 (average) in NJ, preterm birth rates were highest for black infants (12.8%), followed by American Indian/Alaska Natives (10.1%), Asian/Pacific Islanders (8.6%) and White, Non-Hispanics (8.5%). Black infants (12.8%) were about two times as likely as White, Non-Hispanic infants (8.5%) to be born preterm during 2020-2022 (average). In the United States, prematurity/low birthweight is the second leading cause of all infant deaths (during the first year of life) and the leading cause of infant death among Black infants. To address these gaps and reduce the preterm birth rates, the TV Reproductive and Perinatal Health Services Team implement the Preterm Birth Prevention Program (PBPP).

In collaboration with TVP staff, during SFY24, the PBPP accomplished the following:

1. Designed and launched a doula-focused survey to identify potential information barriers and opportunities for partnership.
2. Created new markers in the PRA to identify patients at risk for preterm delivery and began working on a self-service tool based on data pre-populated sections of the PRA.
3. Distributed 539 To-Go Kits with health monitoring tools (e.g., blood pressure cuffs, odometers), self-care resources, and health information referral pamphlets to patients with specific chronic conditions who have been identified as being at risk for preterm delivery.
4. Distributed over 3,330 flyers about clinical services to prevent preterm birth to providers, administrative staff, and pregnant women across the State.

5. Engaged with more than 12,000 unique accounts via social media platforms LinkedIn and Instagram.
6. Hosted 21 community events that engaged 851 community members and attended 58 professional meetings and events providing information that focused on health risks for preterm delivery and resource allocation in NJ Communities.
    - Example: Community Baby Shower at Boys & Girls' Club of Atlantic City. Hosted in partnership with AtlantiCare's Safe Beginnings program, HWHF, and Healthy Families Atlantic County. Donations made by the Bridge of Books Foundation, NanoBebe, Vic's Subs of Galloway, and HWHF. 28 attendees.
7. Designed and planned new educational workshops and whole-health events for pregnant women with complex care needs (e.g., cardiovascular diseases, diabetes, hypertension, and chronic behavioral health needs) at risk for preterm delivery.

The objectives for SFY25 are in accordance with Healthy People 2030 objective, and are as follows:

1. Between 10/2023 and 09/2024, PBPP staff will create or leverage three to five provider-focused resources (such as toolkits, surveys and provider-focused presentations) to support their efforts in providing timely information about preterm birth prevention and available treatment options (e.g., vaginal progesterone cream, cerclage, and education).
2. Between 10/2023 and 09/2024, PPP will host at least four consumer-facing events and at least four Clinical Leadership meetings to develop additional resources and services for future preterm birth prevention service implementation.
3. Between 10/2023 and 09/2024, PBPP staff, using the PRA data, will identify at least 300 individuals who are eligible for preterm birth prevention services in Cumberland, Mercer, Atlantic, Gloucester, Hudson, and Essex counties.
4. Between 10/2023 and 09/2024, PBPP will create at least two statewide clinical service best practice standards and pilot these resources in collaboration with home visiting programs, FQHCs, doulas, and providers in the focus areas.

Annual Report – SPM: The rate of Black Infant Mortality in NJ per 1,000 Live Births

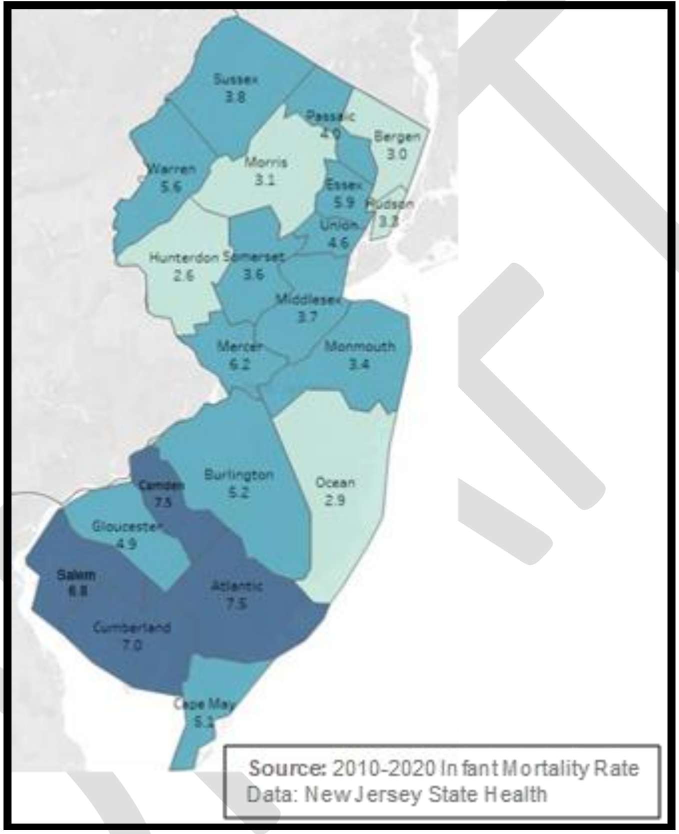
Table 14. Black Infant Mortality in NJ per 1,000 live births

	2017	2018	2019	2020	2021
Annual Indicator	9.4	8.8	8.5	9.1	7.8
Numerator	127	120	111	114	100

Notes - Source - Birth Certificate data from the SHAD system https://www-doh.state.nj.us/doh-shad/

In 2021, the Black, NH infant mortality rate in NJ was 7.8 compared to 2.5 per 1,000 Live Births for White, NH infants (Table 14; Figure 29). The Hispanic infant mortality rate was 3.6 per 1,000 Live Births. Differences exist between NJ counties and municipalities in terms of Black Infant Mortality rates and other health outcomes. Counties such as Atlantic, Camden, Cumberland, Essex, and Warren have high Black Infant Mortality rates (Figure 29). Further investigation within these counties showed that certain municipalities were driving these high county rates, and therefore efforts within these municipalities are the focus of the HWHF initiative. To tackle these gaps, TVP implemented the HWHF in the communities.

Figure 29. Infant Mortality by NJ Counties, 2010-2020



Source: 2010-2020 Infant Mortality Rate
Data: New Jersey State Health

There are many potential causes of these differences, but recent research has highlighted the effects of CHF such as economic disadvantages (i.e., underemployment, or unemployment), limited education (e.g., low educational attainment), environmental barriers (e.g., housing instability, structural), and social/behavioral factors (e.g., nutrition and exercise) as major contributors to health outcomes. Addressing these CHF requires a comprehensive, system-level transformation that begins at the community level.

To better align the ESM with our current initiatives, ESM Number of individuals trained to become community- based doula was selected. Through the NJDLC, the professional home for community doulas in NJ, TVP seeks to reduce maternal and infant mortality and eliminate any gaps in health outcomes. The NJ DLC provides training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ. The NJDLC focuses on developing and supporting the doula workforce that delivers doula care to NJ's Medicaid and CHIP members as enrolled NJ FamilyCare providers. As of December 2024, 105 individual doulas and 7 doula group agencies have enrolled as fee-for-service community doula providers. The DLC recruited, trained, and certified first cohort of 36 Perinatal CHWs (PCHW) to further support birthing individuals and potentially decrease the infant mortality rate. These PCHWs focused on helping birthing individuals navigate the healthcare system, accessing needed services, and improving adverse birth outcomes. The trained doulas provide equitable and culturally responsive care to pregnant women during pregnancy, birth, and postpartum, potentially lowering maternal and infant health complications rates. Multiple studies have shown that doula care can improve maternal and infant health outcomes; reduce preterm births and low birthweight infants; lower rates of cesarean sections; and increase rates of breastfeeding by amplifying pregnant women's voices and listening to their needs.

Perinatal/Infant Health Application Year

Plan for the Application Year: NPM *Breastfeeding*

A) Percent of infants who are ever breastfed and

B) Percent of infants breastfed exclusively through 6 months

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

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

The BSP team plans to prioritize the following initiatives in 2025: launch the NJ Supports Breastfeeding media campaign, engage stakeholders to develop the lactation workforce, facilitate creation of an interactive breastfeeding data dashboard, provide support to hospital-based lactation departments, and bolster lactation education during the perinatal period through collaborations with obstetric and midwifery organizations. The BSP team continues to partner with staff from DOH, NJ WIC, the DCF, the Division on Civil Rights, NJ Division of Medical Assistance and Health Services (Medicaid), the MCH consortia, and other stakeholders to accomplish these goals. NJ has also created and elevated an SPN of Improving Exclusive Breastfeeding Rates for the first Six Months after Birth to further elevate the priority and use metrics to track success over the grant period.

Efforts to promote Baby-Friendly Hospital Initiative (BFHI) designation through training, technical assistance, and mini-grants will continue to promote NPM 4. Surveillance through the Birth Certificate file and the mPINC survey will continue to identify areas of potential improvement.

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

The BSP's primary purpose is to provide a roadmap to identify and foster policy, environmental, and system changes to increase breastfeeding initiation, duration, and exclusivity in NJ. Since the release, TVP staff has been actively involved in the committee and worked on materials to support the implementation of the strategic plan. With the hiring of dedicated breastfeeding coordination staff, TVP staff will remain involved in the implementation process of the strategic plan and continue collaborating with the BSP team on their breastfeeding media campaign and breastfeeding trainings and curriculum for CHWs and doulas. WIC will continue to provide breastfeeding promotion and support services to pregnant and breastfeeding women who participate in the program.

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

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

Plan for the Application Year - NPM Safe Sleep

The SIDS Center of NJ (SCNJ), a part of Rutgers University, was established in 1987 through the SIDS Assistance Act. SCNJ's missions are to: 1) offer emotional support to bereaved families, 2) participate in efforts to learn about possible causes of and risk factors associated with SUID, best practices for providing safe sleep education and other risk-reducing messages, and methods to identify and address systemic challenges and barriers, and 3) provide public health education to reduce the risk of SUID. Research by SCNJ faculty has contributed to the American Academy of Pediatrics (AAP) policy statements identifying risk factors and risk-reducing strategies (i.e., Ostfeld et al. Pediatrics 2006; Ostfeld et al. Pediatrics 2010; Ostfeld et al. Pediatrics 2017). The goal of the latter two missions is to reduce NJ's rate of SUID, which is comprised of SIDS Ill-defined and Unknown Cause, and Accidental Suffocation and Strangulation in Bed, all of which share the same risk factors.

New initiatives will continue to be developed to address existing and emerging risks. For example, recently published national research by the SCNJ (Ostfeld BM et al. Journal of Perinatology, 2022), determined that smoking through all three trimesters of pregnancy elevates the risk of SUID fivefold. Yet, given its addictive properties, continuation of smoking throughout pregnancy among those who smoke is by far the most common pattern for both White, NH, and Black, NH populations. Addressing this ahead of pregnancy underscores the importance of including preconception health in risk reduction strategies. Vaping has now become the most common entry device, delivering nicotine and flavoring via aerosol, all of which are being shown to impart adverse effects upon the pregnancy. SCNJ has been working with colleagues both in the US and abroad to address the new challenges posed by these devices and will continue to promote nicotine free environments for the fetus and infant, again pointing to the importance of preconception health. New findings regarding the association of higher levels of a preconception body mass index with elevated SUID rates again speaks to the increasing focus on preconception health. The SCNJ also continues to develop direct to public education methods, such as through SIDS Info, its free mobile phone app, social media platforms, and community groups.

The SCNJ has updated its free mobile phone app SIDS Info to include the new 2022 American Academy of Pediatrics includes the risk reduction guidelines. It will continue to be available in English and Spanish with voice-over to overcome literacy challenges. A new awareness campaign alerts providers that the tool provides a valuable script for them to access in education parents who then download it to retain and share the information. Intended for NJ, it is in use in other states, as well. SIDS Info was accepted into the Emerging Practice section of the Association of MCH programs.

The SCNJ also identifies risk factors more likely to be associated with specific age clusters in the first year of life, such as Sudden Unexpected Postnatal Collapse in the first days after birth (Hegyi et al. J Maternal, Fetal, and Neonatal Medicine, 2022) and creates programs to highlight and address these. In this case, the initiative will reinforce the importance of hospital policies for supervised skin-to-skin care during this period. SCNJ programs are directed to institutions (i.e., schools, hospitals, clinics, hospital grand rounds programs, public health programs), organizations (i.e., WIC, HWHF grantees, NJAAP, Maternal, and Child Health Consortia, NurtureNJ), providers (i.e., pediatricians, obstetricians, nurses, family medicine practitioners, social service providers, home visitors, clergy, community workers, doulas, first responders), and the public (i.e., baby fairs, community programs). SCNJ will continue to provide its accredited nurse education course. The SCNJ will continue to work closely with the Medical Examiner system to address issues related to coding and to the timely reporting of amendments. A national study wherein SUID codes were used for extremely preterm infants dying proximate to their birth (Ostfeld & Hegyi, Society for Pediatric Research 2022) provides an example. When needed, timely updates of amendments to coding must meet the deadlines of NJSHAD and NCVS to maintain accuracy of public health records.

Breastfeeding reduces the risk of SIDS. Successful breastfeeding and safe infant sleep directives are fully compatible. SCNJ continues to advance both.

Receiving education from a trusted provider, such as a physician or nurse, increases parents' retention and application of the information. The SCNJ will continue working closely with provider groups and their relevant organizations and training programs. The SCNJ educates hospital nurses, who play a key role in modeling and teaching about safe sleep. The SCNJ provides a hospital-based program, Nurses LEAD the Way, by presenting at hospital-level and regional nursing conferences and meetings and communicating through other venues such as listservs, live and on-demand webinars, and e-blasts. The SCNJ works with all three MCHC to reinforce safe sleep messaging within their member hospitals. In addition to providing education, the SCNJ makes educational scripts, videos, behavioral check lists, and hospital safe sleep audit protocols. Moreover, SCNJ developed electronic and hard copy educational materials that are translated into English, Spanish, Haitian-Creole, Farsi, Arabic, and Portuguese. Dari has been added to serve Afghan refugees. Many of the SCNJ resources, including live and on-demand webinars, Frequently Asked Questions, multiple one-minute videos in English and Spanish on safe sleep topics, education summary sheets, information about its free safe sleep app and flyers in multiple languages, are tools that can be accessed from the SCNJ website: www.rwjms.rutgers.edu/sids and its social media site: https://www.facebook.com/SIDSCenterNJ/. Information about these resources will continue to be widely disseminated. SCNJ website also contains links to other major resources. Based on the resources it has developed and its own website, SCNJ is updating the SIDS section of the NJDOH MCH website. The SCNJ's resources, including baby onesies, are also disseminated through collaboration with its many partners. The SCNJ will continue to form partnerships with community-level programs. The SCNJ will continue to study SUID and report findings in academic venues and community settings as warranted. These findings will inform interventions.

Outreach to providers continues to grow and now includes education for obstetricians and pediatricians. Obstetricians and gynecologists serve a critical early window of opportunity for risk reduction by educating families about safe pregnancy practices for lowering the risk of

SUID, such as avoidance of household smoke around the pregnant woman and growing concerns about vaping. Gynecologists also can serve as a conduit of information on risk reduction practices for grandmothers. In response to the growing evidence that preconception health is vital, SCNJ will increase its collaboration with Family Medicine training programs, adding Grand Rounds for this group of trainees and providers to its other Grand Rounds programs.

In 2020 and 2021, SCNJ provided 141 lectures to an audience of 17,000. In the most recent grant cycle, 2023-2024, 152 presentations were made to an audience of 4011. Just in the first two months of 2025, nearly 2000 caseworkers in the NJDCF Division of Child Protection and Permanency have received training. Direct engagement promotes relationships between SCNJ and providers that increases commitment and collaboration, and these efforts will continue. At SCNJ presentations, its infographics on SIDS Info and other tools are distributed for use with families. Because of the extreme popularity of baby onesies with safe sleep messaging, SCNJ has been encouraging hospital systems and other programs to model the SCNJ campaign by developing similar products. There has been progress, and these efforts will continue.

In addition, level of interpersonal connection and differential treatment of various populations contribute to raising stress levels and reducing participation in health care. The SCNJ will continue focusing on these broader issues and working toward best practices for increasing the provision of and compliance with safe sleep practices. Yet, at the core of its mission is advancing safe sleep practices. In 2016, back to sleep was named one of seven leading research findings in pediatrics in the previous 40 years, given its impact. These efforts will continue, as each year brings over 100,000 new infants and typically new parents into NJ.

Plan for the Application Year SPM: The percentage of Black non-Hispanic preterm births in NJ

In partnership with the MHI team and the NJ MCQC, TVP will continue to co-lead multiple activities aiming at reducing preterm birth rates of untimely death for non-Hispanic Black and Hispanic infants. Through the Preterm Birth Prevention Program (PBPP), TVP staff, in collaboration with key stakeholders, will create, disseminate, and evaluate provider-specific resources on preterm birth prevention for identified patients. They will convene multidisciplinary meetings with stakeholders to assess the challenges, opportunities, and the overall impact of identified preterm birth prevention services and resources. They will use data from varying sources and improve timely information sharing to support and identify patients in need of preterm birth prevention services. They will distribute and provide information about preterm birth prevention services and resources. Lastly, they will compile data from activities for recommendations, reports, and presentations to NJDOH leadership and partners. Moreover, TVP, in collaboration with MHI, will continue to support the design of new educational workshops and whole-health events for pregnant women with complex care needs (e.g., cardiovascular diseases, diabetes, hypertension, and chronic behavioral health needs) at risk for preterm delivery.

Plan for the Application Year SPM: The rate of Black Infant Mortality in NJ

The HWHF Initiative will continue to develop partnerships with community-based MCH providers/agencies with proven capabilities in implementing activities/interventions within a targeted community and the ability to focus on reproductive-age women and their families. The HWHF initiative will continue to focus on postpartum care through the novel postpartum doula care municipality program launched this year. Moreover, through the HWHF initiative, TVP will provide evidence-based lactation education to birthing individuals and their social network (e.g., fathers, grandparents, siblings, etc.). The DLC will continue to train community doulas and educate them on how to enroll in NJ FamilyCare fee-for-service and the Managed Care Organization's process to become NJ FamilyCare Community Doula providers. The DLC will expand training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ.

Child Health Annual Report

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

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

Increasing developmental screening rates across the state is an important focus in the domain of Child Health that seeks to improve overall child health and well-being. Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percentage of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine-month visit (see screening rates in Table 13 below).

Table 13. Developmental Screening Rates for children ages 9 months to 35 months

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

parent-completed screening tool						

Source – National Survey of Children's Health (NSCH) https://www.childhealthdata.org/browse/survey/results?q=9597&r=1

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

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

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

Improvements in early childhood systems continued through the NJ Early Childhood Comprehensive System Prenatal-to-three grant (ECCS P-3). A top priority through the grant is to continue to support our universal access to evidence-based developmental screening through the early childhood Connecting NJ (formerly known as Central Intake) system (Help Me Grow Central Access point). Connecting NJ supports linkages and access to programs and services for families within their community. The NJ LTSAE Ambassador activities focus on promoting family-engaged developmental monitoring, screening and referral, and connection to services through trainings, presentations, and materials distributed across the state. As the State Parent Lead for ECCS P-3 and MIEC Home Visiting programs, the LTSAE Ambassador activities also focus on the priorities of the NJCYC ICHC and continues to support the CNJ Hub staff with accessing LTSAE materials as well as with family- engagement activities. NJ’s Child Developmental Passport, was created in collaboration between the NJ LTSAE Ambassador at SPAN and the ECCS team (available in English & Spanish), which includes a developmental tracker to empower parents to track their child’s developmental screening information. In addition, the Roadmap for Advancing Family-Engaged Developmental Monitoring (The Roadmap) and related tools developed in collaboration between the CDC and the Help Me Grow National Center are shared with early childhood professionals so they can better understand what family-engaged developmental monitoring is, what it looks like in practice, and why it is important to improve child and family outcomes.

The selected ESM monitors progress on increasing parent-completed early childhood developmental screening using an online ASQ tool. It also monitors how well early childhood developmental screening is promoted across the Departments of Health, Children and Families, Human Services, and Education, which will drive improvement in NPM of Developmental Screening. NJ DCF, in collaboration with TVP at NJDOH, continues to implement the Early Childhood Comprehensive Systems Prenatal-through-three grant that focuses on enhancing the early childhood system. With the invaluable support of our Help Me Grow Physician Champion, the Early Childhood Champion at the NJ Chapter of the American Academy of Pediatrics, and other Health Care Provider Champions, this iteration has focused on health integration and promotion of the coordinating system of care of families of young children and creating greater awareness with health providers as they support families with young children. The previous iteration of ECCS (Impact) focused on five communities to test and scale up developmental health promotion and parent-completed early childhood developmental screenings in children under three years old.

The ASQ Enterprise software (Brookes Publishing) is being utilized to add a parent/family portal for easy access to developmental screening and links screening to Connecting NJ hubs. NJ's expanded data system links developmental screenings with all 21 Connecting NJ hubs to enhance the engagement of families not connected to early childhood services/programs. This expansion of the data system could potentially be engaged and linked for additional services and supports as identified, including developmental needs as determined by the completed ASQ. Families receive support and referrals to an array of services, for instance, pediatric primary care and/or other systems partners, including home visiting, HWHF, CHWs, and/or other service providers as determined by the family and their needs/interests. The referrals and connections provided through the CNJ Hubs extend to quality Child Care, Early Head Start/Head Start, and Preschool programs. In FY23 and FY24, the Connecting NJ hubs maintained developmental health promotion, screening, and linkage. There were 1513 screens completed in FY24 through the Connecting NJ hubs via the Brookes Publishing Family Access Portal for children 2 months to 60 months. Below is a chart outlining the percentage of children reached by age domain for FY20, 21, 22, 23 and 24 (Table 14). In FY25 the Ages and Stages Questionnaire Social Emotional - 2 (ASQ SE-2) will be added to the Family Access Portal throughout NJ. Families will be able to access the ASQ-3 and ASQ SE-2 development screens in each county in English and in Spanish.

Table 14. Percentage of Completed Screenings of children in NJ using the ASQ

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

<u>Child Health Application Year</u>

Plan for Application Year includes the NPMs of Developmental Screening, Medical Home and Preventive Dental Visit.

The NJDOH will continue to participate as an active interdepartmental partner with the NJ Council for Young Children (NJCYC), the Preschool Development Grant Birth to Five (PDG B-5), CDC's NJ "Learn the Signs. Act Early." (LTSAE) Ambassador and the NJ CYC Infant-Child Health Committee (ICHC). The ICHC has prioritized improving system connections for children and families with health care providers, community services, early intervention, childcare, home visiting, health care, and early care and education settings to support overall child development and well-being. The NJ ECCS P-3 work informs potential improvements in early childhood systems, focusing on universal access to evidence-based developmental screening. The Connecting NJ system (Help Me Grow Central Access Point) supports linkages and access to programs and services for families within their community.

The CDC's NJ LTSAE Ambassador workplan is also focused on supporting health care providers and early care and education providers in their efforts to continue to engage families in developmental health monitoring using the LTSAE materials and for the sustainable integration of LTSAE into their policies and practices. The CDC's NJ LTSAE Ambassador has also been instrumental in supporting the statewide Women, Infants, Children (WIC) agency staff and local

WIC agencies with implementing the WIC Developmental Monitoring Project, a technical assistance grant from the CDC and the Association of State Public Health Nutritionists. SPAN will continue to collaborate with the NJ Chapter of the American Academy of Pediatrics on the HRSA-funded Transforming Pediatrics for Early Childhood grant also known as NJ SEEDlings Project to support family engagement activities to enhance mu in early childhood development. SPAN has been funded by the NJ Department of Human Services Division of Family Development for over 27 years to implement the NJ Inclusive Child Care Project. This provides the unique opportunity for SPAN to continue to support the Child Care Resource and Referral Agencies to host Books, Balls, and Blocks developmental screening events. SPAN will also continue to collaborate on the Autism Detection-Connection-Intervention project with Rutgers NJ Medical School, the NJ site for the CDC's Autism & Developmental Disabilities Monitoring (ADDM) Network to promote awareness about the importance of parent-engaged developmental monitoring and the early identification of autism using a validated screening tool in the Newark, NJ region. This project is funded by the NJDOH (NJ's Early Intervention System and the Governor's Council for Medical Research and Treatment of Autism) and NJ DCF. Project leads are exploring possible expansion of these efforts in Southern NJ. In addition, NJ is also the recipient of HRSA's Early Childhood Development awards to 3 federally qualified health centers (FQHCs) to improve developmental outcomes among children ages 0-5 through increased screenings and follow-up services.

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

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

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

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

Some highlights from NJ-EASEL work this year were:

- Build a secure File Transfer Protocol (SFTP) solution for data exchange between multiple agencies using existing Amazing Web Services (AWS) Infrastructure.
- Migration of the Mathtech NJ-EASEL SharePoint to a DOE NJ-EASEL SharePoint. The new link for current NJ-EASEL SharePoint users is: NJ-EASEL - Home
    - Links within documents on the NJ-EASEL SharePoint will no longer work, however, all links in documents should be proceed by the Path. To open a link, follow the Path listed in the document

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

Adolescent Health Annual Report

Annual Report - NPMs Bullying and Adult Mentor

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

The selection of the ESM of Reducing the percentage of high school students who are electronically bullied and the ESM of Reduce the percentage of high school students who are bullied on school property, is to monitor progress in reducing bullying that takes place on social media and in-person at school, which should lead to a decrease in the percentage of 9-12th graders who reported being bullied on school property or electronically bullied. Through the CAHP, multiple efforts are made to decrease bullying in schools and build the social-emotional learning (SEL) competencies of bullies and bullied youths. Building youth's capacity for self-awareness, social awareness, self-management, relationships, and decision-making helps build the core skills teens need to refrain from bullying others and bounce back when they are bullied.

According to Collaborative for Academic Social and Emotional Learning (CASEL), these skills allow children to calm themselves when angry, initiate friendships, resolve relationship conflicts respectfully, and make ethical and safe choices. To develop these capacities, children need to experience safe, nurturing, and well-managed environments where they feel valued and respected; and have meaningful interactions with others who are socially and emotionally competent; and receive positive and specific guidance.

To tackle the bullying problem at its core, CAHP implements multiple student and parent engagement programs. Parent engagement helps parents and caregivers (PCGs) better understand, support and communicate with their teens which builds protective factors and reduces the impact and incidence of bullying. Teen Speak, one of the parent engagement programs implemented via CAHP, offers skill-building workshops for parents and other supportive adults to help foster critical intergenerational connections and build protective factors in the home and community. Through short, multimedia workshops focused on improving adult-teen communication and in-person facilitated sessions where parents and caregivers can practice new techniques to engage their teens; Teen Speak seeks to reduce harmful behaviors and build strong family relationships. Teen Speak also collects data from participants via post retrospective –surveys and polls during lessons.

In September of 2023, CAHP released an RFA for our new Statewide Parent and Professional Engagement Program (S-PEP). S-PEP will create a centralized space for PCGs, and professionals to access Teen Speak and MITEY Change (for professionals). Ideally, this will expand and streamline access to PCG and professional education to better care for adolescents in NJ. In 2024, CAHP entered the second year of S-PEP with the focus of releasing the new S-PEP site in the summer of 2025.

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

- CAHP and CAHP grantee staff have been trained in multiple approaches to working with our most vulnerable youth. Trainings have included, comprehensive youth suicide prevention and safe messaging, mindfulness, youth mentoring, youth-adult partnering, cyber-bullying, effective use of social media training, and an intensive train the trainer, social and emotional learning (SEL) and trauma-informed care (TIC). Training and technical assistance (TA) occur quarterly. They are required for all PREP, SRAE, and School Health program grantees but are open to all CAH Programs and Program Partners, including schools and community-based organizations where CAH programs operate.

- In November 2020, NJDOH was awarded a Garrett Lee Smith (GLS) Tribal/State Youth Suicide Prevention Grant. In addition to providing training and education for suicide prevention, screening, and treatment to youth-serving professionals, the GLS grant will launch a statewide implementation of Lifelines Trilogy, comprehensive suicide prevention, intervention, and postvention program. In 2023, GLS provided trainings to 4,383 primary care practitioners, behavioral health clinicians, educators, youth serving professionals and parents/caregivers in multiple clinical and non-clinical trainings. Through 988, GLS funds supported screening for 6,586 youth for suicidal ideation, provided 1,290 referrals and confirmed that 684 youth accessed treatment.

- GLS sponsored two Youth Summits that reached 263 youth and school professionals from over 15 school districts. GLS also funded mini grants at 15 county colleges to support campus wide suicide prevention activities. Finally, GLS began implementation of Lifelines at 5 new school districts including New Brunswick School District, one of the largest school districts in NJ. Through Lifelines thousands of school professionals, community partners and students have been trained with two school districts completing the 24-month training and implementation process and are now fully sustaining Lifelines in their districts. By the end of the grant (November 2025) 15 school districts will have completed the process and sustaining Lifelines in their schools.

Through a comprehensive approach aimed at building the skills, competencies, and capacity of teens, parents/caregivers, and youth-serving professionals, the CAHP seeks to decrease bullying and increase resilient responses to bullying in our schools and communities. The most recent program added to the CAHP roster is Lifelines Trilogy, a comprehensive suicide prevention program with a 5th through 12th-grade curriculum. The curriculum is grounded in SEL and focuses on the importance of asking for help. Three schools have completed training and begun the student curriculum. Thus far, 821 students have received the curriculum. Pre and post-test data are being analyzed and will be available in next year's annual report.

SPN: Reducing Teen Pregnancy

Annual Report SPM: TOP program, Reducing the Risk, Teen PEP and Lifelines completion.

Simultaneously, to satisfy the SPN of Promoting Healthy Youth Development by Reducing Teen Pregnancy & Sexually Transmitted Infections (STIs), TVS has selected ESM 9.1 (ESM 9.3: Number of females aged 10-19 who give birth), which monitors progress in reducing teen pregnancy in NJ. The CAHP has adopted the Teen Outreach Program (TOP®), Love Notes, Get Real, FLASH, and Teen PEP, all evidence-based models (EBM) proven to reduce teen pregnancy. In the past year, approximately 3,900 students have been actively engaged in the EBMs indicated. Lifelines, like our other EBM’s is a social and emotional learning (SEL) based program which has been linked to improved decision making and self-regulation behaviors like the other EBMs implemented. Improved SEL is also linked to improved decision-making and healthy relationships and contributes to reducing teen pregnancy. The CAH Programs link teens from various backgrounds and groupings within schools and facilitate dialogues that encourage teens to be introspective, connect with their peers, partner with adults, and participate in bettering their communities. Data is collected for all EBMs implemented via pre- and post-surveys delivered to participants that measure sexual health behaviors such as using birth control, barrier contraceptives, and delaying/abstaining from sexual activities. In addition, SEL questions regarding bullying behaviors, teen connectedness, and resiliency are also measured.

Adolescent Health Application Year

Plan for the Application Year - NPM Bullying, NPM Adult Mentor, and SPN Promoting Healthy Youth Development by Reducing Teen Pregnancy & Sexually Transmitted Infections (STIs).

The CAHP will continue to implement Social and Emotional Learning (SEL) and parent engagement programs along with virtual activities that provide youth with opportunities to lead and educate their peers. The CAHP will continue to promote the adoption of Evidence-based SEL programs, including TOP®, LifeLines Trilogy, Love Notes, Teen PEP, Get Real, FLASH, Ten Connection Project and the WSCC model in NJ schools. In addition, the CAHP will be launching the S-PEP (Statewide Parent and Professional Engagement Program website. Teen Speak currently serves approximately 500 parents statewide and, with the new website and partnership with the NJ DCF, NJ4S program Teen Speak will be available in every county by the end of 2025. CAHP will continue to host the NJDOH Voice of Youth Planning Committee (VYPC) as they plan and implement youth-led virtual programs for their peers. The VYPC has not chosen a focus for 2025 but will plan to select a new topic at our February VoYPC meeting. Finally, NJDOH will continue to provide training and technical assistance to our grantees and partner organizations that will help youth-serving professionals build their competencies to help provide youth opportunities to avoid bullying as a perpetrator or victim. In 2024, S-PEP launched a youth professional development training called MITEY Change. Motivational Interviewing Training for Empowering Youth towards Change provides education and resources to enhance professionals' knowledge, skill, and confidence in providing effective and efficient youth risk coaching. Dr. Jennifer Selerno, the developer of Teen Speak, developed this online course. 50 professionals completed this training in 2024, and we will increase this to 100 in 2025.

CSHCN Health Annual Report

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

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

FCC Services

At the center of our FCCS efforts is our county-based case management program. The SCHSCM Case Management Units are a mix of local county agencies and non-profits organizations. Once registered with the BDARS, children are referred to their county’s CMU. Given the many diagnoses and conditions that are included the BDAR, the types of treatments, supports and services are even more extensive. Therefore, some families may only need a few resources, while others remain engaged with their CMs for many years. In 2024, 60% engaged with their CMUs.

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

Although most CMs are highly experienced, a lot of education and training is provided through our quarterly meetings. These opportunities are part of our continuous quality program improvement process. Additionally, looking at our CMRS data to measure the overall effectiveness of our program has provided important insights into how well the CMUs are doing reaching out and addressing the identified CSHCN population.

FCCS is the center for two NPMs: Medical Home and Transition.
Annual NPM: Percent of children with and without special health care needs having a medical home.

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

Updates continue to be made to CMRS to accommodate reporting, data collection, and tracking of medical home components. Having a primary care physician is the 'first step' in building the infrastructure of a medical home for CSHCN. ESM #11.1 provides a baseline for programmatic needs to increase the percentage of CSHCN with a primary care physician and identify the 'next steps' needed to establish medical homes for CSHCN. A medical home webpage on the Department's website includes a Shared Plan of Care (SPoC), a medical home tool for families.

CSHCN, with a medical home, has been a priority for the SCHSCM program and continues to be supported by several partnerships and collaboratives. Having a primary care physician service identified in a child's ISP developed with a case manager served as a medical home proxy beginning with 2014 reporting. As part of the Medical Home grant, SCHSCM and its partners developed the SPoC, a document meant to increase care coordination for CSHCN. This additional component was added to the medical home proxy in 2017 with reporting continued today for ESM 11.1. While a medical home is more comprehensive than just having a primary care physician, it is also imperative for a child to have consistent health insurance to increase access to the provider.

In SFY 2024, 28.8% of the 19,228 children aged 0 to 18 years served had a primary care physician and/or SPoC documented (Table 15). This is slightly lower than the estimates from the NSCH of 31.8% for NJ and 39.7% for the US. Approximately 42% of those children had insurance identified in their ISP, consistent with the last year. The percent of CSHCN ages 0-18 years served by CMUs with a primary care physician and/or SPoC has been selected as ESM 11.1. The annual state performance indicator below has consistently exceeded the annual objective since 2019. The last two years shows reduction from earlier years upward trend due to lack of documentation of primary care service visits into the Case Management Referral System even though the served children had multiple regular visits to primary and specialist care visits. SCHSCM will continue to address this documentation issue in CMRS through program policy, providing training to new case managers and requiring annual documentation of medical home in the system. During SFY 2024, the FCCS staff met with the SCHSCM Unit Coordinators to finalize program policies around documentation for NPMs so that reports can accurately track these measures in the system.

Table 15. NPM - Percent of children with special health care needs having a medical home.

	2020	2021	2022	2023	2024
Annual NPM #11 Indicator	40.8%	40.1%	40.8%	35.6%	28.8%
Numerator	6,503	5,783	6,347	5852	5,553
Denominator	15,919	14,407	15,619	16417	19,228
Data Provisional or Final	Final	Final	Final	Final	Final

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

While SCHSCM data only include children with special health care needs who live in NJ and participate in our case management system, our findings are not different from those of the National Survey of Children's Health (NSCH). NSCH estimates the percentage of children (0-17) with special health care needs having a medical home. For the combined years of 2022 - 2023, 31.8 (n=117) of children with special health care needs are estimated to have a medical home. For the single year (2022), 36% (n=157) are estimated to have a medical home.

For many CSHCNs, a specialty provider often serves as the child's usual source of care, where care coordination becomes vital to ensure primary care services are not overlooked. Past chart reviews have shown that greater than 90% of CSHCN receiving services through SPSP grant-funded programs have a primary care physician listed. In SFY20, the program included evaluating every child seen in a SPSP grant-funded program for the designation of a primary care provider as part of the grantee's goals and objectives. The Title V CMUs and pediatric specialty providers continue to provide a safety net for families of CSHCN.

Annual Report - NPM Transition to adulthood

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

The NJ Special Child Health Services Case Management Units provide children and youth with special health care needs with transition to adulthood services up to their 22nd birthday. Data for transition services provided by SFY are presented below. As mentioned above, during SFY 2024, the FCCS staff met with SCHSCM Unit Coordinators to review documentation of transition to adulthood in CMRS and formalized policies on proper documentation in the CMRS system. Previously the program did not have formal policies regarding how Unit Coordinators, Senior Case Managers and Case Managers documented in the CMRS systems and with staff retirements, new staff were documenting these performance measures differently. The current limitation of the data system is that transition exists as a single service to be recorded on an ISP, however the redesign will make transition its own service domain, allowing case managers a greater depth of detailed data to be easily recorded and readily obtainable for data analysis, reporting, and evaluation. For 2022 - 2023, the National Children's Heath Survey estimates that 19.6 % (n=29) of adolescents with special health care needs, ages 12 through 17, received services necessary to make transitions to adult health care in NJ (Table 16). While CMUs provide no cost resources and referral services, many children may receive these services through their school; therefore, these two measures are not equivalent.

Table 16: Provision of Transition Service in NJ for children with special health care needs ages 12 to 17 years.

	2020	2021	2022	2023	2024
Annual NPM #12 Indicator	43.6%	45.0%	47.4%	42.5%	30.5%
Numerator	1,102	955	962	806	665
Denominator	2,530	2,125	2030	1912	2178
Data Provisional/Final	Final	Final	Final	Final	Final

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

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

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

The CMUs continue to facilitate transition to adulthood with youth by ensuring a transition to adulthood goal on the ISP. Likewise, exploring youth and their family’s ' needs to ease the transition with insurance, education, employment, and housing, while linking them to community-based partners will continue.

Ongoing CMRS demonstrations to the case managers stimulate active discussions about how

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

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

CMUs largely noted documentation of transition planning to occur on or about age 14. A discussion with families/youth about transition planning and the distribution of transition packets are documented in CMRS. An anecdotal observation by the case managers noted that families prefer to receive materials incrementally, rather than in one large packet filled with resources. That incremental method provides them with the opportunity to focus on one, or a few transition needs at a time, such as primary care provider, access to Supplemental Security Income, and/or health insurance, including Medicaid, Medicaid expansion, and/or private insurance or the Marketplace; education/job training supports; statewide systems of care including the Department of Human Services Division of Developmental Disabilities and/or the DCF's Children's System of Care (CSOC) Initiative, and others.

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

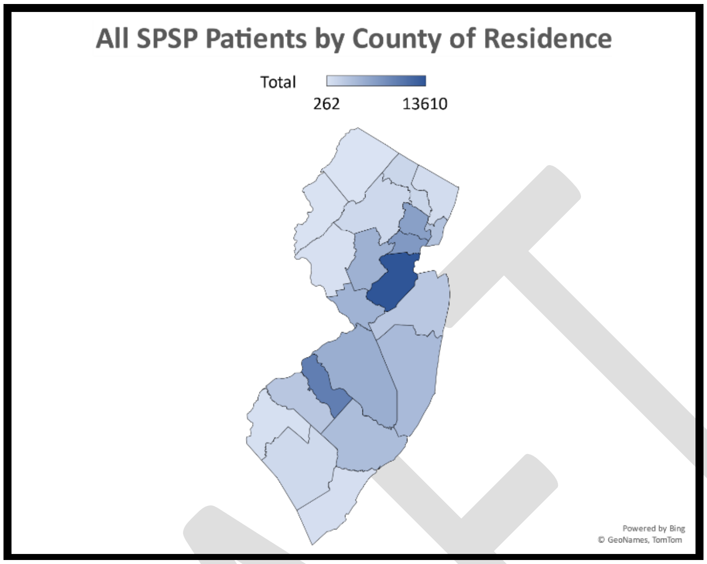
Through an agreement with SPAN, the Family WRAP (Wisdom, Resources, and Parent to Parent) project provides information, resources, and one-to-one family support that are directly helpful to clients active in SCHSCM.

Due to the high percentage of children in NJ diagnosed with Autism Spectrum Disorder (ASD), SCHSCM maintains its partnership with Autism NJ to provide support to case managers for children active in SCHSCM who have a primary diagnosis of ASD. In 2024, FCCS and Autism NJ partnered to launch the Emerging Challenging Behaviors Program (ECB) as a pilot initiative. This pilot is designed to offer an additional layer of support to families of children in SCHSCM who are displaying challenging behaviors by targeting children under age six. A Board-Certified Behavior Analyst (BCBA) was officially onboarded in FCCS in October 2024 and began reviewing potential families in CMRS and drafting introductory documents. This pilot aims to provide families with clinical expertise to address and mitigate emerging challenging behaviors before they become severely challenging and significantly impact the child's and family's safety and quality of life.

Linkages developed through current and previous ISG grants have facilitated the distribution of materials developed by SPAN, NJ AAP, Autism NJ, NJDOH, and other community partners engaged in the Community of Care Consortium (COCC) to medical practices. Community-based partners continue to identify resources and linkages to support transition to adulthood for CSHCN.

The adolescent subset of CSHCN served through TVP remained relatively the same between SFY 2023 and SFY 2024. In SFY24, the most common diagnoses seen at the Child Evaluation Centers are Autism/ASD (18%), ADHD (17%), and Speech Language Delay/Disorder (16%). The top clinical services utilized by the Craniofacial patients are Plastic Surgery and Speech/Language (14% each), Nursing (11%), and Orthodontics (10%). The top clinical services utilized by Tertiary patients are General Pediatrics (14%), Orthopedics and Cardiology (11% each), and Oncology (8%). The SPSP providers engage with adolescents and their families to facilitate transition to adult services. Transition services primarily include discussions about the importance of adult care, options for adult care (providers/locations), sharing resources regarding genetics, family medicine, adult providers, support groups, and other medical and social-related needs. The linkage of CSHCN to multidisciplinary team members, including social work and other community-based systems such as SCHSCM, SPAN, and disability-specific organizations, including the Arc, Tourette's Association, and Parents' Caucus, are strategies implemented by the SPSP agencies. As shown in past reviews and surveys, Shared Plan of Care, and documentation on transition to adult care vary amongst the three SPSP categories: CEC, CLCPC, and PTC Centers. The SPSP collaborates with each grantee to ensure that a definition of transition to adult care is established at each site and that practice policies regarding transition to adult health care are created and implemented. Furthermore, Figure 20. represents the SPSP patients served in FY24 by county of residence across CECs, CLCPCs and PTCs showing all 21 counties are represented (Figure 30).

Figure 30. SPSP Patients by County of Residence



Aligned with the TVP, programs and funded by Part D of the Ryan White Care Act, the NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to Women, Infants, Children, Youth (WICY) and families infected and affected by HIV disease in the State. Consequently, there is ongoing collaboration across systems within the Division of FHS MCH and CSHCN's programs and the Ryan White Part D program to support WICY's needs in the community. NJ ranks third in the nation for pediatric cases. Of youth 13-24 years, 177 were living with HIV/AIDS, and of children 0-12 years, 23 were living with HIV/AIDS in 2024. Through diligent efforts to treat and educate HIV-infected pregnant women, the perinatal transmission rate in NJ remains very low. Intensive case management and appropriate antiretroviral therapy enable children with HIV to survive and successfully transition into adulthood. Lastly, FCCS has begun to incorporate NPM on bullying into the program. During SFY 2024, the FCCS program has begun setting the foundation of understanding bullying for the CSHCN population in NJ. During SFY24, FCCS staff surveyed the SCHSCM program Case Managers to understand how CSHCN bullying victim and perpetrator incidents are reported and documented in CMRS, as well as what resources and trainings were need for Case Managers to assist families in either situation. In March of 2024, a formal bullying training will be provided to SCHSCM staff to that will specifically provide resources on CSHCN victims and perpetrators.

EIM

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

Annual Report- SPM# 3 Percentage of newborns who are discharged from NJ hospitals, reside *in NJ, did not pass their newborn hearing screening, and have outpatient audiological follow-up documented (Table 17).*

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

Provisional data for SFY2024 indicates that 73.2% of infants who did not pass their initial newborn hearing screening prior to discharge from the birthing hospitals had a documented outpatient audiological follow-up visit. Since follow-up exams are still occurring on children born at the end of calendar year 2024, we expect the rate to increase when final data is available. We anticipate that the final rate will be level with prior years and exceed the target. The program also monitors the follow-up rates by certain populations to reduce any differences in outcomes.

Table 17. SPM: Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening, and had a documented outpatient audiological follow-up visit.

	2020	2021	2022	2023	2024*
Annual SPM#3 Indicator	79.7%	81.0%	87.0%	85.3%	73.2%
Numerator	1439	1397	1726	1728	1497
Denominator	1804	1724	1984	2026	2044
Data Provisional or Final	Final	Final	Final	Final	Provisional

*Note Final rate is expected to exceed this rate.

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

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

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

During 2024,

- NJ DOH continued using HRSA EHDI grant funding for county-based special child health services case management staff to conduct follow-up phone calls to parents and physicians of children needing hearing follow-up.
- NJ DOH continued to use HRSA EHDI grant funding for one of the Early Intervention Services (EIS) program's Regional Early Intervention Collaborative's (REIC) to provide three part-time consultants who specialize in working with Deaf and Hard of Hearing children. The process includes an initial phone conversation with parents of children recently diagnosed with hearing loss to review early intervention services and discuss communication options for these children. The consultants participate in the initial EI family meetings via remote access, using laptops with web-cameras. The consultants served a total of 88 families during this year.
- The EHDI Monthly Reconciliation Report is distributed to individual birthing facilities detailing children still in need of additional audiological follow-up after not passing inpatient hearing screening. These reports serve as a notice to the hospitals of babies who still need follow-up. Additionally, an annual report includes statistics comparing the individual hospitals to statewide statistical average.
- An annual report is provided to audiology facilities with feedback on their timeliness of follow-up for children who did not pass their inpatient hearing screening. The report also includes statistics on the timeliness and completeness of the documentation of their results.
- An annual report is provided to midwives providing information about the requirement to advise parents about the mandated hearing screening and comparisons of the newborn hearing screening outcomes of their deliveries in 2024 with the statewide averages for home deliveries.
- The Hearing Evaluation Council (HEC), a commissioner-appointed advisory board to the NJ EHDI program, held three meetings this year. The HEC is made up of physicians (a pediatrician and otolaryngologist), an audiologist, a child of Deaf or Hard of Hearing adults, a member of the Deaf community, a Hard of Hearing individual, and NJ residents interested in the welfare of Deaf and Hard of Hearing Children (including a parent of Deaf and Hard of Hearing children and a teacher of the Deaf and Hard of Hearing).
- The EHDI Advisory Committee was reconvened with members recruited to represent health care professionals, parents/families of deaf or hard of hearing children, individuals that are deaf or hard of hearing, as well as various state programs. The annual meeting provides an opportunity for members to provide information, build partnerships, share concerns, and offer input to the EHDI Program.
- The EHDI program provides ‘next steps’ letters to pediatricians and families who have a child with a newly diagnosed hearing loss. The next steps letter shares recommended follow up

and encourages pediatricians to report those actions to the EHDI program. These letters were edited to be more reader friendly, updated with current family support information, and now include a note to families from a variety of backgrounds of trained support parents who have a child with hearing loss.

Annual Report- SPM Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to NJ's Special Child Health Services Case Management Unit and who received services.

The BDARS links registered children electronically via an interface with the CMRS system so that they are offered services through our county-based Special Child Health Services CMUs (Table 18). Case managers are electronically notified when a child has been registered and released for follow-up. Case managers use the CMRS to create and modify ISPs, track services, create a record of each contact with the child's family, create standardized quarterly reports and register previously unregistered children.

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

Table 18. SPM # 4: Percent of live children registered with the Birth Defects and Autism Reporting System who have been referred to NJ's Special Child Health Services Case Management Unit and who are received services.

	2020	2021	2022	2023	2024
Annual objective	92.4%	92.6%	92.8%	93.0%	93%
Annual Indicator SPM #4	95.1%	95.9%	95.0%	96.1%	96 %
Numerator	13,473	12,753	14,249	14,884	17,991
Denominator	14,178	13,302	14,999	15,492	18,748
Data Provisional or Final	Final	Final	Final	Final	Final

*Data Source- The NJ Special Child Health Services, Family Care Center Services
Note: The numerator reflects all children whose record has a documentation of Case Management Action with in the specified time period (SFY) and The denominator represents the number of children served by SCHSCM in SFY who had been registered with the BDARS regardless of registration date (i.e., the numerator) plus any additional children who were registered and released to case management within a given SFY but did not receive services as currently defined.

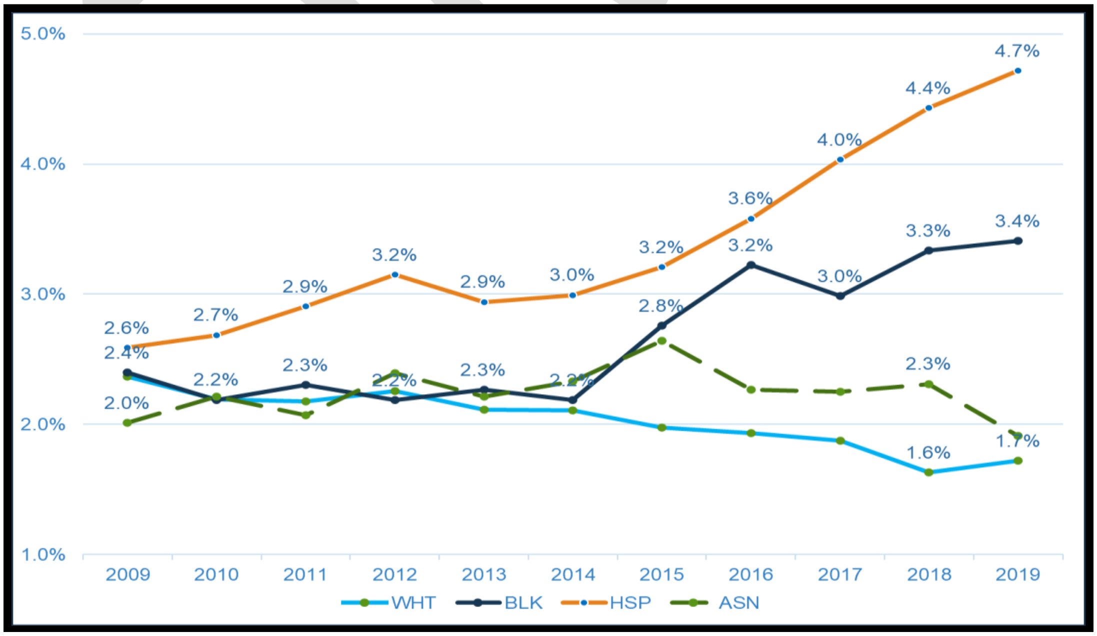
BDAR and SCHSCM staff collaborate to improve the system's functionality, ease of use, and efficiency. CMRS allows CMUs to receive registrations in real time, enables faster family contact, and more rapidly assists a registered child gaining access to appropriate health, education and other resources and services. SCHSCM staff perform annual reviews of electronic records in CMRS to assess key functions and expectations of the CMUs and evaluate Individual Service Plans to assess linkage to services. SCHSCM staff continues to review electronic documentation of the six key performance indicators (e.g., medical home, transition to adulthood), with an expectation of refining how this information is collected within CMRS.

NJ Autism Registry

The Autism Registry monitors prevalence of ASD in all 21 NJ counties. Health care providers who diagnose or provide routine health care (such as a pediatrician) for children with autism up to age 22 are required to register or ensure those children have been registered. The Registry collects information via the Birth Defects and Autism Reporting System (BDARS) which provides secure online access to health care providers. In addition to demographic information such as the child's age, race/ethnicity and county of residence, the Autism Registry collects data related to risk factors such as the child's birthweight, gestational age, and the age of the parents. Additional data fields request information related to autism severity such as the child's verbal abilities, behavioral symptoms, the presence of intellectual disabilities and mood disorders, sensory disorders, and other signs and symptoms associated with autism.

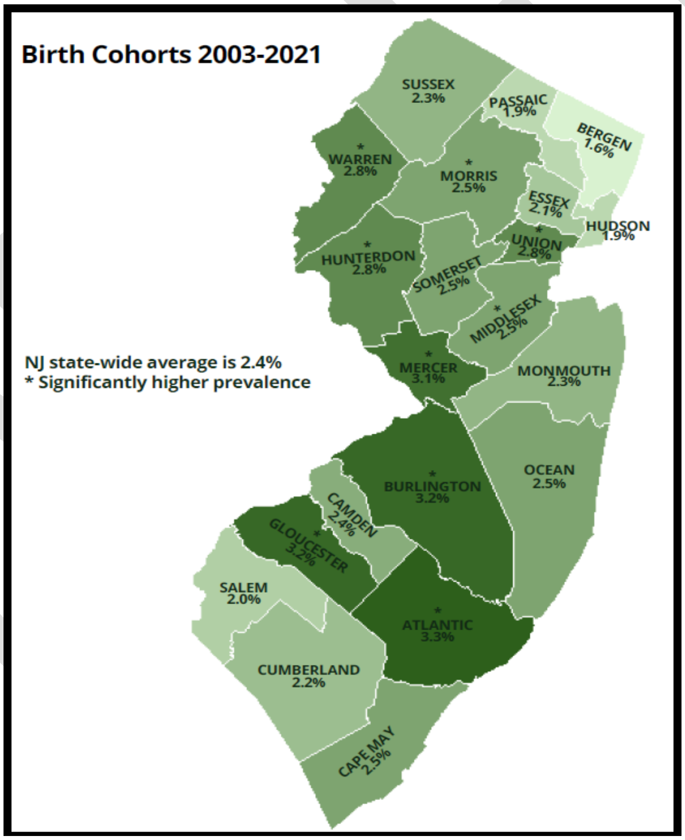
Figure 31 shows changes over time in the overall autism prevalence rates for children born between 2009 and 2019. The rates for white, black, and Asian children were not significantly different, but the rate for Hispanic children was significantly different. For the birth cohorts after 2015, there was a steady and steep rise in prevalence for Hispanic children and a slightly less steep rise for black children. Registry staff have been examining this divergence. While the earlier narrowing of autism rates by race and ethnicity was potentially due to expanded services, more multilingual professionals, and a strong family education program such as the CDC's Learn the Signs, Act Early program, the increase in rates for children born after 2015 indicates that something else may be occurring. So far, the known perinatal risk factors have not explained these differences.

Figure 31. Autism Spectrum Disorder (ASD) Prevalence Rates by Birth Year



The Autism Registry can provide reliable information for autism for children born between 2003 through 2021. Since some children are diagnosed later than others, the population of children between three and eight will increase, but looking at the entire overall prevalence of children with autism is helpful for policy planning, service providers, and others who support families with children on the spectrum. Figure 32 shows the overall average prevalence of autism for all children was 2.4%. The range across counties is 1.6% in Bergen County to 3.3% for Atlantic County. Since the rates of autism began to vary by race/ethnicity since 2015, and the 21 NJ counties have differing populations, these variations may shift over time. Additionally, the county location is at the time of diagnosis. Families with children with ASD might also move to location and school districts that have more robust services. Certainly, this supports the need the continue to analyze by subgroups.

Figure 32. Overall Prevalence of Autism for all Children 3-21 years old



In 2024, Autism Registry staff performed analytics on total autism rates and other metrics for each NJ county as compared to the state overall. Staff used this data to create a snapshot or profile of registry data for each county, which was posted to the Registry website and disseminated to stakeholders. Some counties show a higher prevalence rate than the State overall, while some are lower. Other metrics examined include presence of known perinatal risk factors (low birth weight, multiple birth, and maternal age >35) for children with and without autism in each county compared to children with and without autism in the State overall. The profiles include the average age at which a child is diagnosed in a county compared to the State and examine the percentage of children who were able to receive a diagnosis in the county where they reside or if they had to travel elsewhere (compared to the State overall). The profiles were developed to help families learn more about autism in their communities and the resources available to them, and to help public and private agencies plan for programs and services for people with autism.

Annual Report- SPM Average age (in years) of initial diagnosis for children with an Autism Spectrum Disorder was chosen to measure the timeliness of diagnosing autism in children (Table 19). Early diagnosis is important for initiation of services, as children who receive services at an early age have better functional outcomes. While the causes of autism are not known, receiving intensive services early in a child's life can improve development in speech, cognitive, and motor skills. Appropriate diagnosis at an early age is an important precursor to ensuring that families gain access to early and intensive intervention.

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

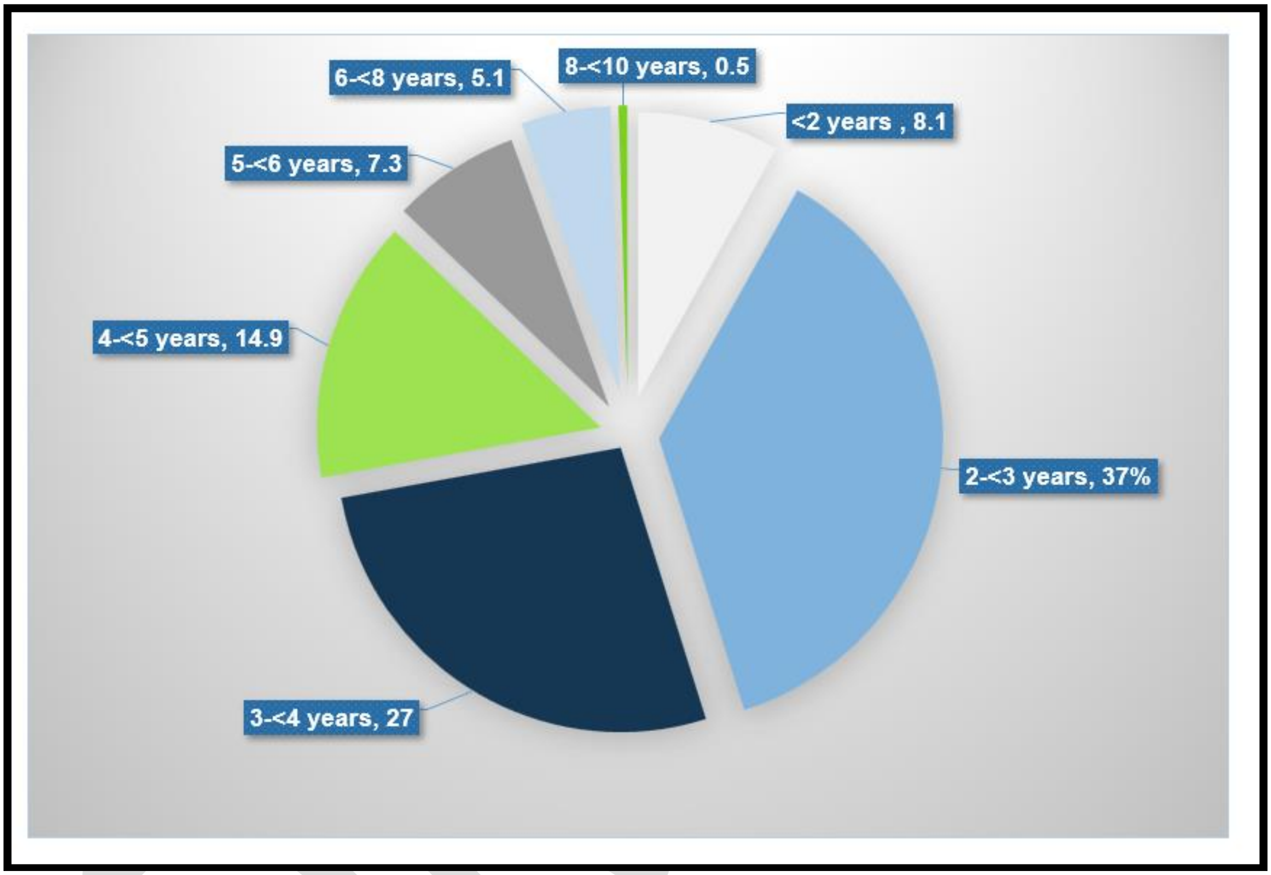
Table 19. SPM: Average age (in years) of initial diagnosis for children with an Autism Spectrum Disorder

	2020	2021	2022	2023	2024
Annual Indicator SPM #5	4.8	4.7	4.6	5.1	5.1

In 2024, there were over 4,800 children diagnosed with autism. The average age of initial autism diagnosis is 5.1 years old. The current average age of 5.1 indicates no change from last year, but still a bit higher than the previous three years (2020-2022) when the average ages were approximately 4.7 years (Figure 33).

When looking at the age of diagnosis, we looked closer at those under the age of 10. These children were born during a time when there were many autism awareness programs and early screening had become well established within primary care. For these children, the average age of autism is 3.4 years, and 37.0% of children had an initial of Autism diagnosis between the ages of two and three (see Figure 23). An additional 8.1% of children were diagnosed even earlier before the age of two and 27.0% were diagnosed between three and four years old. Since the goal is early screening and timely diagnosing, this means that almost 75% were diagnosed prior to the age of four.

Figure 33. Age of Initial Autism Diagnosis for Children born from 2016 through 2024



There are several reasons why some children are diagnosed earlier than others including severity of symptoms, screening efforts, identified risk factors, recognition of symptoms, availability of timely diagnostic evaluations, concerns of labeling, etc. For example, one child might have more severe symptoms and be diagnosed earlier than a child who has some or more nuanced autism symptoms. Autism Registry staff did examine perinatal risk factors and identified that age of diagnosis was related to preterm delivery, plurality, other conditions such as birth defects.

While the average of age of initial symptoms is consistent at 2.3 yrs across the population of children with autism, there were differences in age at diagnosis. Black children are less likely to get diagnosed before 36 months (35.9%) versus White (39.9%), Hispanic (42.5%) and Asian (38.2%) children.

To ensure the quality of the data, BDARS staff have conducted outreach to educate and inform physicians and health facilities about the Registry, how they can register children with autism living in NJ, and the rules regarding the Registry. Registry staff has visited and trained staff from medical centers specializing in child development, developmental evaluations, and behavioral health. Additionally, they have trained staff from many private pediatric practices that follow older children with autism through annual well visits. Registry staff has also trained several psychiatric/behavioral departments located within hospitals. Another area of outreach was identifying telehealth providers who are licensed in NJ and provide diagnostic services. Staff notified the provider of the state mandate and provided instructions on how to register children.

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

TVP will continue to address this performance measure by working with the NJ Chapter of the American Academy of Pediatrics and the Elizabeth M. Boggs Center on Developmental Disabilities, NJ's University Centers for Excellence in Developmental Disabilities (UCEDD), in reaching out to various health care providers and distributing information and trainings on the Learn the Signs, Act Early campaign that educates providers on childhood development, including early warning signs of autism and other developmental disorders, as well as to encourage developmental screenings and intervention.

One of the most important BDARS changes this year was to include a Master Person Index (MPI) number. Basically, a unique identifier is created by an algorithm of the child’s personal identification information. Many data systems such as the VERI system also include the MPI number. This makes matching the data sets easier and more reliable.

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

The Registry is currently piloting additional batch import projects with select birth facilities. Following a similar process, hospital staff enter registration information for multiple children into an Excel file before uploading it to the BDARS. Once the facility imports the file, the system runs validation checks for errors before creating individual registrations for each child in the file. Staff nurses then review each case to ensure each registration has all fields completed and enters correct diagnostic information before completing the registration.

NBS and Genetic Services

This year NSGS celebrated 60 years of being a program! To celebrate this milestone, we hosted an event that brought together our stakeholders and families. The highlight was our parent panel, where we had three families share their stories. Additionally, many hospital staff attended and were able to tour the lab and hear how their efforts to obtain quality blood spots is vital to our testing program.

Calendar year 2024 was similar to past years. Over 97,000 babies were screened and close to 11,000 abnormal results were received by the STFU group. From this work, close to 200 children were confirmed to have a disorder from the NJ NBS panel. Children with confirmed diagnoses require continued care, and in line with State requirements, these children are registered in the BDAR that includes referral to our County Case Management services. Additionally, there were approximately 3,500 children identified as likely to be carriers of disease. These children are not registered in the BDR, but their families do receive a letter making them aware of their potential carrier status with recommendations for follow-up testing.

Time for follow-up on low-risk results ranges from two to eight weeks until cases are closed. Time-critical presumptive results require expedient actions to ensure that those babies receive prompt medical intervention and treatment. As per protocol, presumptive cases must be reported to physicians and specialists within three hours of receipt of the result from the NBS Laboratory. However, the NSGS team has averaged approximately 30 minutes to report. Time for follow-up on presumptive results ranges from one week to twelve months until cases are closed. These cases can remain open longer if the complexity of a disorder requires multiple office visits/diagnostic tests to confirm a diagnosis.

The program is committed to ongoing quality improvement and actively participates with APHL/NewSTEPs on QI initiatives. An internal QI project this year focused on why and how to handle an increased workload of out-of-range results. A review of the follow-up reporting processes identified areas of redundancy. With the areas of redundancy identified, we were able to work with our software vendor to update our workflows to reduce the number of letters physically printed and mailed out. This has led to efficiencies in workflows, reduced administrative work, and a reduction in overall printing and mailing costs. Additionally, Follow-up staff conducted 45 hospital in-services in collaboration with the NBS lab to provide updated information and strengthen relationships.

In our efforts to establish a system of long term follow up (LTFU) for children identified through NBS, we continued to make progress in Year 2 of the NBS Propel grant. We strengthened the groundwork of the project by collaborating with FCCS and BDARs staff to develop a highlighted label to easily identify BDR/CM records as being part of NBS LTFU, we hired a nurse to do the primary outreach to families and worked with our state office of information technology and other programs to establish a public-facing application of REDCap to employ a more family-friendly survey tool.

In SFY2024, the program also provided 12 health services grants to support the efforts of Follow Up, to help ensure access to services. These health services grants provide funds to 25 individual programs to support their clinical services for the children identified through NBS and those who need on going services. The grants fund clinical programs for cystic fibrosis, sickle cell and other hemoglobinopathies, endocrine, genetic, immunologic, metabolic, and lysosomal disorders. While we do not yet have funding for neurological care, the NSARC subcommittees have grown to include a subcommittee for neurological disorders; namely spinal muscular atrophy (SMA), x-linked adrenoleukodystrophy (X-ALD), and planning for the anticipated addition of metachromatic leukodystrophy (MLD) Our grantees and our specialty groups committees help us strengthen the overall capacity of services available in our state.

Data Systems and Emerging Threats

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

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

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

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

CSHCN Health Application Year

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

Voices, SPAN, Autism NJ, there continues to be more work to be done.

In the coming year, the CSHCNs program plans to increase our efforts with Medicaid to ensure better financing of services which will improve the quality of life for our children and their families and ensure access to care. Our programs also plan to expand their efforts to engage families and persons with lived experience. Our long-term follow-up efforts will be expanding. Our registries will also be launching new audit processes to ensure that our data is complete, and no child is delayed or not connected to services due to providers not registering appropriately. Lastly, we plan to provide more public facing information so that providers, families, policymakers, and other stakeholders learn more about our programs and services, more about the populations that we service, and more about the potential epidemiological information we can provide about the conditions which we monitor.

EHDI

Selected during the last Five-Year Needs Assessment, SPM #3 (Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening, and who have outpatient audiological follow-up documented) remains an important measure to assess. While our initial newborn hearing screening rates are extremely high, for those newborns who fail this screening, it’s vital to ensure that they receive follow-up testing. There continues to be much room for improvement.

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

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

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

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

EHDI staff will continue educational presentations to hospital staff, pediatricians, audiologists, Special Child Health Service Case Managers, Early Intervention Service Coordinators, and other healthcare professionals, focusing on decreasing the number of lost children to follow-up. The EHDI program frequently uses online meeting platforms to make educational outreach efforts more accessible to the target audiences, reduce staff travel time, and improve efficiency while decreasing costs. The EHDI Coordinator will be meeting with successful birth facilities to develop instructional materials on ensuring hearing screenings are completed by one month of age for statewide dissemination.

The EHDI program will continue to build on its "0-3 Expansion Plan." The existing partnership with Montclair State University (MSU) paved the way for an introduction between Monmouth University and four Head Start sites that were interested in hearing screenings for their students. This expansion will continue to enhance access to early identification and potentially, intervention services for more children.

Regarding CMV/pediatric hearing loss awareness/prevention, NJ EHDI has updated its brochure with public service information in multiple languages geared toward women of childbearing age. In 2021, NJ law (P.L. 2021, c.413) requires all infants born in our state to be screened for congenital Cytomegalovirus (CMV). This legislation also requires the establishment of a public awareness campaign to educate New Jerseyans on the value of early detection, intervention, and treatment options for children diagnosed with this condition. cCMV is the most common congenital infection in the United States, with approximately 1 in 200 children born with this condition or approximately 30,000 children born yearly. According to the CDC, 10–20% of children born with cCMV will go on to have neurodevelopmental disabilities, including sensorineural hearing loss. Every year, as many as 400 infants die because of this virus. Our CMV staff are working with the Communications office to provide them with materials and to connect them to the national organization.

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

The screening of cCMV through the state newborn blood spot screening program has been on hold for several reasons. The laboratory is waiting for cCMV to be added to the RUSP, and the filter paper used to collect the blood spot needs to be changed to collect an additional spot to support the test process. In the interim, a few hospitals are testing for cCMV if there are indications at birth that suggest the condition. An ad hoc committee that includes different groups of healthcare professionals and NJ DOH staff who share an interest in this topic has been meeting regularly to investigate evidence-based universal cCMV screening protocols and formulate follow-up guidelines for those children in NJ who have tested positive for this diagnosis.

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

The EHDI program also convenes the EHDI Advisory Council (EAC) three times per year. The EAC is composed of stakeholders in the EHDI system that includes health care professionals, parents of deaf and hard of hearing (DHH) children, individuals who are DHH, and various state program representatives. The EAC will meet in July 2025 to finalize the EHDI infrastructure report for submission to the Health Resources and Services Administration (HRSA). The objective of the report is to highlight the EHDI system’s key strengths and challenges, and to propose strategies for building and sustaining an infrastructure that supports the national 1-3-6 benchmarks (screening, identification, and enrollment in early intervention) and improving language outcomes for DHH children.

BDR

SPM # 4 (Percent of live children registered with the Birth Defects and Autism Reporting System who have been referred to NJ's Special Child Health Services Case Management Unit and are receiving services) was chosen to improve the timeliness and effectiveness of the BDARS. The system has been an invaluable tool for surveillance, needs assessment, service planning, research, and linking families to services. Through CDC funding, the BDARS continues to be upgraded and improved. BDARS staff has developed a training schedule to ensure that staff at birthing facilities, autism centers, audiologists, and other agencies who use the revised electronic BDARS and its modules are trained on how to properly complete the data fields that are specific to birth defects and autism registrations. Staff will continue to assist reporting agencies with individual inquiries and concerns and provide trainings to new users if needed in between regularly scheduled training sessions. In addition, BDARS staff will continue to review the quality of the data in the BDARS and its modules and ensure completeness through data matching with other DOH sources such as the electronic birth certificate system.

Another initiative of the BDR is an agreement with the Children’s Hospital of Philadelphia (CHOP) to ensure that NJ children who are transferred to or born at CHOP are included in the BDR if they are diagnosed with a birth defect. The children receiving care at CHOP are usually those with the most complex birth defects and otherwise may not be referred to case management or be identified in NJ’s surveillance activities. BDR staff nurses undergo security clearance checks and a series of trainings prior to being provided access to CHOP electronic medical records. They conduct chart abstractions on cases identified by CHOP and enter them into the BDARS. We plan to study the impact of including this group of children in our birth defects surveillance program and have proposed it as a potential topic at this year’s National

Birth Defects Prevention Network (NBDPN) Conference.

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

Autism Registry

As we report on SPM # 5(Average age (in years) of initial diagnosis for children with an Autism Spectrum Disorder), we rely on the quality of the data from the diagnosticians and medical home providers to ensure that our statistics are correct. The Autism Registry will also begin a new audit process to ensure that all children are being registered and to improve the quality of the information about the diagnosis. The audit cycle is similar to that of the BDR. A particular focus will be on the completeness of details of the diagnosis. The Autism Registry staff are planning a series of trainings for facilities that will focus on navigating the BDARS system and completing registrations to ensure data quality. Training materials will be available to participants. Our goal has been to decrease the average age of diagnosis, but that has been a difficult task for several reasons. While we support early screening efforts, we also recognized the nuances and complexity of the presentation of autism. Getting improved data on the DSM5 criteria scores, symptoms, and co-occurring conditions will provide a better understanding of the needs of children with ASD and prevalence across the state.

FCC Services & Redesign of CMRS

FCCS received CDC-Enhancing Laboratory Capacity funding to redesign the CMRS system to improve performance on the Six Core Outcomes for CSHCN and promote targeted improvement to the documentation for all performance measures. The system redesign has recently developed two new features to help minimize the lost to follow up opportunities by improving the record transfer feature and incorporating an intercommunication feature. The improved transfer feature allows the units to transfer records electronically from one county unit to another county unit, putting an additional safeguard in place to ensure a successful transfer. An additional advantage of this improvement is that the new unit may begin engagement with the family sooner. The new intercommunication feature provides units with a functional and efficient method for Case Managers (CMs) to communicate both within and between units. This feature enables the sharing of relevant information directly related to a child's record. By facilitating direct and immediate communication within CMRS, this enhancement streamlines information exchange and ensures successful collaboration.

The CMRS redesign will also provide additional insights, improve functionality, and increase data captured in the ISP module. FCCS staff will further examine the population they serve and how they can establish quality improvement and quality assurance measures for maintaining an improved and uniform practice of case management, developing policies and procedures, and monitoring equitable services across the population. The main priorities of this redesign are to improve the quality of data reporting, improve the user experience, and implement an acuity measurement. The redesign will allow for enhanced reporting regarding medical homes for the CSHCN population and improved data quality surrounding the transition to adulthood process for the adolescent population served by SCHSCM. FCCS will use a weighted scale that utilizes pivotal information in CMRS, such as diagnosis, linkage to services, insurance information, medical home, transition to adulthood, and other key data points, to determine each child's acuity level in a format that the end users easily understand. These data will also allow FCCS staff to evaluate staffing of CMUs, identify communities of greater need, and determine each child's real-time level of need at-a-glance.

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

Improvement of Program Monitoring

On-site visits will be conducted at each CMU to ensure proper usage of the CMRS as needed and to strengthen the relations with FCCS staff; this will allow more consistent use of the system linking referred families to services and refine tracking of Performance Measures. FCCS staff will continue to provide ongoing feedback and technical assistance to CMUs on a statewide, county-level, and individual- level basis and formal manuals and guides for training.

During FY24, FCCS SCHSCM staff completed the review and revision of program policies that will establish a more uniform standard of practice for case management services and consistent documentation in a child's electronic record across the state. The policies are being finalized through the NJDOH legal process and will be implemented in SFY26, thus enhancing statewide monitoring and aid the CMUs in providing comprehensive and equitable care in every county.

Emerging Challenging Behaviors

In FY25, FCCS will continue piloting a new way to address the clinical needs of families with children with profound autism under the age of six who are at risk for severe challenging behavior. FCCS has partnered with Autism NJ (ANJ) to employ a statewide Emerging Challenging Behavior (ECB) Case Manager who will work with the CMUs to identify children who exhibit emerging challenging behavior. Criteria were developed by ANJ in collaboration with FCCS staff. FCCS estimated 900 children with profound autism under age six are eligible. Children are then identified by local case managers via review of clinical criteria. Following identification, the ECB Case Manager engages with the family and determines next steps which include a comprehensive service review and identification of priorities to create an individualized plan. The goal of the project is to provide families with best practice information, evidence-based strategies, resources, and referrals to decrease the likelihood of severe challenging behavior. If the pilot is successful, the program plans on expanding to three regional ECB Case Managers. Currently the ECB Case Manager has 9 families enrolled from the 21 counties. One of the families enrolled has reported:

I am so glad the case manager reached out to me about this program. The support you are offering is exactly what I need. I have tried on my own to do things for my son but have hit roadblocks every time. This is amazing, thank you!

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

- Family #1: A single mother raising her daughter with autism. Child was in a lot of pain because of teething issues and not being able to communicate how she was feeling. Mom tried many ways to get her to take Tylenol to ease the pain. ECB Case Manager discussed different options for masking the medication in a preferred food (type and presentation) to help her take the medication. Mom said she was grateful for the novel suggestion and had some new ideas about how to present the medication.
- Family #2: A single mom raising a son with autism and a sibling. They live with the mother’s parents. Behaviors are impacting the family dynamic. Mom is working with the school to better understand the behaviors that occur in school and seeking services in the home. Mom recently attended an IEP meeting and felt overwhelmed and unsure of how to ask the questions she had about the IEP and behavior at school. After reviewing the IEP and explaining the functions of behavior to mom, she feels much more prepared to converse about her child’s behaviors with school staff and was grateful for the support and feels more comfortable asking her questions.
- Family #3: A mom and dad who have a son with autism. After meeting, doing intake and assessment, and discussing available support, parents reached out prior to the next meeting seeking guidance on how to collaborate with school to address a behavior that occurred. Mom was emotional, but able to work through her emotions and ask the relevant questions of the school staff to make sure this behavior is addressed in a meaningful, purposeful way for him.

CSHCN and Bullying

In SFY25, FCCS will implement its family survey to all SCHSCM families to understand the impact of bullying on their families. This will be a new NPM for the CSHCNs moving forward. According to the National Child Health Survey (2022-2023), 51.3% of all CSHCN ages 12-17 years old experienced bullying. The NJ estimate was similar at 49.3%. Additionally, of the same population nationwide, 19.4% of bullied others, while in NJ the estimate was 13.8% of CSHCN bullied others. During SFY 24, FCCS surveyed SCHSCM Case Managers to establish the baseline of services currently available to assist families that are victims or perpetrators of bullying, in addition to providing training to Case Managers on how to specifically assist CSCHN families. From the initial survey with SCHSCM Case Managers:

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

In SFY 25, FCCS plans to establish the programs baseline for future reporting on this performance measure statewide and nationally.

Challenges in Specialized Pediatric Clinics

CECs report mental health challenges increasing for their patients, and as a response several have enhanced collaboration with their Psychiatry Departments to expand their child psychiatry and behavioral health services. To address this rise, CECs have expanded their collaborations with community-based agencies, LEAs, clinics, and emergency rooms. The TV staff will monitor these new efforts.

NBS and Genetic Services

The NBS & GS program continues to collaborate with internal and external stakeholders. Following the 45 hospitals in-service visits done in 2024, the Program has started a series of in-service offerings for midwives and community birth providers. Together with the lab, the Program established three work groups for 2025: one to focus on communication with pediatricians, one to focus on lab and follow-up protocols, and one to focus on our Saturday and holiday workflows. Staff will also continue to follow up on all newborns with out-of-range screening results and conduct long-term follow-up to better understand the experience of families engaged in the NBS community and to help ensure access to services and family and child well-being.

DSET

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

Cross-Cutting/Systems Building Annual Report

This section concerning the domain of Life Course includes the SPN #8 Improving Integration of Information Systems and the NPM #13 Oral Health. ESM 13.1 for oral preventive and dental services for children enrolled in Medicaid or CHIP (CMS-416).

Annual Report – NPM: Preventive Dental Visit:

A. Percent of women who had a dental visit during pregnancy
    a. 28% pregnant recipients were reported with any dental service utilization by the Medicaid Recipient Metrics, SFY24.
    b. Note: While NJ does not currently have a mechanism to track the % of the pregnant women who have had a dental visit during pregnancy, the NJDOH collaborates with NJ FamilyCare (Medicaid) staff and tracks % of pregnant women covered by Medicaid that have had a dental visit during their pregnancy.

B. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
    a. Of the nearly half million children covered by NJ Family Care (Medicaid & Chips) aged 1 through 17 that had a reported dental treatment utilization, 94% were reported to have had preventative dental service utilization by the Medicaid Recipient Metrics, SFY24.

Overall health cannot be achieved without good oral health. According to the Centers for Disease Control and Prevention (CDC), oral health affects our ability to eat, speak, smile, and show emotions. Oral health also affects a person’s self-esteem, school performance, and attendance at work or school. Oral diseases—which range from cavities and gum disease to oral cancer—cause pain and disability for millions of Americans and cost taxpayers billions of dollars each year. Additionally, oral health care remains the greatest unmet health need for children. To address this problem, the NPM of Oral Health focuses on improving Oral Health for some of the most vulnerable populations, i.e., pregnant women, children and, adolescents.

13.1: Percent of women who had a preventive dental visit during pregnancy

13.2: Percent of children and adolescents, ages 1 through 17, who had a preventive dental visit in the past year.

Since the 1980s, the Children’s OHP has provided age-appropriate and developmentally targeted oral health education programs to school-age children covering all 21 counties in NJ. In addition, COHP offers oral health education programs, including a newsletter for parenting and community groups for women and all children. School and community presentations are conducted in areas of high risk for dental disease and high need of oral health services by registered dental professionals, who provide evidence-based oral health and hygiene information, including the oral disease process, tooth anatomy, healthy food choices, reducing the use of sugary foods and beverages, tobacco cessation and the dangers of vape and e-cigarette products, positive lifestyle choices to increase health and reduce systemic disease, and oral injury prevention education. Additionally, all children and families participating in COHP education and outreach programs received free oral health personal care items, including toothbrushes and floss. Currently, schools and community groups have the option of in-person, virtual recorded, and virtual live oral health education, increasing flexibility and access.

Some of the COHP achievements in 2024 includes:

- Provided fluoride varnish applications to 1,321 children, helping to prevent tooth decay.
- Delivered oral health literacy, education, and promotion programs to over 35,000 school-aged children across NJ, including 551 children with special health care needs.
- Provided 10,555 individual oral health-related nutritional counseling sessions to the families of low-income children and adolescents, promoting healthy food choices to improve oral health and overall well-being. This initiative also resulted in the placement of 14,094 dental sealants in school-aged children.
- Launched NJ's third Basic Screening Survey (BSS), targeting adolescents in grades 7-8 (first in the nation to be completed for this population). This nationally recognized dental survey collects oral health data and is expected to be completed by March 2025.
- In 2022, NJ introduced its first-ever BSS for third-grade students, with results submitted to the CDC.
- In 2023, NJ launched its second BSS for the Head Start population (ages 3-5).
- Results from the first and second BSS:

    - Our first BSS for third-grade students in 2022 indicated that the burden of oral health diseases in NJ children is significantly higher than the national average.

    - 36% have untreated decay (national average 20%)
    - Only 29% have dental sealants (national average 42%)
    - 15% need URGENT dental care now = 13,200 students have active tooth decay and experience pain

    - Our second BSS was for HeadStart children. Consistent with the findings of the BSS for third-grade students.

    - Almost 1 out of 3 NJ Head Start children (32%) has already experienced tooth decay.
    - Almost 1 out of 4 Head Start children (24%) in NJ has untreated tooth decay, demonstrating that many young children are not getting the dental care they need.
    - Compared to all U.S. children aged 3-5 years, NJ's low-income Head Start children have a higher prevalence of decay experience and untreated decay (12% national average).
    - About 4% of NJ's Head Start children need urgent dental care because of pain or infection. If applied to the number of 3-5-year-olds in NJ on Medicaid, more than 5,000 young children 3-5 years of age experience pain or infection due to dental disease on any given day.

- The State Dental Director and the State Dental Hygienists participated in several conferences aimed at enhancing partnerships with local organizations focused on improving the overall health of children and pregnant individuals in NJ. Notable conferences included:

    - School Health Conference at the NJ American Academy of Pediatrics
    - NurtureNJ Leadership Summit: This summit brought together experts to discuss and identify solutions for NJ's maternal and infant health crisis.
    - Arc of NJ Conference: Focused on improving the health of individuals with intellectual and developmental disabilities.
    - Horizon Day at NJ Dental Association: Emphasized collaboration between medical and dental fields. The State Dental Director presented on improving the oral health of pregnant individuals and their children at this event.
    - Additionally, the State Dental Director and Hygienist presented at a council meeting at Perth Amboy, advocating for the reintroduction of fluoride into the community water supply.

- The Oral Health Services Unit at DOH recently completed a pilot program with preschool nurses through the NJDOE, focusing on training them to screen young children for oral health issues and providing appropriate follow-up recommendations. Based on attendee input, we made necessary adjustments and will deliver the final presentation in future sessions. This oral health training program will be presented and recorded to an anticipated 600 preschool nurses. The recorded session will be hosted on the DOE's website for ongoing access.

Cross-Cutting/Systems Building Application Year

NJDOH-Division of Community Health Services-Oral Health Services Unit

- Since the 1980s, the Children's OHP has educated the public about the importance of preventive oral health services and good oral health, with programs predominately targeted to school-aged children and pregnant women. With ongoing funding from the Health Resources and Services Administration (HRSA), the NJDOH will continue to direct the activities of several programs to address two public health priorities. COHP will continue its outreach, education, and preventive oral health services to children and adolescents throughout NJ. COHP aims to expand its oral health training for professionals working directly with the pregnant population, such as training OB/GYN Physicians, doulas and staff within the Women, Infants, and Children (WIC) program. The State Dental Director and State Dental Hygienist will continue to provide technical assistance, serve on multiple committees as subject matter experts, and advocate for the oral health of all NJ residents.

- Nearly 1/3 of all births in NJ are covered by our State Medicaid program, NJ FamilyCare. Additionally, in SFY24, 85,523 pregnant individuals received services through NJ FamilyCare. However, only 24,094 of those individuals (28%) accessed dental services, and only 19,746 (23%) accessed preventive oral health services during the same timeframe. Additionally, there were 3,393 pre-term births among patients covered by NJ FamilyCare, and 2,497 of these individuals (74%) had not received NJ FamilyCare-covered dental services during their pregnancies. The data confirms the available evidence on the direct correlation between poor oral health and sub-optimal pregnancy outcomes, including pre-term labor and maternal morbidity in connection with childbirth. To address maternal oral health problems, the NJDOH submitted a new MCH grant application to create a medical-dental integration program between the NJDOH's Oral Health Services Unit and MCH collaborating with practitioners within the obstetrics and gynecology community throughout the State, with a focus on developing policy, systems, and environmental changes that will lead to more expansive oral health screenings of pregnant individuals and appropriate dental services, as applicable. NJDOH, if funded, would also implement demonstration projects to deliver integrated oral health services within primary care settings for pregnant individuals within two communities and six clinical settings where particularly vulnerable pregnant individuals access medical services in NJ.

- Our first Basic Screening Survey (BSS) for third-grade students in 2022 indicated that the burden of oral health diseases in NJ children is significantly higher than the national average.
    - 36% have untreated decay (national average 20%)
    - only 29% have dental sealants, a highly effective preventative oral health measure (national average 42%)
    - 15% need URGENT dental care now
    - 13,200 students have active tooth decay and experience pain

- Our second BSS was for HeadStart children (3–5-year-olds). Consistent with the findings of the BSS for third-grade students.
    - Almost 1 out of 3 NJ Head Start children (32%) has already experienced tooth decay.
    - Almost 1 out of 4 Head Start children (24%) in NJ has untreated tooth decay, double the national average, demonstrating that many children are not getting the dental care they need.
    - Compared to all U.S. children aged 3-5 years, NJ's low-income Head Start children have a higher prevalence of decay experience and untreated decay.
    - About 4% of NJ's Head Start children need urgent dental care because of pain or infection. If applied to the number of 3-5-year-olds in NJ on Medicaid, more than

5,000 young children 3-5 years of age experience pain or infection due to dental disease on any given day.

- COHP is currently in process with a third BSS. This time with middle school children (7-8 grade) and we have plans to institute a BSS for Pregnant Women where on a national level in 2007–2009, 35% of U.S. women reported that they did not have a dental visit within the past year and 56% of women did not visit a dentist during pregnancy. Of note, NJDOH reached out to NJ Family Care (Medicaid) and confirmed that dental visitation was extremely low among its constituents.

- To address the significant gap NJ has with national averages, the Oral Health Services Unit will continue its grant activities focused on expanding the availability of dental sealant programs as one of the most compelling evidence-based practices for low-income children and provide nutritional counseling to this at-risk population to reduce the intake of sugary products that increase the incidence of tooth decays. In addition to past activities on nutritional counseling an additional focus on training providers and patients on the adverse consequences of consuming ultra processed foods and its impact on both oral and general health. In this regard, COHP has the potential of adding an additional seven interested new grantees to our Oral Health Caries Prevention Program grant that will add significant coverage particularly in Southern NJ.

- Other ongoing initiative and activities include but are not limited to the following:
    - Working with Head Start grantees to ensure that daily classroom toothbrushing and other preventive dental programs are available in all Head Start centers.
    - Improving access to evidence-based, community-based primary prevention programs for pregnant women, infants, toddlers, and their families.
    - Developing and implementing programs to ensure that all children have access to dental care, including expanding the network of Medicaid participating dentists. Expand community-based screening and referral programs that include a case management component so that children in need have better access to dental care.
    - Expanding integrated community-based prevention programs, screening and referral services, and restorative dental care programs that target low-income populations.
    - Kinder Smile Foundation perinatal – oral health integration.

- NJ FamilyCare is the state's Medicaid program, and it has adopted very favorable policies that will help ensure that pregnant residents have access to comprehensive oral health services throughout the term of this demonstration project. First, NJ adopted Medicaid expansion through the Affordable Care Act on January 1, 2014. Through the NJ FamilyCare program, covered individuals receive comprehensive oral health services. In 2021, NJ expanded its state-funded Supplemental Prenatal and Contraceptive Program to ensure that undocumented women receive necessary prenatal care services. Finally, in

January 2023, NJ FamilyCare began covering all youth under the age of 19 in the state, irrespective of immigration status, with incomes at or below 355% of the federal poverty level through Cover All Kids. This program extends to eligible youth with comprehensive medical and dental benefits.

- Nearly 1/3 of all births in NJ are covered by our State Medicaid program, NJ FamilyCare (35,572 out of 99,346 births in NJ from July 1, 2022 – June 30, 2023). Additionally, 86,021 pregnant individuals received services through NJ FamilyCare. However, only 24,919 of those individuals (28%) accessed dental services, and only 17,702 (20%) accessed preventive oral health services during the same timeframe. Additionally, there were 3,336 pre-term births among patients covered by NJ FamilyCare, and 2,417 of these individuals (72%) had not received NJ FamilyCare-covered dental services during their pregnancies. The data confirms the available evidence on the direct correlation between poor oral health and sub-optimal pregnancy outcomes, including pre-term labor and maternal morbidity in connection with childbirth. To address maternal oral health problems, NJDOH submitted a new MCH grant application to create a medical-dental integration program between the NJDOH's Oral Health Services Unit and MCH collaborating with practitioners within the obstetrics and gynecology community throughout the State, with a focus on developing policy, systems, and environmental changes that will lead to more expansive oral health screenings of pregnant individuals and appropriate dental services, as applicable. NJDOH, unfortunately did not score enough to be awarded a grant. However, through State funding introduced a pilot consistent with the proposal, working with a non-profit in Bloomfield, Newark (both in Essex County) and Trenton (Mercer County to introduce the program. NJDOH plans to conduct the BSS for pregnant individuals as the fourth, Basic Screening Survey (BSS), followed by the BSS for third graders, HeadStart, and adolescent populations. The survey findings will be publicly shared as a valuable resource for all oral health advocates and stakeholders.

- NJDOH added the following four new dental survey questions to the NJ Behavioral Risk Factor Surveillance System, which allows a better understanding of the oral health landscape in NJ and future planning to meet the needs of the NJ population.

  Q1. Including all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists, have you visited a dentist or a dental clinic for any reason within the past year?
  Q2. What is the main reason you have not visited the dentist in the past year?
  Q3. How long has it been since you had your teeth cleaned by a dentist or dental hygienist?
  Q4. During the past 12 months have you ever gone to an emergency room for tooth pain because you could not get a dental appointment (or do not have dental home/office to go to on regular basis)?

III.F. Public Input

*To be integrated before final submission of the document.

III.G. Technical Assistance

None needed at this time.

IV. Title V-Medicaid IAA/MOU

*In formal review process: to be completed by July of 2025

Appendix

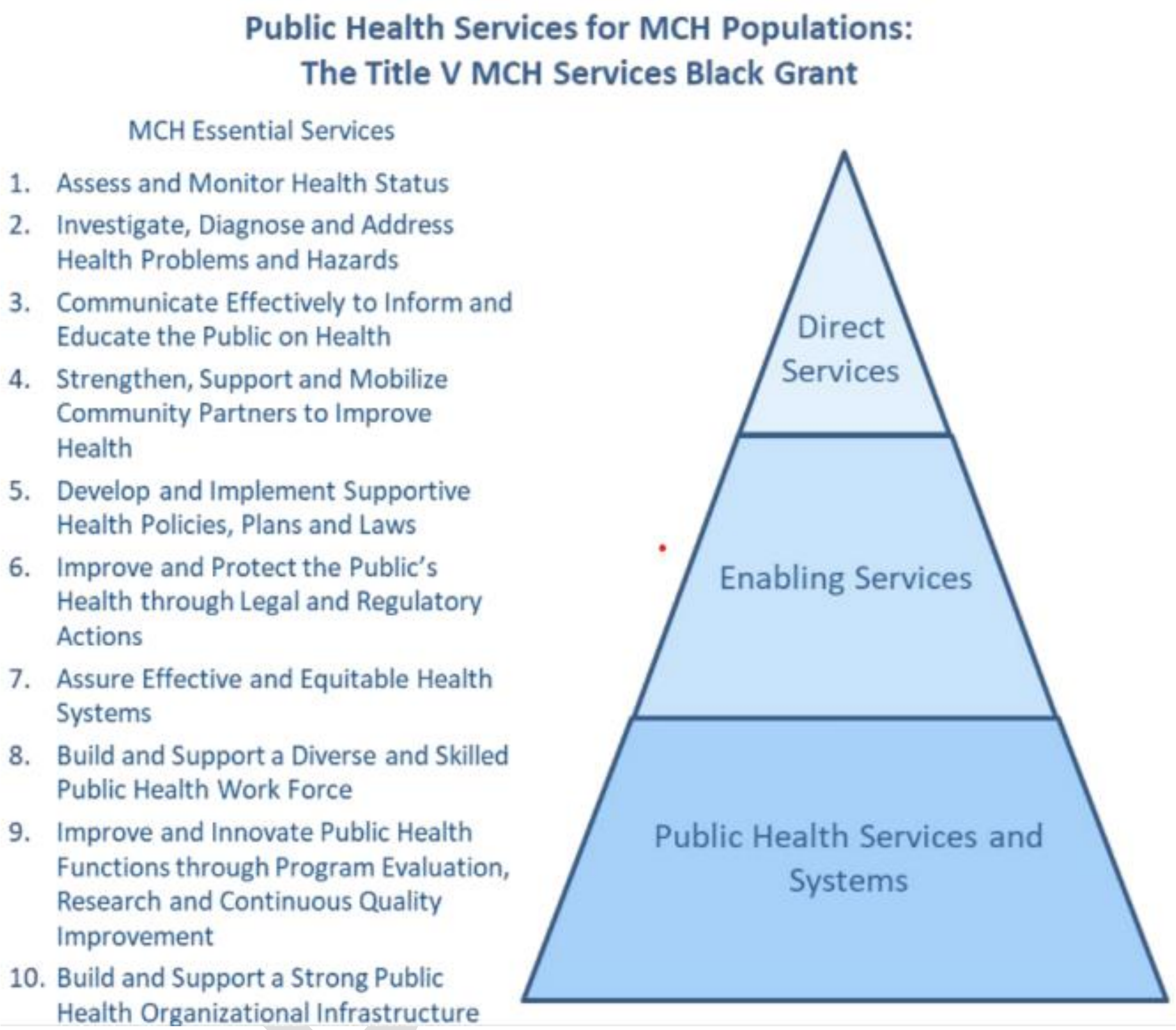
Appendix 1: Acronyms

Full Name	*Acronym*
General	
Black infant mortality	BIM
Centers for Disease Control and Prevention's	CDC
Community Health Worker	CHW
Certified Nurse Assistants	CNAs
Department of Children and Families	DCF
Division of Developmental Disabilities	DDD
Department of Human Services	DHS
Department of Education	DOE
Division of Vocational Rehabilitation	DVRS
Evidence-Based Informed Strategy Measures	ESMs
Family Health Services	FHS
Federally Qualified Health Centers	FQHCs
Health Resources Service Administration	HRSA
Healthy Women, Healthy Families	HWHF
Maternal and Child Health	MCH
Maternal Child Health Bureau	MCHB
Maternal and Child Health Block Grant	MCHBG
non- Hispanic	NH
New Jersey	NJ
National Performance Measures	NPMs
Request for Application	RFA
Request For Proposals	RFP
State Priority Needs	SPNs
Title V Program	TVP
Title V staff	TVS
Women Infants and Children	WIC
Women's Health	
Colette Lamothe-Galette Community Health Worker Institute	CLG-CHWI
Connecting NJ	CNJ
Doula Learning Collaborative	DLC
Maternal Child Health Services	MCHS
Maternal, Infant, and Early Childhood Home Visiting	MIECHV
Maternal Mortality Review Committee	NJMMRC
Postpartum Depression and Mood Disorders	PPD-MD
New Jersey Pregnancy Risk Assessment Monitoring System	PRAMS
Reproductive and Perinatal Health Workforce	RPHW

Perinatal Infant Health	
Fetal Infant Mortality Review	FIMR
Substance use disorder (SUD	SUD
Child Health	
Basic Screening Survey	BSS
Early Childhood Comprehensive System	ECCS
Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder	FAS/FASD
National Survey of Children's Health	NSCH
Adolescent Health	
Adolescents and young adults	AYA
Child and Adolescent Health Program	CAHP
Teen Prevention Education Program	PEP
Personal Responsibility Education Program	PREP
Sexual Risk Avoidance Education	SRAE
Teen Outreach Program	TOP
Youth Risk Behavioral Surveillance	YRBS
Children with Special Health Care Needs	
American Academy of Pediatrics	AAP
Autism Spectrum Disorders	ASD
American Sign Language	ASL
Birth Defects and Autism Registry	BDR
Birth Defects and Autism Reporting System	BDARS
Critical Congenital Heart Defects	CCHD
congenital Cytomegalovirus	cCMV
Child Evaluation Centers	CECs
Case Management Referral System	CMRS
Case Management Units	CMUs
Statewide Community of Care Consortium	COCC
Children and Youth with Special Health Care Needs	CYSHCN
Data Systems and Emerging Threat Response	DSET
Early Hearing Detection and Intervention	EHDI
Early Identification and Monitoring	EIM
Early Intervention Services	EIS
Expanded Laboratory Capacity	ELC
Family Centered Care Services	FCCS
Individual Service Plan	ISP

Newborn Biochemical Screening	**NBS**
New Jersey Early Intervention Services	**NJEIS**
New Jersey Immunization Information System	**NJIIS**
NJ Stakeholders	**NJSH**
Newborn Screening Follow-up and Genetic Services	**NSGS**
Pediatric Tertiary Care	**PTC**
Special Child Health Services	**SCHS**
Special Child Health Services Case Management	**SCHSCM**
Shared Plan of Care	**SPoC**
Specialized Pediatric Services Program	**SPSP**

Appendix 2: MCH Essential Services



Public Health Services for MCH Populations:
The Title V MCH Services Black Grant

MCH Essential Services

1. Assess and Monitor Health Status
2. Investigate, Diagnose and Address Health Problems and Hazards
3. Communicate Effectively to Inform and Educate the Public on Health
4. Strengthen, Support and Mobilize Community Partners to Improve Health
5. Develop and Implement Supportive Health Policies, Plans and Laws
6. Improve and Protect the Public's Health through Legal and Regulatory Actions
7. Assure Effective and Equitable Health Systems
8. Build and Support a Diverse and Skilled Public Health Work Force
9. Improve and Innovate Public Health Functions through Program Evaluation, Research and Continuous Quality Improvement
10. Build and Support a Strong Public Health Organizational Infrastructure

Appendix 3: Guiding Principles and Associated Activities of the Needs Assessment Process

Key Principle	**Activities Associated**
Health Equity: Integrate Health Equity throughout the process using the Health Equity Framework as a guide	Expand understanding of health, with a specific focus on CHF Consult data on measures of health Collaborate with partners to ensure health equity is discussed and community voices are elevated in the discussion
Trauma-informed: Recognize the widespread impact of trauma and promote healing and recovery environments	Begin discussions acknowledging the epidemic of trauma
Quality Improvement: Engage in a continuous quality improvement process	Engage in SWOT Analyses with internal and external partners Gather community feedback
Community Engagement: Actively engage with community stakeholders from across systems	Invite community members and stakeholders to discussions on community resources Make a special effort to recruit from racially, ethnically, geographically and culturally diverse backgrounds Actively apply feedback from community members to inform activities
Transparency: Share information regarding the needs assessment process regarding goals, and engage in shared decision-making	Document and public sources of data and evidence used in needs assessment Document meeting notes and minutes and share publicly Communicate with community members regularly throughout the needs assessment process
Accountability: Be available to answer questions and take responsibility for unforeseen consequences of decisions	Evaluate effectiveness of processes and programs Consistently report to the Work Group and Steering Committee (?)
Adaptability: Demonstrate openness, flexibility, and humility to adapt throughout the process if necessary	Remain open to change and modification of process in order to be maximize efficiency
Data-driven Decisions: Use quantitative and qualitative data to inform decision making	Seek out relevant, valid and updated data to describe MCH populations and their needs Utilize the prioritization process
Evidence-Based and Informed Practices: Apply evidence-based and informed practices related to methodology and other efforts across the needs assessment process	Use qualitative and quantitative designs to enhance the process
Collaboration with Systems/Service Recipients: Connect and cultivate relationship	Identify internal and external partners Cultivate relationships with partners

with internal and external stakeholders to DOH in achieve desired outcomes	Seek input, guidance, and support from traditional and non-traditional partners

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