Maternal and Child Health Services Title V Block Grant

New Jersey

FY 2022 Application/ FY 2020 Annual Report

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III.A.1. Program Overview

3.A. Executive Summary

The mission of the NJ Department of Health (NJDOH), Division of Family Health Services (FHS) is to improve the health, safety, and well-being of families and communities in New Jersey (NJ). FHS works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. The Maternal and Child Health Block Grant Application and Annual Report that FHS submits each year to the Maternal Child Health Bureau (MCHB) provides an overview of initiatives, State-supported programs, and other State-based responses designed to address the maternal and child health (MCH) needs in NJ as identified through our continuous needs assessment process and in concert with the NJDOH's strategic plan, the State's Health Improvement Plan, Healthy NJ 2030, and the collaborative process with other MCH partners.

NJ is the most urbanized and densely populated state in the nation with 9.0 million residents; it is also one of the most racially and ethnically diverse states in the country. The racial and ethnic mix for NJ mothers, infants, and children is more diverse than the overall population composition. This growing diversity not only raises the importance of addressing disparities in health outcomes, but also of the need to ensure a culturally competent workforce and service delivery system. One of the three priority goals of the FHS Title V program is to increase the delivery of culturally competent services through a well-trained workforce. The other two goals are to improve access to health services through partnerships and collaboration and to reduce disparities in health outcomes.

The goals and State Priority Needs (SPNs) selected by FHS are consistent with the findings of the Five-Year Needs Assessment, built upon the work of prior MCH Block Grant Applications/Annual Reports and in alignment with NJDOH's and FHS' goals and objectives. The State Priority Needs (SPNs) are:
SPN 1-Increasing Equity in Healthy Births,
SPN 2-Reducing Black Maternal and Infant Mortality,
SPN 3-Improving Nutrition & Physical Activity,
SPN 4-Promoting Youth Development Programs,
SPN 5-Improving Access to Quality Care for CYSHCN,
SPN 6-Reducing Teen Pregnancy,
SPN 7-Improving & Integrating Information Systems, and
SPN 8-Smoking Prevention.

Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure building to meet the health of all NJ's families.

NJ has selected the following nine of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:
NPM 1-Well Woman Care,
NPM 4-Breastfeeding,
NPM 5-Safe Sleep,
NPM 6-Developmental Screening,
NPM 9-Bullying,
NPM 11-Medical Home,
NPM 12-Transitioning to Adulthood,
NPM 13-Oral Health, and
NPM 14-Household Smoking.

Although the overall infant mortality rate in New Jersey is lower than the national rate, the disparity between white, non-Hispanic (NH), and black, NH, is significant and persistent. NJ's NH Black women experience related mortality at nearly five times their White counterparts and greater severe maternal morbidity (SMM) burdens than all other groups. Regional focus groups with consumers and stakeholders identified some of the social determinants of health (SDOH), including lack of social support and timely access to care, that contribute to

the persisting disparities. As a result, the Healthy Women, Healthy Families (HWHF) Initiative was implemented in July 2018 to improve maternal and infant health outcomes for women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes through a collaborative coordinated community driven approach through the use of Community Health Workers and Central Intake Hubs.

New Jersey is taking a targeted approach to reducing black infant mortality (BIM) rates. Specific BIM reduction activities including breastfeeding support, fatherhood support, Centering and Doula programs, have been implemented in 8 municipalities found to have the highest rates of BIM (Atlantic City, Camden, East Orange, Irvington, Jersey City, Newark, Paterson, and Trenton). Statewide collaboration with traditional and non-traditional partners to address the SDOH is instrumental in moving the needle on Black Infant Mortality reduction. As a result, partners from the Departments of Labor and Workforce Development, Education, Transportation, Children and Families, Human Services, the Office of the Attorney General and the community, regularly collaborate to reduce BIM. FHS is working very closely with the Office of Population Health with the purpose of: (a) ensuring health in all policies, (b) leveraging resources and inter- and intra-departmental collaborations, and, (c) addressing health disparities using a multi-sectorial approach.

The State Health Improvement Plan (SHIP) identified Birth Outcomes as a priority health issue to be addressed by the NJ DOH, sister agencies, community-based stakeholders, and local public health agencies. The SHIP with its focus on health equity has identified several policy related strategies to improve birth outcomes. FHS and the Office of Population Health have successfully applied for several federal grants focused on maternal mortality and morbidity including the Maternal Mortality Review Committee Grant from the CDC and the State Maternal Health Innovation Program Grant from HRSA to fund the strategies of the SHIP.

The NJ Maternal Mortality Review Committee grant from the CDC ($450,000 per year for 5 years) will fund the NJ DOH to coordinate and manage the NJ Maternal Mortality Review Committee (NJ MMRC) to identify and characterize maternal deaths for identifying prevention opportunities. The strengthening of the NJ MMRC and the implementation of the strategies and activities outlined in the NJ MMRC grant will produce the short-term, intermediate, and long-term outcomes necessary to reduce preventable maternal deaths. NJ legislation (P.L.2019, c.75) provides the legal authority to convene and strengthen the MMRC.

HRSA funding for the State Maternal Health Innovation Program (SMHIP) Grant will support the NJDOH initiatives to enable New Jersey becomes the safest place in the United States to give birth. The SMHIP will leverage progress to-date, anchor multi-sector collaboration, establish sustainable mechanisms that will extend beyond the five-year period of performance and improve data infrastructure to complement activities in New Jersey’s Title V program.

Nurture NJ is the First Lady of NJ’s statewide awareness campaign that is committed to reducing infant and maternal mortality and morbidity and ensuring equitable maternal and infant care among women and children of all races and ethnicities. The campaign includes a multi-pronged, multi-agency approach to improve maternal and infant health among New Jersey women and children. Initiatives include an annual Black Maternal and Infant Health Leadership Summit; the First Lady’s Family Festival event series; quarterly interdepartmental maternal and infant health meetings; and a comprehensive, statewide strategic plan to reduce maternal mortality by 50% over five years and eliminate racial disparities in birth outcomes.

Another program augmenting efforts to reduce infant mortality, pre-term births, and maternal morbidity is the Maternal and Infant Early Child Home Visiting (MIECHV) Program which has expanded Home Visiting (HV) across all 21 NJ counties. The goal of the NJ MIECHV Program is to expand NJ’s existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness.
Other initiatives contributing towards positive outcomes in addressing the State’s priority areas of reducing teen pregnancy, promoting youth development, and improving physical activity and nutrition are the Whole School, Whole Community, Whole Child (WSCC) School Health NJ Project, the NJ Personal Responsibility Education Program (PREP), and the NJ Sexual Risk Avoidance Education (SRAE) Program.

New Jersey's Title V Children and Youth with Special Health Care Needs (CYSHCN) program includes Newborn Screening and Genetic Services (NSGS), the Birth Defects and Autism Registry (BDAR), the Early Hearing Detection and Intervention (EHDI) program, Family Centered Care Services (FCCS), Specialized Pediatric Services (SPS), and Early Intervention Services (EIS). Both NSGS and EIS are primarily funded by other sources but are co-located and coordinate with our HRSA-funded programs.

The NSGS Program ensures that all newborns and families affected by an out-of-range screening result receive timely and appropriate follow-up services. NJ remains among the leading states in offering the most screenings, with

59 disorders on the current screening panel. In addition to disorders detected through heel stick, NJ's newborns are also screened with pulse oximetry through the Critical Congenital Heart Defects (CCHD) screening program. This screening was instituted to ensure that babies who appear healthy but have a CCHD are identified before they are discharged. Since inception of this screening in August of 2011, NJDOH has received reports of 35 infants with previously unsuspected CCHDs detected through the screening program, 7 of those were reported in 2020. Additionally, EHDI program continues to screen all newborns for hearing loss.

The BDAR ensures that all children 0 through five-years-old who have a congenital birth defect and all children 0 through 21 years old who have an Autism Spectrum Disorder (ASD) are registered. The BDAR provides valuable public surveillance data for needs assessment, service planning, and research. Most importantly, the BDAR links families to important resources through our Special Child Health Services Case Management Units (SCHS CMUs).

The Early Hearing Detection and Intervention Program (EHDI) monitors compliance with the NJ Universal Newborn Hearing Screening law, and measures NJ's progress in achieving the national EHDI goals of ensuring that all infants receive a hearing screening by one month of age, that children who do not pass screening receive diagnostic testing by three months of age, and that children who are diagnosed with hearing loss receive family-centered, culturally competent Early Intervention Services by six months of age. Hospitals have been very successful in ensuring that newborns receive hearing screening prior to hospital discharge. Ensuring that children who did not pass their initial screening receive timely and appropriate follow-up remains an area for continued efforts.

The FCCS program promotes access to care through early identification, referral to community-based culturally competent services and follow-up for CYSHCNs up to 21 years of age. These services and supports are provided through SCHS CMUs, . Ryan White Part D is also housed within FCCS and provides direct care to women, infants, children, and youth who are infected or affected with HIV/AIDS. FCCS services support NJ's efforts to address the six MCH Core Outcomes for CYSHCN. This safety net is supported by State and Title V funds administered via community health service grants, local support by the County Boards of Chosen Freeholders, reimbursement for direct service provision, and technical assistance to grantees. Through our Title V program partners, FHS continues to address families' medical and social conditions by providing, in addition to quality health care, referrals to support accessible services within state departments, and divisions as well as county and municipal agencies. Such referrals could include but not be limited to public health insurance options; legal services; food stamps; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); employment; public assistance; and the Catastrophic Illness in Children Relief Fund. These service referrals have been shown to drastically improve health outcomes and decrease the need for additional medical interventions, improve quality of life, and reduce costs.

Specialized Pediatric Services (SPS) consists of eight Child Evaluation Centers (CECs):of which four house Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder Centers and three provide newborn hearing screening follow-up, three Pediatric Tertiary Centers, and five Cleft Lip/Palate Craniofacial Anomalies Centers. The goal of the SPS program is to provide access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services to families with CYSHCN that are 21 years old or younger. With support from the State and Title V funds, health service grants are distributed to multiple agencies throughout NJ.

New Jersey Early Intervention Services (NJEIS) provides over 1.5 million services to over 30,000 children per year. In addition to state funds, Medicaid reimbursement, and family cost share funds, NJEIS receives federal funds as an IDEA Part C program. Located within our Special Child Health Services unit, they work collaboratively with the other programs. Our FCCS case managers refer children to NJEIS to ensure that eligible children receive important services in a timely manner, and as children age out of NJEIS and continue to need case management, these

children move back to our county-based CMUs.

New Jersey's Title V CYSHCN program diligently collaborates with intergovernmental and community-based partners to ensure that care through these multiple systems will be coordinated, family centered, community-based, and culturally competent. Communication across State agencies and timely training for State staffs, community-based organizations and families with CYSHCN remains a priority to ensure that families are adequately supported.

Additionally, family and youth input on multi-system access to care is obtained through the Community of Care Consortium, a coalition led by SPAN Parent Advocacy Network (SPAN). A key partner to NJ's Title V program, SPAN is comprised of parents of CYSHCN and youth, State agency representatives, and community-based organizations.

The impact of COVID-19 on all areas of maternal and child health has been and continues to be significant. COVID-19 necessitated a rapid transition from in-person programs and services to those being administered remotely whenever possible. Title V staff as well as Title V grantees operate remotely from home. Innovations in telehealth as well as Medicaid reimbursements were created. As the situation with COVID-19 continues to be rapidly evolving, Title V continues to collaborate with partners and families to deliver services and support.

New Jersey continues to support the work and mission of Title V and actively works on developing innovative ways to improve the health and well-being of New Jersey women, children, and families. As with addressing challenges to improve birth outcomes, reduce disparities, and operate within the public health COVID19 pandemic, NJDOH will work to further strengthen its partnerships with the MCH Bureau as well as families, providers, agencies, and other stakeholders.

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

Title V Funds are essential in supporting NJ's MCH efforts. NJDOH provides Title V funds to the Central Jersey Family Health Consortia to implement the Maternal Mortality Review Committee. The funds are used for staff to do chart abstraction, case summaries and data entry into CDC's Maternal Mortality Review Information Application (MMRIA) system. Improving maternal and infant health and reducing both Black Infant and Black Maternal mortality are priorities in NJ. Title V funds contribute to the Healthy Women, Healthy Families initiative, which is focused on addressing disparities, including Black Infant Mortality. The Table in Section 3.D.1. Expenditures, demonstrates the federal / state partnership and how FY 2020 Federal Title V funds are supported by State MCH funds.

Title V funds are used to partially fund the Fetal Infant Mortality Review (FIMR) programs in the Maternal Child Health Consortia. Title V funds are also used to partially fund the Family Health Line which is the 1-800 number for referrals to a variety of programs and services.

Title V funds are used to support NJ's state priority MCH efforts including increasing equity in healthy births, reducing BIM, improving nutrition and physical activity, promoting youth development, improving access to quality care for children and youth with special health care needs, reducing teen pregnancy, improving and integrating health information systems and smoking prevention.

III.A.3. MCH Success Story

MCH Success Story

The world is amid combatting the Coronavirus pandemic that is affecting all of humanity; there are no race, class or social group exempt. However, New Jersey has developed an innovative response to utilizing frontline workers, such as community health workers and doulas to provide vital information to local communities about healthcare, COVID-19 virus testing and treatment, vaccine education, safety, precautions, procedures as well as linking families to needed social services.

In 2020, the NJDOH established the Colette Lamothe-Galette Community Health Worker Institute (CLG-CHW) through a New Jersey Department of Labor Apprenticeship award initiated in 2019. The goal of the Institute is to create a standardized community health worker training and certification program, resulting in a robust CHW workforce. Through this work, the DOH will create career pipelines for CHWs, enhance CHW skill sets, and lead sustainable efforts to support this indispensable workforce. The training institute is named in memory of a public health champion that passed in April 2020 due to COVID-19 complications. New Jersey is proud to continue this work in her name. DOH was also awarded funding through the Epidemiology and Laboratory Capacity (ELC) grant to address COVID-19 in vulnerable populations. This grant creates an opportunity for Community Based Organizations (CBOs) to join our statewide forces to mitigate the spread of COVID-19 through a CDC Cooperative Agreement (2020-2023). The ELC project is prioritized under the CLG-CHW Institute through the use of CHWs.

New Jersey also engaged in a Doula Pilot Project through the Healthy Women Healthy Families Initiative. Approximately 100 doulas have been trained through this program. In 2021, as part of the Murphy Administration's continued effort to improve maternal and infant health, First Lady Tammy Murphy and the Department of Human Services announced the state Medicaid program would cover doula care. This and other initiatives are outlined in the First Lady's Nurture NJ Maternal and Infant Health Strategic Plan, which aims to the combat New Jersey's maternal and infant health mortality crisis by eliminating racial disparities in maternal and infant care. NJDOH and Rutgers Project Echo offered an educational series to meet a portion of the Medicaid certification requirements. Designed for doulas, the sessions provided information, peer to peer discussions, and resources for doulas serving Medicaid-enrolled pregnant women.

A poster presentation entitled "The Coronavirus Pandemic: New Jersey's Innovative Response to Educating, Training, and Leading a new Frontline Workforce," which included the CHW and Doula workforce was accepted and shared at the National AMCHP 2021 Conference.

Special Child Health and Early Intervention - Newborn Screening Success Story

Just ahead of the 4th of July weekend, the Newborn Screening Follow-up Program received a critical result after 5pm on a Thursday. The critical result was for Propionic Acidemia, which is a very rare and potentially life threatening disorder. As an essential program, the staff acted quickly to connect the family with the specialty care the baby required. The Newborn Screening Follow-Up Program worked with the primary care provider, provided translation services for this Spanish-speaking family, and assisted with figuring out transportation for the family to get to the specialist. The baby was brought to the Emergency Department of the nearest metabolic center. The specialist met the family in the waiting room and admitted the baby promptly. This baby was diagnosed with that very rare disorder over the holiday weekend. Had the Follow-up Program not acted so quickly, late in the day, ahead of a holiday, the baby could have died. We are happy to report the baby is alive and well because of newborn screening!

III.B. Overview of the State

III.B Overview of the State

The Maternal and Child Health Block Grant Application and Annual Report, submitted annually to the Maternal Child Health Bureau (MCHB), provides an overview of initiatives, State-supported programs, and other State-based responses designed to address the maternal and child health (MCH) needs in New Jersey. The Division of Family Health Services (FHS) in the NJ Department of Health (NJDOH), Public Health Services Branch posts a draft of the MCH Block Grant Application and Annual Report to its website in the second quarter of each calendar year to receive feedback from the maternal and child health community.

The mission of the Division of Family Health Services (FHS) is to improve the health, safety, and well-being of families and communities in NJ. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. The Division's ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

A brief overview of NJ demographics is included to provide a background for the maternal and child health needs of the State. While NJ is the most urbanized and densely populated state in the nation with 9.0 million residents, it has no single very large city. Only seven municipalities have more than 100,000 residents.

NJ is one of the most racially and ethnically diverse states in the country. According to the 2019 New Jersey Population Estimates of race, 54.3% of the population was white (alone not Hispanic), 12.7.0% was black, 9.6% was Asian, 0.1% was American Indian and Alaska Native, and 1.9% reported two or more races. In terms of ethnicity, 20.9% of the population was Hispanic. The racial and ethnic mix for NJ mothers, infants, and children is more diverse than the overall population composition. According to 2018 birth certificate data, 27.6% of mothers delivering infants in NJ were Hispanic, 44.4% were white non-Hispanic, 13.1% were black non-Hispanic, and 11.0% were Asian non-Hispanic. The growing diversity of NJ's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

MCH priorities continue to be a focus for the NJDOH. FHS, the Title V agency in NJ, has identified 1) improving access to health services thru partnerships and collaboration, 2) reducing disparities in health outcomes across the life span, 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 inter-related web of social, economic, environmental, and physiological factors contribute in varying degrees through the course of a person's life and across generations, to good health and well-being. Social determinants of health (SDOH), the conditions in the environments in which people live, learn, work, play, worship, and age, have a significant effect on health, functioning, and quality of life. Healthy People 2030 identifies five key areas of SDOH as economic stability, education, social and community context, health and health care, and neighborhood and built environment. In consideration of SDOH, there is a heightened need for integrating both health and non-health partners, as well as state, and external partners in addressing infant, maternal mortality, the opioid crisis and other public health issues facing NJ.

The selection of the NJ's eight State Priority Needs is a product of FHS's continuous needs assessment. Influenced by the MCH Block Grant needs assessment process, the NJDOH budget process, the New Jersey State Health Improvement Plan, Healthy New Jersey 2030, Community Health Improvement Plans and the collaborative process with other MCH partners, The process of identifying NJ priority needs is further detailed in the Needs Assessment Summary Section 3.C. FHS has selected the following State Priority Needs (see Section II.C. State Selected Priorities):

SPN #1) Increasing Equity in Healthy Births,
SPN #2) Reducing Black Maternal and Infant Mortality,
SPN #3) Improving Nutrition & Physical Activity,
SPN #4) Promoting Youth Development Programs,
SPN #5) Improving Access to Quality Care for CYSHCN,
SPN #6) Reducing Teen Pregnancy,

SPN #7) Improving & Integrating Information Systems, and
SPN #8) Smoking Prevention.

These goals and State Priority Needs (SPNs) are consistent with the findings of the Five-Year Needs Assessment and are built upon the work of prior MCH Block Grant Applications/Annual reports.
Consistent with federal guidelines from the MCH Bureau, Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all NJ's families. During a period of economic hardship and federal funding uncertainty magnified by the COVID-19 public health emergency, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services.

Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the following nine of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:
NPM #1 Well Woman Care,
NPM #4 Breastfeeding,
NPM #5 Safe Sleep,
NPM #6 Developmental Screening,
NPM #9 Bullying
NPM #11 Medical Home,
NPM #12 Transitioning to Adulthood,
NPM #13 Oral Health, and
NPM #14 Household Smoking.

State Performance Measures (SPM) have been reassessed through the needs assessment process. Four existing SPMs will be kept, and one old SPMs will be dropped. The existing SPMs which will be continued are:
SPM #1 Black Non-Hispanic Preterm Infants in NJ,
SPM #2 Hearing Screening Follow-up,
SPM #3 Referral from BDARS to Case Management Unit, and
SPM #4 Age of Initial Autism Diagnosis.

Table 1 - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model (See Supporting Document #1) summarizes the selected nine NPMs and aligns the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). The purpose of the ESMs is to identify state Title V program efforts which 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 which summarizes the Five-Year Needs Assessment process and includes the three-tiered performance measurement system with Evidence-Based or Informed Strategy Measures (ESM), National Performance Measures (NPM), and National Outcome Measures (NOMs). The Logic Model represents a more integrated system created by the three-tiered performance measure framework which ties the ESMs to the NPMs which in turn influence the NOMs.

The following is a brief overview of MCH services to put into context the Title V program within the State's health care delivery environment. Healthy Women Healthy Families (HWHF) grants have been awarded in fiscal year 2019 (start date of July 1, 2018) through a request for proposals process. The goal of this initiative is to improve maternal and infant health outcomes for women of childbearing age (defined by CDC as 15-44 years of age) and their families, especially black families, through a collaborative and coordinated community-driven approach. This is being done using a two-pronged approach: 1) county level activities focus on providing high-risk families and/or women of childbearing age access to resource information and referrals to local community services that promote child and family wellness and 2) Black Infant Mortality (BIM) municipality level activities focus on black NH women of child-bearing age by facilitating community linkages and supports, implementing specific BIM programs, and providing education and outreach to health providers, social service providers and other community level stakeholders. BIM activities include breastfeeding support groups, fatherhood support groups, Centering (group prenatal care), and Doulas. Using two models, Central Intake Hubs (CIH) and Community Health Workers (CHW), the HWHF Initiative works to improve maternal and infant health outcomes including preconception care, prenatal care, interconceptual care, preterm birth, low birth weight, and infant mortality through implementation of evidence-based and best practice strategies across three key life course stages: preconception, prenatal/postpartum and interconception.

Central Intake Hubs (CIH) are a single point of entry for screening and referral of women of reproductive age and their families to necessary medical and social services. The Community Health Worker (CHW) model performs outreach and client recruitment within the targeted community to identify and enroll women and their families in appropriate programs and services. CIHs work closely with community providers and partners, including CHWs, to eliminate duplication of effort and services. Standardized screening tools are used and referrals to programs and services are tracked in a centralized web-based system (SPECT – Single Point of Entry and Client Tracking). HWHF and

Doula grantees have received additional training on the NJCHART system, which is a new electronic health assessment and referral tracking system which can help ensure that all participating HWHF women are receiving prenatal care, have a primary care physician and/or an obstetrics and gynecology provider. Additionally, all HWHF newborns within the NJCHART system will have a record of insurance and pediatric medical provider information.

New Jersey is taking a targeted approach to reducing BIM rates through the enhancement of existing programs and creating new programs with the emphasis on this priority population. New Jersey recognizes the importance of a statewide collaboration of existing and non-traditional partners to address the SDOH which will be instrumental in moving the needle on Black Infant Mortality reduction. As a result, partners from the Department of Labor and Workforce Development, Division of Community Affairs, Department of Education, Department of Transportation, Department of Children and Families, Department of Human Services, the Office of the Attorney General and the Community will strategically collaborate to reduce black Infant mortality. FHS will be working very closely with NJDOH Office of Population Health and has created an FHS-Population Health Team (FHS-PHT) with the purpose of (a) ensuring health in all policies, (b) Leverage resources and inter- and intra-departmental collaborations, and, (c) addressing health disparities using a multi-sectorial approach.

Another program promoting the Life Course Perspective is the Maternal and Infant Early Child Home Visiting (MIECHV) Program which has expanded Home Visiting across all 21 NJ counties with over 6,500 families served annually through HV over the prior five year period. The goal of the NJ MIECHV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the NJ MIECHV Program is being carried out in collaboration with the Department of Children and Families (DCF) and is promoting a system of care of early childhood (see Support Document #5). NJ is a FY2018 recipient of both a federal MIECHV Formula and Competitive grant. DOH was also awarded approximately $1.2 HRSA American Rescue Plan funding for COVID-19 response efforts for the time period of May 1, 2021 through September 30, 2023. The funding will be used to support families with emergency supplies and prepaid grocery cards needed for both the immediate needs of families in response to COVID-19 and in responding to ongoing COVID-related needs going forward.

The Child and Adolescent Health Program (CAHP) successfully applied in 2010 for two federal grants to prevent teen pregnancy and promote youth development - the Personal Responsibility Education Program (PREP) and the Abstinence Education Program (AEP). In February of 2018, the NJDOH was awarded continuing funding for federal fiscal year 2018 and 2019 for PREP. AEP funding ended September 2018 and was replaced by the Sexual Risk Avoidance Education (SRAE) Grant Program. NJ received the grant award in April 2018. In addition, CAHP now has a Coordinator to direct statewide youth engagement collaboration amongst PREP, SRAE program and WSCC School Health NJ grantees.

The SRAE program focuses on building protective factors for youth aged 12-14 to help delay sexual activity, reduce pregnancy and Sexually Transmitted Infections (STIs)., SRAE also provides engagement opportunities including mentoring, youth leadership and parent education on talking with teens about risks. SRAE is a developmentally appropriate public health approach to sexual health education complimentary to the PREP program which provides extensive education on Sexual Risk Reduction in addition to avoidance. In December of 2018 a competitive RFA was released by NJDOH and new grantees were selected for a two-year grant cycle. All SRAE programming is complete, medically accurate and Lesbian, Gay, Bisexual, Transgender, Intersex, Asexual and Questioning (LGBTIAQ)-inclusive and trauma-informed.

PREP is a school- and community-based comprehensive sexual health education program that replicates evidence-based, medically accurate programs proven effective in reducing initial and repeat pregnancies among teens aged 14-19. Beginning in SFY18 NJ PREP began to implement programing in high schools only. NJ PREP also seeks to help teens avoid and reduce high risk sexual behaviors through the promotion of delay, abstinence, refusal skills, use of condoms and other forms of birth control and reducing the number of sexual partners. NJ PREP provides education on these adult preparation topics: Healthy Relationships, Life Skills and Adolescent Development. NJ PREP has program continuation funds through September 30, 2021 and continues to build on the success of the last six years by supporting three evidence-based models (EBM), two of which, The Teen Outreach Program (TOP®) and Reducing the Risk were selected from the Centers for Disease Control and Prevention's (CDC) Evidence-based Teen Pregnancy Prevention (TPP) Program List. In addition, CAHP added the NJ-based peer education program, Teen PEP, to the PREP Program beginning 10/1/2018.

New Jersey joined the second cohort of the Leadership Exchange for Adolescent Health Promotion (LEAHP), a National learning collaborative supporting adolescent health, established by the National Coalition of STD Directors (NCSD) and Child Trends in partnership with the National Association of State Boards of Education (NASBE). Cohort 2 began January 2020 and was scheduled to end June 2021, but an extension may be granted due to the pandemic. NJ has created a multi-sector, state-level leadership team with the goal to develop state-specific action plans in support of policy assessment, development, implementation, monitoring, and evaluation to address adolescent health in three priority areas: sexual health education (SHE), sexual health services (SHS), and safe and supportive

environments (SSE). The
NJ team is led by Jennie Blakney, (NJDOH), with colleagues from the NJDOE, NJDOH Division of HIV, STD and TB services, DCF and the NJ State Board of Education. Together, with stakeholders, NJ LEAHP will build capacity to assess, develop, monitor, evaluate and implement adolescent health policy for SHE, SHS and SSE; access and leverage lessons learned from national policies in adolescent health and education expertise; strengthen our state leadership knowledge and understanding of adolescent health issues and promote collaborative peer based learning to improve our strategies, policies and leadership related to adolescent health. A major obstacle for NJ in assessing SHE, SHS and SSE is a lack of published YRBS data due to an inability of the State to get weighted data, which is needed to be part of the National YRBS report. The LEAHP team brainstormed several solutions and the NJDOE representative brought this back to their management. NJDOH along with their YRBS team at Rutgers negotiated with CDC to use a different methodology (number of teen total respondents versus number of schools with respondents) allowing NJ to obtain weighted data and be included in the National sample in 2019 for the first time since 2013.

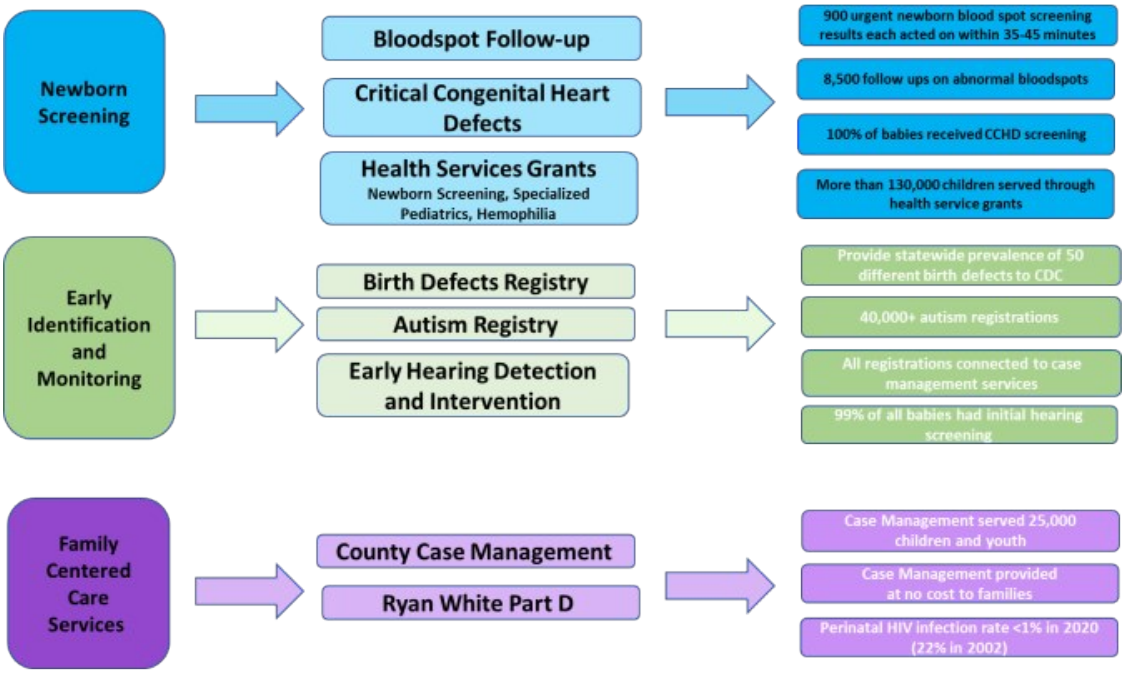
In September 2018, FHS was awarded a five-year HRSA grant of $445,000/year for the Pediatric Mental Health (PMH) Care Access Program. An additional required 20% non-federal match ($89,000) is currently supported by in-kind staff contribution of time. This grant enhances the existing Department of Children and Families (DCF) administered statewide network of nine regional Hubs, with telehealth technology, to improve access to pediatric mental and behavioral health services. Other key partners include: Hackensack Meridian Health, the American Academy of Pediatrics-NJ Chapter, and Rutgers University Behavioral Health Care. To date, over 182,022 youth less than 18 years of age have been screened and 11,219 mental health consultations/ referrals were completed. Due to COVID-19, the SFY2020 New Jersey workplan indicated that telehealth technology would be piloted at five of the nine regional Hubs that exist statewide and it is now implemented at all nine Hubs throughout the state.
As of April 2021, 47 pediatric practices, representing approximately 90 providers, have been equipped with telehealth technology through this HRSA grant.

Lastly, on November 30, 2020, New Jersey was awarded a five-year Garrett Lee Smith State/Tribal Youth Suicide Prevention from the DHHS Substance Abuse and Mental Health Services Administration (SAMHSA). The project period ends 11/29/25 and the award is for $736,000 per year. Readiness to Stand United Against Youth Suicide: A New Jersey Public Health Community Initiative (NJ R2S Challenge) is a collaborative grant with NJ Department of Children and Families, Office of the Secretary of Higher Education and multiple community-based organizations. The grant will focus on providing support to public schools, colleges and universities to improve awareness and intervention as well as direct services to youth at risk for suicide and youth who have attempted suicide. In addition, existing infrastructure including Training provided by NJ TLC's, NJ Hopeline and the Children's System of Care (CSOC) will be expanded through this grant. On April 29, 2021, NJDOH sponsored a kickoff event for the GLS grant, bringing experts in the field of mental health/suicidology to talk to NJ based youth serving professionals about youth suicide prevention. Hiding in Plain Sight: Working Together to Prevent Teen Suicide featured national and State experts. Over 1,300 professionals (pediatricians, nurse practitioners, social workers, guidance counselors, school nurses and other youth serving professionals) attended this half-day conference, larger than any other suicide prevention event held in NJ.

New Jersey's Title V CYSHCN program is known as Special Child Health and Early Intervention Services (SCHEIS) and includes four programs coordinated within one operational unit. The SCHEIS unit includes Newborn Screening Follow-up and Genetic Services (NSGS), the Early Identification and Monitoring (EIM) program, Family Centered Care Services (FCCS) and Early Intervention Services (EIS). Located within these programs are the Birth Defects and Autism Registry (BDAR), the Early Hearing and Detection Program, Specialized Pediatric Services Program (SPSP), and the Ryan White Part D program. These four programs work as an integrated continuum of care for children and youth with special health care needs. The diagram below highlights some of our 2020 successes.

New Jersey Department of Health
Division of Family Health Services
2020 Special Child Health and Early Intervention Services (SCHEIS)

Newborn Screening and Genetic Services



The NSGS Program ensures that all newborns and families affected by an out-of-range screening result receive timely and appropriate follow-up services. In January 2020, legislation was enacted to add the screening of spinal muscular atrophy (SMA). SMA will be added to the NJ newborn screening panel by the end of 2021 bringing the total number of biochemical/bloodspot screenings to 60 disorders for the state of New Jersey. Over 95,000 babies are screened annually, 7,328 babies were referred to our follow-up team in 2020. Because of 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 Newborn Biochemical Screening (NBS) Laboratory for these disorders during regular business hours, Saturdays, and certain State holidays to maximize timely referral to the appropriate specialists. To ensure NJ's program is state-of-the-art in terms of screening technologies and operations and is responsive to any current concerns regarding newborn screening, the NSGS program staff meets and communicates regularly with several advisory panels composed of parents, physicians, specialists, and others. The NSGS program is funded by the sale of newborn biochemical bloodspot filter cards.

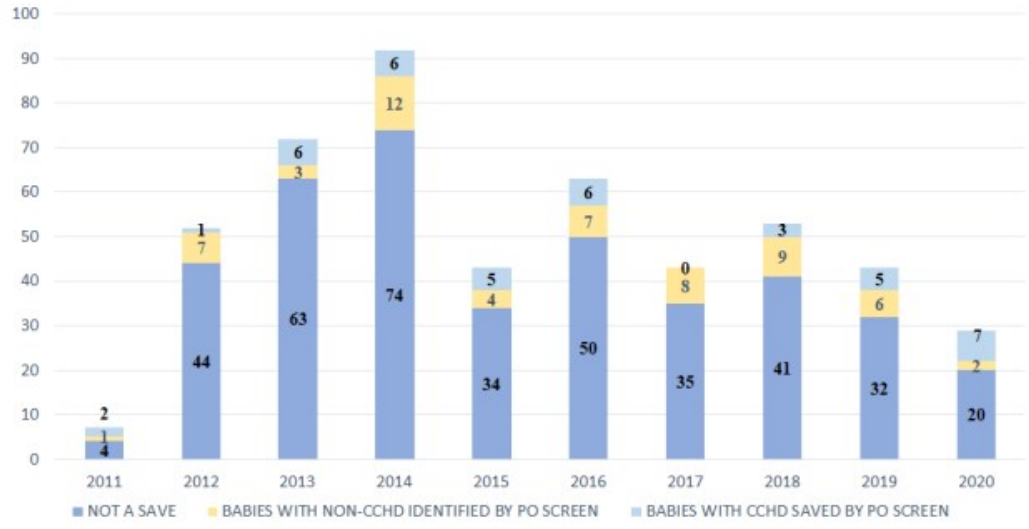
The Newborn Screening Follow-Up staff contact primary care providers, specialty care providers and parents to ensure timely evaluation, confirmatory testing and to obtain a final diagnosis. Results received from the NBS Laboratory range from low risk to critical and are handled accordingly. The majority of the results reported are considered to be low risk (> 6,000) which involves sending letters to parents, making telephone calls to physicians and hospitals, and utilizing multiple resources to locate babies for further testing. Time for follow-up on low-risk results ranges from two to eight weeks until cases are closed. In 2020, there were approximately 900 results referred to our Follow-up team which required aggressive actions to ensure that those babies received prompt medical intervention and treatment. As per protocol, critical cases must be reported to physicians and specialists within three hours from receipt from the NBS Laboratory, however, the NSGS team has averaged approximately 30 minutes to report. Time for follow-up on critical results ranges from one week to twelve months until cases are closed. These cases are left open longer due to the complexity of the disorders that often require multiple office visits/diagnostic tests to be completed to accurately confirm diagnoses. The NSGS team confirmed 155 classic cases during FY20.

The nature of the work this program does is illustrated through this success story:
In September 2020, a baby was born with a variant of a disorder that needed to be addressed within 10 days of birth to avoid a life-threatening outcome. Our NBS team, Karyn Dynak and Ondia Barron, received the critical results at 4 days of life, and together with our consulting specialist determined that "all the levers needed to be pulled." This was truly an around the clock effort with phone calls at 1am to the specialist. Ms. Barron worked around the clock from Friday through Monday engaging with police and the Department of Children and Families to find the family who had two different addresses listed (in different municipalities) and were nowhere to be found. The family was located early that Monday morning via text messaging and the baby was seen that day, later diagnosed with the variant, began receiving care and is doing well today!

New Jersey has mandated newborn pulse oximetry screening to detect Critical Congenital Heart Defects (CCHD) since 2011. Pulse Oximetry results are now captured by the New Jersey's Birth Certificate system, the Vital Information Platform (VIP). The Pulse Oximetry Module collects information used to identify children at risk for CCHD, which may not be apparent at birth. NJ is the first state in the nation to integrate the CCHD screening with their birth defects registry. The Newborn Screening staff work in collaboration with the BDAR staff to educate hospitals about the screening protocol, ensure compliance with the screening mandate, and the reporting of any confirmed diagnoses. All infants with failed screens were reported by each birthing facility to the BDAR. As pulse oximetry is a screening tool and

not a diagnostic tool, the BDAR staff follow up to ensure that these babies' congenital cardiac conditions have also been correctly reported. NSGS program staff review information monthly from the Pulse Oximetry Module to determine the final diagnosis of a child who failed the screening test. This review involves determining whether the child has been diagnosed with a CCHD by reviewing BDAR registrations and contacting the hospital that performed the screening. As of June 2020, NJDOH has received a total of 41 reports for previously unsuspected critical congenital heart defects detected through the screening program. As part of our quality assurance methods, the BDAR data is compared to the VIP to ensure that all babies who failed the screening are registered.

Figure 1. CCHD and NON-CCHD Babies "Saved" by Pulse Oximetry Screening by Year



Early Hearing Detection and Intervention

The New Jersey Early Hearing Detection and Intervention (EHDI) Program abides by the national public health initiative "'1-3-6' Guidelines" seeks to ensure that all babies born in New Jersey receive newborn hearing screening before the age of one month, complete diagnostic audiologic evaluation prior to three months of age for infants that 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. Hospitals continue to be successful in ensuring that newborns receive hearing screening prior to hospital discharge, ensuring that children who did not pass their initial screening receive timely and appropriate follow-up remains an area for continued efforts. The New Jersey EHDI program offers technical support to hospitals on their newborn hearing screening and follow-up programs. New Jersey EHDI tracks the number of infants screened and how many children are identified with hearing loss in a timely manner. New Jersey 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.

Specialized Pediatric Services Program (SPSP)

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. In addition, there are three Pediatric Tertiary Care (PTC) Centers, and five Cleft Lip Cleft Palate Craniofacial (CLCPC) Centers. The goal of the SPSP is to provide access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services to families with CYSHCN that are 21 years old or younger. With support from the State and Title V funds, health service grants are distributed to multiple agencies throughout NJ.

Early Identification and Monitoring

Within the EIM Program is the BDAR. Dating back to 1928, New Jersey is proud to have the oldest requirement in the nation for the reporting of birth defects. Over the years, our Registry has become a population-based birth defects registry of children with all defects (as of 1985); added Autism Spectrum Disorders (ASD) as reportable diagnoses (2007); expanded the mandatory reporting age for children diagnosed with birth defects to age 6; added severe hyperbilirubinemia as a reportable condition if the level is 25mg/dl or greater; and

become an invaluable surveillance and needs assessment data for service planning and research. All 49 birthing hospitals and hundreds of non-hospital-based practices report to the BDAR through our on-line registry. Annually, we receive an average of 5,600 registrations. In 2021, we will begin having non-New Jersey hospitals begin to register New Jersey-resident babies. A nurse abstractor has been contracted to register for the Children's Hospital of Philadelphia (CHOP). This will greatly improve our ability to register high-risk babies whose mother were sent to CHOP for delivery.

New Jersey continues to have one of the highest rates of autism in the United States. According to the Centers for Disease Control and Prevention's (CDC) 2016 prevalence figures published in the Morbidity and Mortality Weekly Report (MMWR) on March 27, 2020, cited NJ as having the highest prevalence rate of approximately one in 31.4 based on studies from four counties (Union, Hudson, Essex, and Ocean). This prevalence rate is not significantly different than the 2014 rate of 1 in 34.

The Autism Registry is the largest mandated autism registry in the country with over 40,000 children registered as of March 2021, and annually registers an average of 3,200 children. We are the only registry in the country that includes children up to the age of 22 and refers them to case management services. We serve as a model registry and continue to provide technical assistance with other states considering a registry. The Autism Registry provides quality prevalence information for the entire state, information about racial and ethnic disparities, and examines known perinatal risk factors and how they influence the New Jersey prevalence rates.

In the upcoming year, EIM will be redesigning of the Birth Defects and Autism Reporting System (BDARS) and rewriting the Autism Registry rules and regulations. The changes to the BDARS include a statewide search to reduce duplication, reduction of questions, and more checkoff lists for common comorbidities, symptoms, and behaviors. As NJ has the statutory authority to capture fetal deaths due to birth defects at 15 weeks' gestation and over, a module within BDARS is being developed and will be implemented in 2021 to capture and report those fetal deaths to the CDC. These changes will improve the accuracy of our data and improve our overall surveillance efforts. The new Autism Registry rules will propose registering a child with autism within six months of diagnosis or entry into a practice for previously diagnosed children. Timely reporting ensures that children diagnosed with autism are quickly linked to Early Intervention Services and/or SCHS Case Management. While some families are eager to have their child's condition diagnosed so that they can move forward with treatment, some families need time to come to terms with a diagnosis. Providers are given six months to work with families so that they are less apprehensive about having their child registered and open to seeking services.

BDARS staff continue 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 have visited and trained staff from medical centers specializing in child development, developmental evaluations, and behavioral health. Staff will continue to create reports and resources for both providers and families. Now that the registry data is sufficiently robust, the first Annual Autism Registry report has been completed and is awaiting approval for publication. This report provides the public with important statistics and information about autism in New Jersey.

Family Centered Care Services

Family Centered Care Services, Special Child Health Services Case Management Units (SCHSCM)receive referrals for all children registered with the BDARS. SCHS CM offers CM services through resource & referral for the CYSHCN from the ages of birth through 21 years. Through FCCS, NJ remains successful in linking children registered with the BDARS with services offered not only through the SCHS CMUs, but CECs including the Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders (FAS/FASD) Centers, and Newborn Hearing Screening Follow-up; Cleft Lip Cleft Palate Craniofacial (CLCPC) Centers; Pediatric Tertiary Care (PTC) Centers; Family WRAP; and Catastrophic Illness in Children Relief Fund (CICRF). With CDC Surveillance grant funding, the system is undergoing enhancements to support tracking of CYSHCN referred to SCHS CM and monitoring of services offered and/or provided to determine client outcomes.

FCCS's intergovernmental and interagency collaboration is ongoing among federal, state, and community partners and families including, but not limited to: Social Security Administration; NJ State Departments of Children and Families, Labor, Banking and Insurance, the Boggs Center/Association of University Centers on Disabilities, NJ Council on Developmental Disabilities, and community-based organizations such as Autism NJ, NJAAP, NJ Hospital Association, and the disability specific organizations such as the Arc of NJ, SPAN, and the COCC. Consultation and collaboration with NJDOH's other programs such as EIS, RWPD, MCH, WIC, FQHC, HIV/AIDS, STD and Tuberculosis, as well as Public Health Infrastructure Laboratories, and Emergency Preparedness affords FCCS with opportunities to communicate and partner in supporting CYSHCN and their families.

CMU staff continue to build upon a quality improvement (QI) initiative initially launched in 2014 to enhance consistency in documentation within individual service plans across the SCHS CMUs, and to improve upon the Case Management Referral System's (CMRS) data gathering capability. Information garnered from this initiative was anticipated to enhance NJ's efforts to improve performance on the Six Core Outcomes for CYSHCN, as well as, to promote targeted improvement in CMRS documentation in the following two areas; transition to adulthood and access to a medical home. Staff used the 2014 findings as a baseline to compare with NJ and the nation's performance as reported on the National Survey, and comparison data has been collected annually since 2015. Results are discussed in Plan for the

Application Year – National Performance Measure (NPM) #11 and NPM #12.

All 21 CMUs continue to use CMRS to track and monitor services provided to the children and their families. The system electronically notifies a CMU when a child living in their county has been registered and referred to their unit. CMRS provides the ability for CMs to create and modify an Individual Service Plan (ISP), track services, document each contact with the child and child's family, and register previously unregistered children. It provides the State Title V program with the opportunity for desktop review, referral, and linkage to care. As newly referred cases are entered into the database, CMRS continues to provide the ability to track access to care, ensures more measurable and readily tracked outcomes. Although reconfiguring data, reporting tracking systems, and report development, is a challenge, our biggest challenge remains the state staff vacancies for critical positions.

Early Intervention

Many children are also referred to our New Jersey Early Intervention Services (NJEIS) NJEIS has over 5,000 practitioners providing Developmental Intervention (DI), Speech Therapy (ST), Physical Therapy (PT), and Occupational (OT.) Over 1.5 million services are provided annually. At any point in time NJEIS is serving over 15,000 children and serves over 30,000 families annually as children enter and leave the program at age three. Although NJEIS is not funded by MCH Block grant funds, they do manage a budget of 200 million dollars per year and are an invaluable partner in our CYSCHN program.

III.C. Needs Assessment

FY 2022 Application/FY 2020 Annual Report Update

Needs Assessment Update

The NJ Title V Program continues to address and develop innovative ways to meet the needs of the MCH population as the COVID-19 pandemic continues to evolve. Many programs are currently in transition in terms of returning to offering in-person services and resources. We remain intentional in our approach to promote health equity and reduce disparities. New Jersey has the third-highest Black maternal mortality rate in the country. New Jersey also remains one of the most racially and ethnically diverse states, as well as one of the most densely populated state. Many pre-COVID-19 challenges for MCH populations, such as food insecurity, mental health and substance use issues, employment and childcare concerns, as well as access to comprehensive culturally competent community-based health care services, have been exacerbated during the COVID-19 pandemic especially for the most vulnerable populations, such as pregnant women and families with young children. COVID-19 and vaccine confusion and myths have continued to develop since the submission of last year's 5 year Needs Assessment.

Several efforts to assess and identify needs in the MCH population have continued and further been developed since last year's 5 year needs assessment. For example, New Jersey's Perinatal and Reproductive Health Program has partners with programs addressing MCH needs in other state departments including the Departments of Children and Families; Human Services; and Education. Several Town Hall webinars have been presented to large audiences of Community Health Care Workers, Home Visitors, Doulas, and Early Childhood Specialists regarding resources and information and updates on COVID-19. These webinars also offer audience members a chance to share concerns and needs of families in the community as well as ask questions.

Findings from the most recent 5 year needs assessment include the need to address New Jersey's maternal mortality crisis, especially with regard to disparities. New Jersey's maternal health outcomes and disparities are among the worst in the country. In 2014-2016, 30.5% of deaths were pregnancy-related. In 2018, NJ mothers' racial/ethnic profile changed, with minorities representing 55% of all births compared to 46% in 2000. Non-Hispanic Black mothers had the fourth highest rate of severe maternal morbidity (SMM) with a transfusion rate of 37.7 per 1,000 delivery hospitalizations, suffered the highest rate of post-admission infections at a rate of 20.6 per 1,000 delivery hospitalizations, and had the highest rate of obstetric hemorrhage with a rate of 60.5 per 1,000 delivery hospitalizations. New Jersey's non-Hispanic Black women experience pregnancy-related mortality at more than seven times their White counterparts and greater SMM burdens than all other groups.

Black women in New Jersey experience pregnancy-related mortality at more than seven times their white counterparts, as well as greater SMM burdens than all other racial and ethnic groups. In a recent report (NJ SHAD, 2018), New Jersey ranks as the eighth healthiest state overall, up from eleventh in 2018 and twenty-second in 2000, which consistently puts it among the states with the largest improvements. However, in key indicators, Black and Brown New Jersey residents fare worse than in other state populations. There are considerable disparities by race/ethnicity in poverty, unemployment, and per capita income. New Jersey leadership created a new, multisector initiative to address the common contributors and consequences of adverse Black and Brown maternal health outcomes to address the alarming statistics.

NJDOH, under the direction of and in collaboration with Governor Phil Murphy and First Lady Tammy Murphy, is working to ensure that New Jersey becomes the safest place in the United States to give birth. To this end, First Lady Tammy Murphy launched a statewide, public-private initiative, Nurture NJ, in 2019 to help eradicate maternal mortality and morbidity health disparities for black and Latinx birthing people, especially women, in NJ. Nurture NJ staff and DOH, including Title V, along with other state agencies, the state legislature, health systems, other clinical stakeholders, and communities are tasked with identifying additional strategies to turn the tide in maternal health outcomes and build upon work already being done to address these health disparities in NJ. By creating new public-private relationships and leveraging new resources supported by legislation and federal funding Nurture NJ aims to be a thought partner and culture shifter.

NJDOH is the state-designated entity responsible for public health protection and serves with the explicit mission to represent the interests of all the residents of the state, including women. Consequently, since August 2018, NJDOH has initiated an internal strategic planning process to assess root causes, make a case for change, identify opportunities, and establish evidence-based goals to guide reforms. Work to date includes examining New Jersey data, a broad sectors assessment, and a review of national and state-level evidence to prevent most maternal deaths and injuries.

Between December 2020 and May 2021, DOH's Title V MCH team and Maternal Health Innovations Team in the Office of Population Health have been meeting with stakeholders across the state in preparation for the launch of the New Jersey Maternal Care Quality Collaborative. Stakeholder groups include the Maternal Child Health Consortia, Professional Societies, New Jersey Hospital organizations, Regional Health Hubs, the New Jersey Health Care Quality Institute, Medical Societies, Planned Parenthood, the New Jersey Primary Care Association, New Jersey Federally Qualified Health Centers, the New Jersey Family Planning League, and the New Jersey Perinatal Quality Collaborative. The purpose of these meetings was to achieve level-setting, discuss stakeholder MCH initiatives, priorities and services; gather input on Hospital-based maternal morbidity and mortality, NSTV Cesarean rates, and risk appropriate care, and to identify areas of synergy for collaboration. Key barriers identified to maternal health in New Jersey were the following: funding, workforce (training and diversity), working in silos, and data use, access, and connectivity. Stakeholders shared a focus on health equity to

eliminate bias in care, increase access to equitable care, collect and share data that illustrates disparities, and advocate for underserved and minority patients and families.

The first meeting of the New Jersey Maternal Care Quality Collaborative (MCQC) was launched on June 29, 2021. The MCQC is a multidisciplinary team of stakeholders who will oversee the transformation of maternal healthcare in NJ. The collaborative will establish a shared vision and statewide goals for key health services-focused on decreasing maternal deaths, injuries and racial and ethnic disparities under the umbrella of Nurture NJ. Nurture NJ, First Lady Tammy Murphy's statewide awareness campaign, is committed to reducing infant and maternal mortality and morbidity and ensuring equitable maternal and infant care among women and children of all races and ethnicities. The campaign, which is devoted to serving every mother, every baby, and every family, includes a multi-pronged, multi-agency approach to improve maternal and infant health among New Jersey women and children. Nurture NJ includes internal collaboration and programing between departments and agencies, an annual Black Maternal and Infant Health Leadership Summit, the First Lady's Family Festival event series, and a robust social media strategy to inform and raise awareness.

Ongoing data collection and research initiatives to better assess MCH population needs has also continued. Data review from several innovative programs including Doulas and Centering is underway. New Jersey's Perinatal Risk Assessment Monitoring System (PRAMS) samples one out of every 50 mothers each month, when newborns are 2-6 months old. Survey questions address the feelings and experiences before, during, and after pregnancy. The PRAMS sample design oversamples smokers and minorities. Data are weighted to give representative estimates of proportions in specific categories and of actual persons. More than 26,500 New Jersey mothers were included between 2002 and 2019 with an average response rate of 70%. Additional questions have been incorporated into the PRAMS survey to include COVID-19 and also most recently, questions concerning the COVID-19 vaccine have been added. Information from PRAMS is used to improve health programs for New Jersey mothers and infants, such as improving access to high quality prenatal care, reduction of smoking during pregnancy and encouraging breastfeeding.

New Jersey is voluntarily participating in the Centers for Disease Control and Prevention (CDC) Surveillance of Emerging Threats to Mothers and Babies Network, also known in New Jersey as "Project W." Tracking of maternal and infant outcomes is ongoing. What is known about COVID-19 is rapidly evolving and documented outcome rates is likely to shift as the rate and distribution of infection changes. Thus far, most pregnancies do not have adverse outcomes, however continued monitoring is needed.

New Jersey Title V has also been assessing workforce development needs as the work force of Community Health Workers, Doulas, and most recently Perinatal Community Health Workers and Certified Nurse Assistants are developed and expanded. Title V staff are meeting with workers in these areas to determine training needs and employment tracks and opportunities. We are also working with Medicaid concerning reimbursement for these services. Together, DOH Title V staff and Rutgers University Project Echo offered an educational series designed for doulas, so that they could meet a portion of the Medicaid Certification requirements. These sessions provided information, peer to peer discussions and resources for doula serving Medicaid-enrolled pregnant women.

Title V seeks public input on the Maternal Child Health Block grant (MCHBG) throughout the year at the quarterly Community of Care Consortium meetings spearheaded by the Statewide Parent Advocacy Network, the New Jersey Chapter of the American Academy of Pediatrics and the NJDOH Title V program. Every year, in accordance with Title requirements, public input on the MCHBG is officially requested with the posting of the draft MCHBG on the NJDOH's website. Due to ongoing issues with the COVID-19 Pandemic, written testimonies are being accepted through late August for inclusion in the public input section of this year's MCHBG.

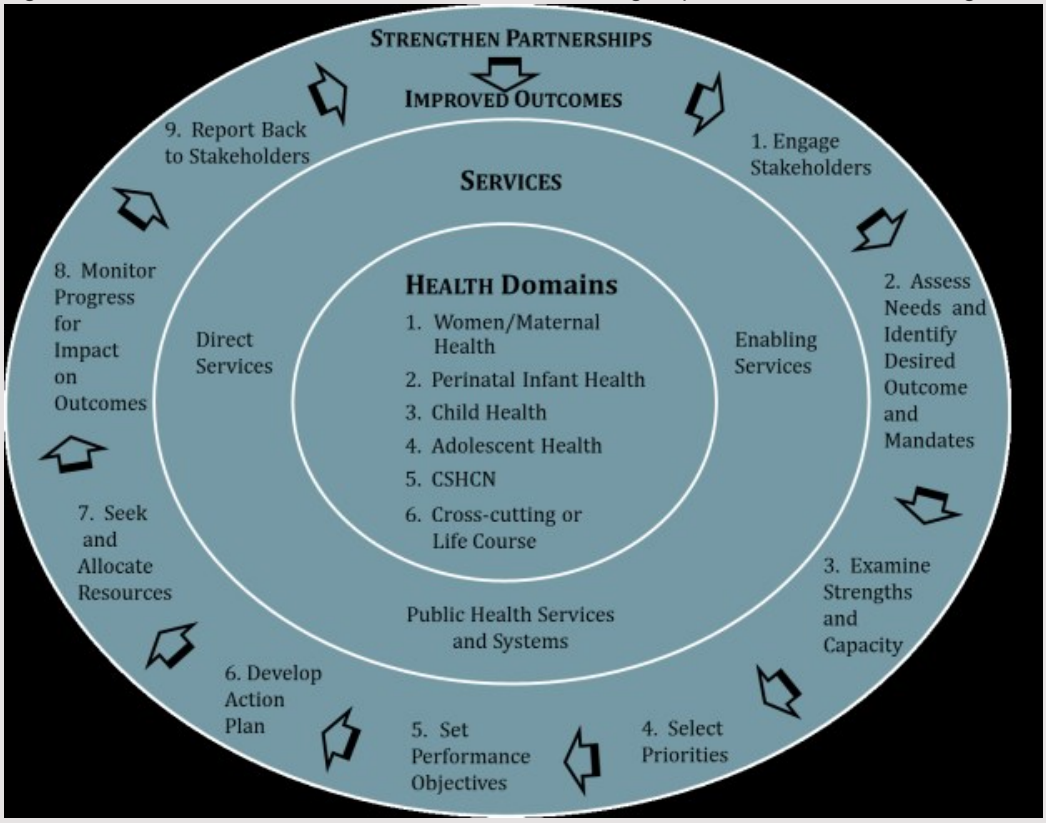
Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

The NJ Title V program, has prepared the following Five-Year Needs Assessment Summary according to HRSA guidelines. This year the COVID19 public health emergency has added a heightened examination of the needs for the MCH population. COVID-19 is an unprecedented public health threat that continues to rapidly evolve. In the effort to transition many in-person programs and services to remote and virtual operations in order to limit exposures to COVID19, additional needs have been identified. Food insecurity, domestic violence issues, unemployment issues, confusion and fear concerning labor and delivery issues, as well as many other health concerns have all been and continue to be identified.

The completion of a comprehensive needs assessment for the MCH population groups is a continual process that FHS performs in collaboration with families, providers, many other organizations and partners. The ultimate goals of the needs assessment process are to strengthen partnerships and collaboration efforts within FHS, the New Jersey Department of Health (NJDOH), the MCH Bureau, and other agencies and organizations involved with MCH and to improve outcomes for the MCH populations.

Figure 1 – NJ MCH Block Grant Needs Assessment, Planning, Implementation and Monitoring Process



The starting point (**Stage 1**) of the needs assessment process, is to engage stakeholders. Coalitions involving stakeholders help FHS in the needs assessment process by identifying desired outcomes, assessing strengths, examining capacity, selecting priorities, seeking resources, setting performance objectives, developing action plans, allocating resources, and monitoring progress for impact on outcomes.

Maternal and Child Health Services (MCHS) has engaged stakeholders and strengthened partnerships to maintain a regional system of MCH services and programs in several priority areas. A system of regional MCH services and programs has been developed and provided through the Maternal Child Health Consortia (MCHC), an established regionalized

network of maternal and child health providers with emphasis on prevention and community-based activities.

An example of partnerships to address a specific MCH priority involve NJs efforts to reduce infant mortality. The Healthy Women, Healthy Families (HWHF) Initiative is focused on working to help community-based programs improve services and provide quality access to perinatal care to reduce disparities in birth outcomes. HWHF's partners include the Departments of Labor and Workforce Development, Education, Transportation, Children and Families, Human Services, the Office of the Attorney General, community advisory boards and many others to strategically collaborate to reduce black infant mortality.

Nurture NJ is the First Lady of NJ's statewide awareness campaign that is committed to reducing infant and maternal mortality and morbidity and ensuring equitable maternal and infant care among women and children of all races and ethnicities. Nurture NJ is focused on improving partnerships and collaboration between departments, agencies, and stakeholders to achieve its goal of making New Jersey the safest place in the country to give birth and raise a baby. In collaboration with other state agencies, including DOH FHS, The Nurture NJ strategic planning team is working to develop a comprehensive, actionable plan focused on equity and improved outcomes overall.

Another inter-Departmental initiative augmenting our efforts to reduce infant mortality, pre-term births and maternal morbidity and mortality is the Maternal and Infant Early Child Home Visiting (MIECHV) Program which has expanded Home Visiting (HV) across all 21 NJ counties with 5,805 families participating in HV during SFY 2018. The goal of the NJ MIECHV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness.

Stakeholder engagement, strong partnerships and program funding have been developed in the following State Priority areas (see Table 1f - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination in Attachment 1 for listed partnerships covering all 6 Health Domains and all 3 MCH Population groups by the following priority areas):

SPN1- Increasing Equity in Healthy Births,
SPN2- Reducing Black Maternal and Infant Mortality,
SPN3- Improving Nutrition & Physical Activity,
SPN4- Promoting Youth Development Programs,
SPN5- Improving Access to Quality Care for CYSHCN,
SPN6- Reducing Teen Pregnancy,
SPN7- Improving & Integrating Information Systems, and
SPN8- Smoking Prevention.

Special Child Health and Early Intervention Services (SCHEIS) works closely with its partners in early identification, pediatric specialty care, and case management, towards engaging stakeholders and strengthening partnerships to build and maintain a statewide system of access to care. In addition, for over 30 years, DOH has formed a strong partnership with the Statewide Parent Advocacy Network (SPAN), home to NJ Family Voices (FV), that has been a model for promoting family-professional partnerships and family involvement in policymaking at all levels. SCHEIS and the NJ Chapter of the American Academy of Pediatrics (NJ AAP), continue to collaborate on medical home implementation and transitioning CYSHCN. Through the Newborn Screening Advisory Review Committee (NSARC), first convened in 2005, SCHEIS partners with many stakeholders including parents, primary care physicians, specialty care physicians, nurses, allied health professionals, attorneys, scientists, as well as health insurance companies and hospital representatives in ongoing reviews of NJ's newborn screening policies and activities.

The **second** stage in the process is to identify the community/system needs and desired outcomes by specific MCH population group and to identify legislative, political, community-driven, financial, or other internal and external mandates that are required.

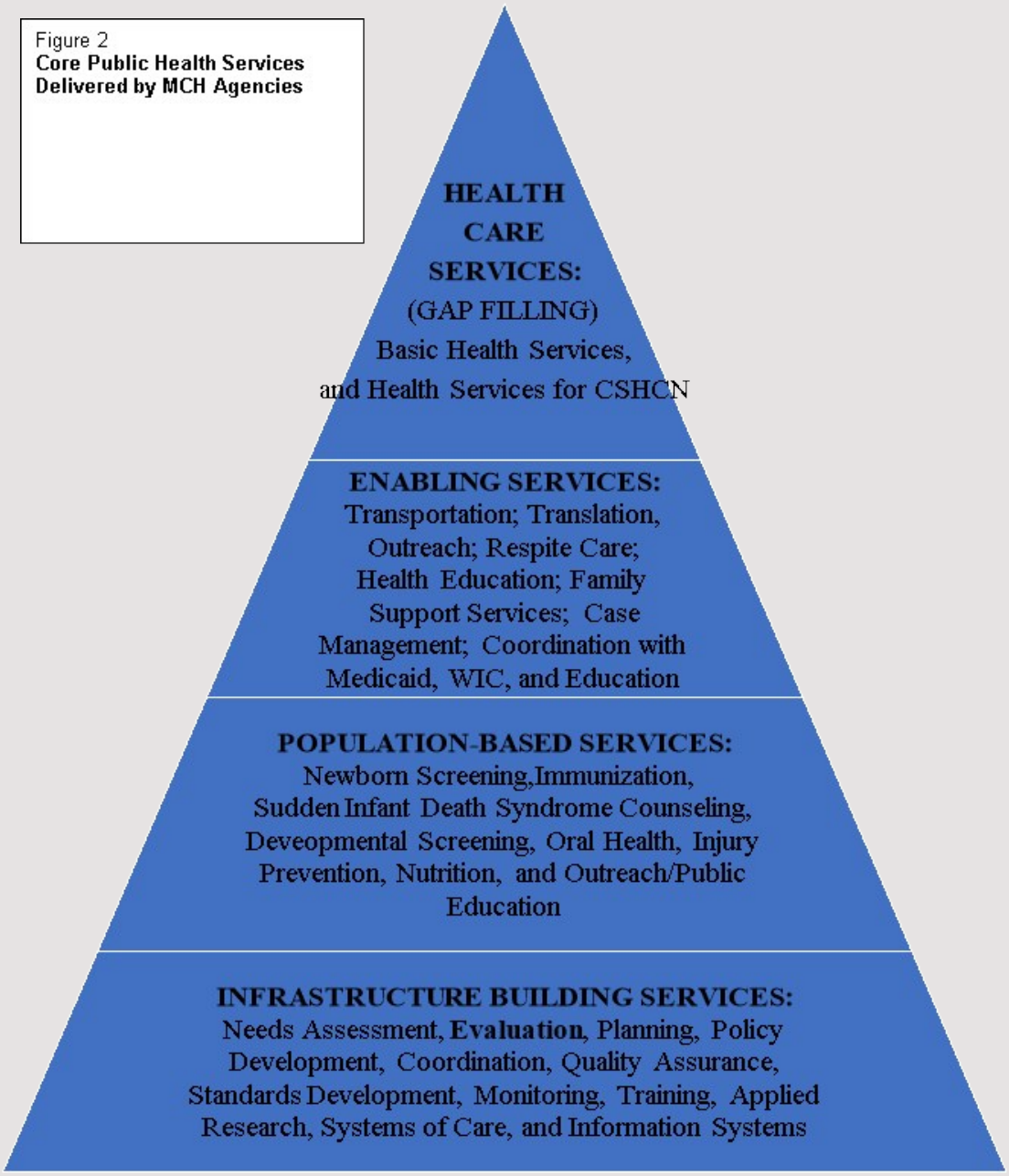
Multiple processes contribute to the overall MCH Title V Block Grants needs assessment process including the NJ DOH planning and budget process, regional and county needs assessments, grant-driven needs assessments, surveys and public comment on the MCH Block Grant, and strategic plans completed by other state departments and organizations. Needs Assessments that focus on MCH topics such as maternal health and birth outcomes include: the Healthy New Jersey 2030 (HNJ2030) process, State Health Improvement Plan (SHIP) process, the NJ State Health Assessment process, the

NJDOH budget process, Departmental strategic planning, the Public Health accreditation process, the NJ Preventive Health and Health Services Block Grant, Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs), grant-driven needs assessments (MIECHV, MMRC, SMHIP, PREP), the Breastfeeding Strategic plan, the First Lady's Nurture NJ initiative, as well as public comment on the MCH Block Grant Application, and the collaborative process with other MCH partners. In the past year, the state legislature, Governor's Office and the First Lady's Office have focused significant attention on maternal child health issues.

Community and systems needs were informed by prior needs assessments from other State Departments and organizations which serve children and families including: DHS, DCF, DOE (Head Start), the Maternal Infant and Early Childhood Home Visiting Program (MIECHV), Advocates for Children of New Jersey (Pritzker Children's Initiative), and the Preschool Development Grant Birth – 3 (PDG).
Recent legislative priorities including several statutory mandates have identified the desired need to improve birth and maternal outcomes. The numerous laws adopted by the New Jersey Legislature and enacted by the Office of the Governor in 2018 and 2019 are listed later in this Needs Assessment Summary. Nearly a dozen additional maternal health focused bills remain under consideration, reflecting a legislative focus on maternal mortality and morbidity.

The **third** stage in the process is examining strengths and capacity. This stage involves examining the State's capacity to engage in various activities, including conducting the 5-year Needs Assessment and collecting annual performance data, and to provide services by each pyramid level. The pyramid, Figure 2 Core Public Health Services Delivered by MCH Agencies, is as below.

Figure 2
Core Public Health Services Delivered by MCH Agencies



The **fourth** stage in the process is selecting priorities. FHS examines the needs identified and matches those needs to desired outcomes, required mandates, and level of existing capacity. The process of selecting priorities is also guided by the departmental strategic planning process, grant funding opportunities, Governor priorities, legislative mandates, budget process, survey results and public input into the MCH Title V Block Grant. Based on the results of this process, NJDOH then selects its most important, or highest priority, MCH strengths and needs, to receive targeted efforts for improvement and/or continuation of progress.

The selection of New Jersey's priority needs is a product of FHS's continuous needs assessment. Influenced by the departmental budget process, the MCH Block Grant's needs assessment process and the collaborative process with other MCH partners has enabled FHS to select the eight priorities as identified in the third stage.

The selected SPN reflect ongoing and new statewide public health initiatives. SPN #1 has been a recent focus of several new initiatives including the Healthy Women, Healthy Families Initiative, the MIEC Home Visiting Program, Nurture NJ, the Maternal Mortality Review Committee, and the State Maternal Health Innovation Program.

Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the nine of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period.

The **fifth** stage is the identification of State selected national Performance Measures and Performance Measure targets and is summarized in Table 1.

Setting performance objectives consisted of two phases. In the first phase, action strategies to address their identified priority needs were developed. National Performance Measures (NPMs), Evidence-based Strategy Measures (ESMs) for addressing each of the selected NPMs and State Performance Measures (SPMs) were selected based on the priority needs and program strategies. SPMs were based on the state's identified MCH priorities that are not fully addressed by the selected NPMs and their related ESMs.

In the second phase of the fifth stage, five-year targets (i.e., performance objectives) were set for the selected NPMs, the ESMs and the SPMs. The anticipated results of this stage are the identification of NOMs, NPMs, ESMs and SPMs that directly relate to the state priorities and establish a level of accountability for achieving measurable progress.

The **sixth** stage is to develop an action plan, which includes identifying activities to address priority strengths and needs at the four pyramid levels: direct health care services, enabling services, population-based services, and infrastructure building services. This is an on-going process involving several workgroups and Action Plans (Strategic Plans, Needs Assessments) and is described in Section 3 of the full NJ MCH Title V Block Grant Needs Assessment and annually updated in the MCH Block Grant Annual Application/Report. Sometimes Action Plans start as workplans in grant applications or are developed by initiative in other organizations (NJ DOH Strategic Plan, Nurture NJ, MIECHV Needs Assessments, MMRC Grant).

Divisional and departmental strategic planning also contributes to the needs assessment process and the development of action plans. Many of the Healthy People 2030 objectives and the MCH Block Grant national and state performance measures are included in both the departmental and divisional plans. Strategic plans that are specific to targeted areas have also been developed and assist the Division in setting priorities. Targeted plans include those developed for HWHF, MIECHV and The State Maternal Health Innovation Grant.

The development of Healthy New Jersey 2030, the New Jersey state equivalent of Healthy People 2030, is a major departmental planning and needs assessment process that incorporates the MCH population. Representation included the Departments of Health, Environmental Protection, Human Services, Education, Children and Families, and Law and Public Safety. One of the overarching goals for public health improvement is the elimination of health disparities. Public input was received through comments on a disseminated draft document and public hearings held in three sections of the State.

At the regional level the MCH Consortia conduct planning and needs assessment to promote a coordinated prevention-oriented approach to MCH services. Their regional plans, due every 3 years, must address pediatric morbidity and mortality, risk-appropriate prenatal care, low birth weight, and teen births. The social, cultural, economic and demographic factors influencing the perinatal and pediatric needs of their communities must also be described.

The **seventh** stage is focused on the funding of planned activities to address state priorities. Inputs include the five-year State Action Plan, current budgets, political priorities, and partnerships. The anticipated outcome is the development of a program budget and plan that directs available resources towards the activities identified in Stage Six as the most important for addressing the state's priorities. The funding of planned activities depends on the selected priorities and existing resources identified and may involve the identification of additional resources, funds, or authority from the State legislature or funding agencies in order to address priority areas.

The seventh stage includes allocating resources and the development of a budget that directs available resources towards activities that have been identified as most important for addressing the State's priorities. The annual State budget process includes several steps that are very similar to the stages and functions to the MCH Block Grant needs assessment. In preparation for the annual State budget hearings where the Department's budget priorities are presented to the Governor

and legislature, FHS reviews and summarizes programmatic activities, service capacity, budgets, key performance indicators and emerging issues. Activities, budgets and priorities are justified in terms of standard health indicators, key performance indicators and program evaluation data. This annual several month process takes place at the program level, the division level, then the department level, and finally is presented to the Governor and in turn the legislature.

The grant awarding, renewal and monitoring processes continually assess local needs that are specific to geographic areas. FHS funds numerous grantees involved with MCH programs on a regional or local level. The selection process includes a review of local identified need. Renewal and monitoring of grantees is based on measurable outcomes that are designed to address identified needs. Many of the agencies that are awarded health services grants by FHS use the MCH Block Grant performance measures or Healthy People 2030 objectives as their outcome measures. Examples of local grants include the Healthy Women, Healthy Families Initiative and the Personal Responsibility Education Program (PREP) grants.

The **eighth** stage (8. Monitoring Progress for Impact on Outcomes) examines the results of NJDOH's efforts to see if there has been improvement in State Performance Measures, National Performance Measures, Outcome Measures, Evidence-Based Strategies, performance objectives, and other quantitative and qualitative information.

The quantitative surveillance and analysis of MCH data by FHS programs and the MCH Epidemiology Program provides continuous input into the assessing needs and the monitoring progress for impact on outcomes stage of the needs assessment. The MCH Epidemiology Program produces standardized MCH health indicator reports for FHS, for the MCH Consortia, and for other public health related organizations by special request. The MCH Epidemiology Program works with the Vital Statistics Program, the Center for Health Statistics, other departments in NJDOH, and the MCH Consortia Data/TQI Workgroup to support data needs for regional planning. The MCH Epidemiology Program also conducts applied research projects which currently focus on issues related to breastfeeding, smoking and pregnancy, pregnancy intention, maternal mental health, and maternal morbidity.

The **ninth** stage (9. Report Back to Stakeholders) assures accountability to the stakeholders and partners who have worked with the MCH staff throughout the year and the Needs Assessment process. Public comment on regulations and publications is an ongoing process of needs assessment and input from both public and private constituents. Rules implementing laws sunset every five years, and therefore, programs must readopt rules every five years. Proposed rules are published in the New Jersey Registry (NJR) with a 60-day open comment period. Public comment on the development of the MCH Block Grant application is also encouraged through a public input process.

The NJ MCH Title V Block Grant Needs Assessment process is also consistent with the MCH Block Grant Logic Model in Figure 4 below which depicts how NJ's priority needs "drive" the development of a five-year program plan that is responsive to the needs identified and is performance driven.

Figure 4. MCH Block Grant Logic Model

Step 1	Step 2	Step 3	Step 4	Step 5
Conduct a comprehensive Title V MCH program Five-year Needs Assessment.	Review and summarize MCH Population Needs, Program Capacity, and Partnerships/ Collaborations.	**Identify (7-10**) State Title V Program priority needs, which will guide the development of the state's five-year Title V Action Plan.	Develop program strategies to address the identified priority needs during the five-year reporting period.	Identify areas of alignment between the state priorities/ strategies and the NOMs.
Step 6	**Step 7**	**Step 8**	**Step 9**	**Step 10**
Based on priorities and strategies, **select five of the 15 NPMs** (one per each of the five population domains) for programmatic focus.	Establish **SPMs** to address each priority need that is not being addressed by one of the five selected NPMs.	Review the selected NPMs and SPMs to ensure that every identified priority need is being addressed through one or more of the NPMS or SPMs.	Develop one or more ESMs for each of the five selected NPMS.	At the state's discretion, consider the need to develop one or more **SOMs**.
Step 11	**Step 12**	**Step 13**	**Step 14**	**Step 15**
Establish five-year performance objectives for each selected NPM, SPM, and, SOM, if applicable.	Report performance indicators for NPMs, ESMs, SPMs and SOMs in Annual Report/ Application.	Analyze annual and multi-year performance trends.	In interim year, Annual Reports/ Applications, reassess and update strategies and objectives for selected NPMs, SPMS, & SOMs, if applicable, to achieve desired outcomes.	Conduct comprehensive Title V MCH program Five-year Needs Assessment.

The current methods and procedures for the comprehensive needs assessment have both strengths and weaknesses. The evolution of the MCH Block Grant to include standardized performance measures, outcome measures, and Evidence-Based Strategies has added structure and accountability to the needs assessment process. Each year the state is able to build and add detail to prior needs assessment efforts. Utilizing the departmental budget process is also an efficient use of time and effort. One strength that may be unique to New Jersey is the role the MCH Consortia play in contributing valuable

information to the Title V comprehensive needs assessment.

A challenge of the needs assessment process is recording the breadth and diversity of activities that could be included under a comprehensive needs assessment. New Jersey's Title V activities intersect with numerous other federal and state programs, making it difficult to identify what most appropriately falls under the Title V needs assessment and what does not. Many activities that come to the attention of FHS staff are relevant to the MCH populations but may not be specifically administered or "formally" linked with Title V programs. There are numerous activities that other public or private organizations are involved with that affect the public health of MCH populations that are carried out without FHS involvement. Limitations in the scope of influence and accountability of FHS, limitations of staff, and limitations of funding must be recognized. However, we believe that the major activities and priorities effecting MCH services are being addressed.

The goals and vision that guide the Needs Assessment originate from the mission statement of the Division of Family Health Services (FHS). Leadership for directing and completing a comprehensive needs assessment is provided by the Assistant Commissioner of FHS, Service Directors in FHS, and the Program Managers in FHS. The overall needs assessment methodology is similar for each of the three population groups - preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children with special health care needs. Though many of the functions occur simultaneously the sequential process is described below and in Figure 1. This is a continuous and on-going process throughout the year.

Table 1a - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model summarizes the selected nine national Performance Measures (NPMs) and aligns the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). The purpose of the ESMs is to identify state Title V program efforts which 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 which summarizes the Five-Year Needs Assessment process and includes the three-tiered performance measurement system with Evidence-Based or Informed Strategy Measures (ESM), National Performance Measures (NPM), and National Outcome Measures (NOMs). The Logic Model represents a more integrated system created by the three-tiered performance measure framework which ties the ESMs to the NPMs which in turn influence the NOMs.

This year the COVID-19 public health emergency has added a heightened examination of the needs for the MCH population. Necessary restrictions to promote social distancing have dramatically impacted NJ DOH staffing and staffing at grantee agencies. The workforces of NJ DOH and grantee agencies have been forced a shift to work remotely from home in order to comply with state social distancing requirements. Title V staff are maintaining weekly communications with grantees and partners to monitor program administration and service provisions in this new virtual environment. "Town Halls" where Title V staff hold virtual meetings for grantees and other partners are scheduled on a monthly basis. Ongoing needs are being assessed to assess what changes can be made to meet the needs of the MCH populations as well as to help ensure resiliency for the future. Ongoing communications are occurring with Medicaid regarding telehealth reimbursements.

NJ DOH is adapting the way it provides the four types of services (Direct Health Care Services, Enabling Services, Population-Based Services, and Infrastructure Building Services) illustrated in the Figure 2 – Core Public Health Services Delivered by MCH Agencies (Pyramid Diagram). The DOH does not use Title V MCH funding to provide Direct Health Care Services. The provision of Enabling Services such as outreach, health education, family support and case management have all shifted to virtual services which are not conducted face-to-face unless absolutely necessary. Increased use of telecommunication tools have facilitated the shift with new development of protocols and practices to meet the needs of the programs. Population-Based Services are continuing as prior to the COVID-10 pandemic with changings in communications to the public to assure follow-up and ongoing outreach. The DOH has added multiple new communication channels to keep the public and MCH professionals informed of COVID-19 issues and changes to MCH Services including the NJ DOH COVID19 website, the NJ Parent Link website, and virtual town hall forums held with program constituents. Despite the disruption created by the COVID-19 crisis, the Infrastructure Building Services of DOH are continuing and have adapted to being conducted remotely.

Many of the Title V grantees are small community-based service organizations whose staffing and financial stability will be adverse impacted by the ongoing COVID-19 pandemic. The uncertainty of federal, state and local private funding sources

will challenge the sustainability of many grantees. Telecommunication tools are being adapted to provide Title V services to families such as family support services, health education and care coordination by Community Health Workers, Home Visitors and SCHEIS case managers.

Families have been dramatically impacted by the COVID-19 crises and challenged by the restrictions of social distancing reducing access to MCH funded as well as other needed services. Social distancing influences every aspect of family life, leading to significant changes in how MCH Title V programs can work with families. COVID19 has exacerbated many of the challenges and SDOH issues faced by our most vulnerable populations, including pregnant women, new moms, children, including those with special health care needs, and families.

During this evolving public health emergency, NJ Title V programs are poised to provide infrastructural and leadership support to improve the health of mothers, children, and families. One of the strengths of the Title V program is its role in conducting ongoing assessment of maternal and child health (MCH) population needs and in implementing science-based approaches to address current and emerging issues.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Overall the majority of health measures concerning Title V as measured by national performance measures, state performance measures, outcome measures and the new health status indicators are stable or improving. Table 1c - Summary of MCH Population Needs (See Supporting Document #1) displays the **health status** for each of the six population health domains according to the nine selected NPMs. The table provides a summary of population-specific **strengths/needs** and identifies major health issues for each of the 6 population health domains which came from identified **successes, challenges, gaps and areas of disparity** identified during the needs assessment process. Statewide trend charts for key national performance measures, outcome measures, and health system capacity indicators mentioned in this section are presented in the Appendix (Charts 1-11).

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

The Organizational Structure of the NJ Department of Health and the Division of Family Health Services (FHS), the NJ Title V agency, remains unchanged. Lisa Asare MPH was appointed the Assistant Commissioner for FHS in 2016. Dr. Marilyn Gorney-Daley was appointed the Director of MCH Services for FHS in April 2017. Dr. Sandra Howell was appointed the Director of Special Child and Early Intervention Services in June 2018. The Agency Capacity of FHS remains unchanged with the continuation of all major federal grants. Efforts continues toward Workforce Development and Capacity.

All Maternal and Child Health (MCH) programs including programs for Children and Youth with Special Health Care Needs (CYSHCN) are organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of the Assistant Commissioner for the Division of FHS.

The Division of FHS is the Title V agency for the state of NJ and is within the NJ Department of Health (NJ DOH). The NJ DOH is one of 11 departments under the Governor.

The Division of FHS is "responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V".

III.C.2.b.ii.b. Agency Capacity

This section describes Family Health Service's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN). The Division of Family Health Services (FHS) supports the infrastructure to provide Title V services to each of the six population health domains. FHS supports the state's

capacity to provide services to CYSHCN and address its ability to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (the Supplemental Security Income Program) to the extent medical assistance for such services is not provided under Title XIX (Medicaid). The Maternal and Child Health Services (MCHS) and Special Child Health and Early Intervention Services (SCHEIS) Units ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level.

The statutory basis for maternal and child health services in NJ originates from the statute passed in 1936 (L.1936, c.62, #1, p.157) authorizing the Department of Health to receive Title V funds for its existing maternal and child services. When the State constitution and statutes were revised in 1947, maternal and child health services were incorporated under the basic functions of the Department under Title 26:1A-37, which states that the Department shall "Administer and supervise a program of maternal and child health services, encourage and aid in coordinating local programs concerning maternal and infant hygiene, and aid in coordination of local programs concerning prenatal, and postnatal care, and may when requested by a local board of education, supervise the work of school nurses."

Other statutes exist to provide regulatory authority for Title V related services such as: services for children with Sickle Cell Anemia (N.J.S.A. 9:14B); the Newborn Screening Program services (N.J.S.A. 26:2-110, 26:2-111 and 26:2-111.1); genetic testing, counseling and treatment services (N.J.S.A. 26:5B-1 et. seq.,); services for children with hemophilia (N.J.S.A. 26:2-90); the birth defects registry (N.J.S.A. 26:8-40.2); the Catastrophic Illness in Children Relief Fund (P.L. 1987, C370); and the Sudden Infant Death Syndrome (SIDS) Resource Center (Title 26:5d1-4). Recent updates to Title V related statutes are mentioned in their relevant sections.

Table 1d – Title V Program Capacity and Collaboration to Ensure a Statewide System of Services
(See Supporting Document #1) summarizes according to the six MCH population health domains the collaborations with other state agencies and private organizations, the state support for communities, the coordination with community-based systems, and the coordination of health services with other services at the community level.

III.C.2.b.ii.b. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal and Child Health Services (MCHS) within FHS is to improve the health status of NJ families, infants, children and adolescents in a culturally competent manner, with an emphasis on low-income and special populations. Prenatal care, reproductive health services, perinatal risk reduction services for women and their partners, postpartum depression, mortality review, child care, early childhood systems development, childhood lead exposure prevention, immunization, oral health and hygiene, student health and wellness, nutrition and physical fitness and teen pregnancy prevention are all part of the MCHS effort. The population Domains addressed by MCHS include 1, 2, 3, 4, and 6.

Reproductive and Perinatal Health Services (RPHS), within MCHS, coordinates a regionalized system of care of mothers and children in collaboration with the Maternal and Child Health Consortia (MCHC). The MCHC were developed to promote the delivery of the highest quality care to all pregnant women and newborns, to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC.

Under RPHS, the goal of the Healthy Women Healthy Families (HWHF) Initiative is to improve maternal and infant health outcomes for women of childbearing age and their families and reduce disparities, especially with black families, though a collaborative and coordinated community-driven approach. Participants in the HWHF program receive individual support from a Community Health Worker (CHW). CHWs link families to community resources through a centralized referral system of Central Intake Hubs.

NJ successfully applied in 2010 for the Maternal, Infant and Early Childhood Home Visiting Program (MIEC HV) Formula and Competitive Grants to the Health Resources and Services Administration. The goal of the NJ MIEC HV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full

implementation of the grant project is being carried out in collaboration with the Department of Children and Families (DCF). Currently evidence-based home visiting services are provided by 65 Local Implementing Agencies (LIAs) providing three national models (Healthy Families America, Parents As Teachers and Nurse Family Partnership) in all 21 NJ counties serving 5,805 families in SFY 2019.

III.C.2.b.ii.b. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program (CAHP), within MCHS, focuses on primary prevention strategies involving the three MCH domains of Child Health, Adolescent/Young Adult Health, and the Life Course.

Adolescent Health (AH) supports three main focus areas: Teen Pregnancy Prevention (PREP, SRAE), the WSCC School Health NJ project and Pediatric (inclusive of adolescents) Mental Health (PMH). Additionally, areas of adolescent mental health, other than access, address positive youth development and/or teen suicide prevention. CAHP grantees (PREP, SRAE and WSCC School Health NJ) have been trained in developing safe, caring, and inclusive environments for teens by the Transgender Training Institute and the Society for the Prevention of Teen Suicide (SPTS), Evidenced-based models (Teen PEP and TOP®), grounded in social and emotional learning (SEL), positive youth development (PYD), and motivational interviewing, are implemented among middle and high school students. Eleven CAHP grantees are required to maintain a youth advisory board (YAB). Through these YABs, youth work with trained adult advisors at their local level. Each YAB nominates two members to be represented on a Statewide YAB who meet with State staff annually to provide program input. For their SFY2020 focus, youth chose teen suicide awareness and prevention.

III.C.2.b.ii.b. Preventive and Primary Care for Children with Special Health Care Needs

NJ maintains a comprehensive system to promote and support access to preventive and primary care for CYSHCN through early identification, linkage to care, and family support. Title V partially supports this safety net that is comprised of pediatric specialty and sub-specialty, case management, and family support agencies that provide in-state regionalized and/or county-based services. It is designed to provide family-centered, culturally competent, community-based services for CYSHCN age birth to 21 years of age, and to enhance access to medical home, facilitate transition to adult systems, and health insurance coverage. The Specialized Pediatric Services Programs (SPSP) agencies are a significant resource of pediatric specialty and subspecialty care in NJ, and are used widely by CYSHCN including Medicaid recipients. Although clients are screened for their ability to pay for clinical services, the support provided by Title V enables all CYSHCN to be served regardless of their ability to pay. There is no charge for SCHS CM and family support.

Administratively housed in the Family Centered Care Services (FCCS) Unit these services include 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, multiple Specialized Pediatric Services Programs (SPSP) which include 8 Child Evaluation Centers (CECs) of which 4 house Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder Centers, and 3 provide newborn hearing screening follow-up, 3 Pediatric Tertiary Centers, and 5 Cleft Lip/Palate Craniofacial Anomalies Centers and a small State operated Fee-for-Service program. Likewise, State and federal collaborations among the FCCS programs and non-Title V funded programs such as the Ryan White Part D Family Centered HIV Care Network (RWPD), Early Intervention System (EIS), Federally Qualified Health Centers (FQHC), medical home initiatives, Supplemental Security Income (SSI), Catastrophic Illness in Children Relief Fund (CICRF) and other community-based initiatives extend the safety net through which Title V links CYSHCN with preventive and primary care.

State Title V staffs, SCHS CMUs and SPSP providers, and SPAN Family Resource Specialists receive training from State agencies such as the NJ Department of Human Services, and the Department of Children and Families to become Informal Application Assistors for Medicaid/NJ FamilyCare programs as well as to learn about Managed Long Term Services and Supports, how to obtain care through the Marketplace, and behavioral services through PerformCare. These trainings build capacity among Title V agency providers to enhance access to primary and preventive care for CYSCHN. For example, an SCHS CM reported being able to assist a parent to problem solve a denial of home health aide services for a 12-year-old with autism and significant developmental delays by advocating on Mom's behalf with PerformCare, her child's school

district, and her Family Support Organization. Repeated phone calls, home visits, and written appeals by the SCHS CM supported Mom's efforts to clarify the missing information and resolve her child's needs.

III.C.2.b.ii.c. MCH Workforce Capacity

NJDOH has identified through the State Health Assessment, the State Health Improvement Plan and the Departments' 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 is also a priority for the Division of Family Health Services (FHS). As such, the FHS developed and has initiated a MCH Workforce Development and Capacity Plan with the overall goal to prepare present and future maternal and child health workers with the skills and knowledge to succeed in the transformed public health system. 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 an experienced and trained staff, the FHS has taken action to improve the capacity of the MCH workforce despite a long-standing hiring freeze.

The FHS implemented the development of succession planning to assure essential functions were considered in long-term planning. During this past fiscal year, cross-training of staff was implemented to assure the ability to maintain key roles in the event of short-term staffing shortages. A Division-wide survey was conducted to identify gaps and needs related to skills development and training. Staff identified several areas such as the need for further training and the development of metrics that are specific to the long-term outcome measurement of maternal and child health in order to maintain the momentum of quality improvement already begun by the NJDOH. Additional training is needed for staff to become skilled in collecting data appropriate for accountability documentation and to develop accountability metrics. FHS also 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.

Given the diversity of our state, cultural competency trainings continue to be provided to staff as an essential component of their continuing education activities. Other available opportunities have been pursued through trainings 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.

The following section describes the strengths and needs of the state MCH and CSHCN workforce:

III.C.2.b.ii.c Preventive and Primary Care for Pregnant Women, Mothers and Infants

Maternal and Child Health Services (MCHS) is comprised of one program manager, nine professionals and three support staff. All staff members are housed in the central office. Dr. Marilyn Gorney-Daley was appointed the Director of MCH Services for FHS in April 2017.

Reproductive and Perinatal Health Services (RPHS) is staffed by five professionals. The Program Manager, Coordinator, and three other professional positions are currently vacant. RPHS responsibilities include: the HWHF Initiative; Black Infant Mortality reducing activities including breastfeeding, fatherhood support, Centering programs and a doula pilot program; regional MCH Consortia; Certificate of Need rules and MCH Consortia regulations; Maternal morbidity and mortality reviews; Fetal Infant Mortality Reviews; Title V Liaison with the Healthy Start projects; perinatal addictions and fetal alcohol syndrome prevention projects; postpartum mood disorders initiative; and the Sudden Infant Death Syndrome prevention program.

III.C.2.b.ii.c Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program (CAHP), within MCHS, focuses on primary prevention strategies and is comprised of 3 full-time professional staff, one support staff and one program manager. There are two vacant full-time positions, one each being covered by the Health Projects Coordinator and the CAHP Manager. The CAHP receives only federal funding

through the MCH Block Grant, HRSA, and DHHS, FYSB, ACF. The CAHP Manager has oversight responsibilities for child and adolescent health programs including PREP, SRAE and, the Pediatric Mental Health Care Access Program and covers the vacant grant management position for the CDC WSCC School Health NJ grant in 26 schools; and, the Mercer County Traumatic Loss Coalition grant on youth suicide prevention. CAHP staff have varied professional backgrounds in nutrition, physical education, sexuality education and social work. In January 2019, the Childhood Lead Exposure and Prevention Program (CLEPP) was transferred from CAHP to the Office of Local Public Health. Lead exposure and its management is still a NJ DOH priority and FHS continues to collaborate on this issue.

The Children's Oral Health Program (COHP) is comprised of 1 professional staff, Yvonne Mikalopas, a Registered Dental Hygienist, who reports to the New Jersey State Dental Director, Dr. Darwin K Hayes, in the Division of Community Health Services, Oral Health Service Unit.

The Maternal and Child Health Epidemiology Program (MCH Epi) provides MCH surveillance and evaluation support to MCHS. The mission of the MCH Epi Program is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects. The MCH Epi Program promotes the central collection, integration and analysis of MCH data. The Pregnancy Risk Assessment Monitoring System (PRAMS) survey is coordinated by the MCH Epi Program. MCH Epi is staffed with one professional and one support staff. Two research professional positions are currently vacant.

III.C.2.b.ii.c Special Child Health and Early Intervention Systems (SCHEIS)

NJ maintains a comprehensive system to promote and support access to preventive and primary care for CYSHCN through early identification, linkage to care, and family support. Title V partially supports this safety net that is comprised of pediatric specialty and sub-specialty, case management, and family support agencies that provide in-state regionalized and/or county-based services. It is designed to provide family-centered, culturally competent, community-based services for CYSHCN age birth through 21 years of age, and to enhance access to medical home, facilitate transition to adult systems, and health insurance coverage. The Specialized Pediatric Services Programs (SPSP) agencies are a significant resource of pediatric specialty and subspecialty care in NJ and are used widely by CYSHCN including Medicaid recipients. Although clients are screened for their ability to pay for clinical services, the support provided by Title V enables all CYSHCN to be served regardless of their ability to pay. There is no charge for SCHS CM and family support.

Administratively housed in the Family Centered Care Services (FCCS) Unit these services include 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, multiple Specialized Pediatric Services Programs (SPSP) which include 8 Child Evaluation Centers (CECs) of which 4 house Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder Centers, and 3 provide newborn hearing screening follow-up, 3 Pediatric Tertiary Centers, and 5 Cleft Lip/Palate Craniofacial Anomalies Centers and a small State operated Fee-for-Service program. Likewise, State and federal collaborations among the FCCS programs and non-Title V funded programs such as the Ryan White Part D Family Centered HIV Care Network (RWPD), Early Intervention System (EIS), Federally Qualified Health Centers (FQHC), medical home initiatives, Supplemental Security Income (SSI), Catastrophic Illness in Children Relief Fund (CICRF) and other community-based initiatives extend the safety net through which Title V links CYSHCN with preventive and primary care.

State Title V staffs, SCHS CMUs and SPSP providers, receive training from State agencies such as the NJ Department of Human Services, and the Department of Children and Families to become Informal Application Assistors for Medicaid/NJ FamilyCare programs as well as to learn about Managed Long Term Services and Supports, how to obtain care through the Marketplace, and behavioral services through PerformCare. These trainings build capacity among Title V agency providers to enhance access to primary and preventive care for CYSCHN.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Expanded partnerships, collaborations, and coordination of MCH programs continue especially involving HWHF. FHS is working very closely with the NJDOH newly created Office of Population Health, where the Maternal Mortality Review

Commission and the State Maternal Health Innovation Program are both housed. Together FHS and the Office of Population Health work collaboratively to improve birth outcomes and reduce disparities.

Building the capacity of women, children and youth, including those with special health care needs, and families to partner in decision making with Title V programs at the federal, state and community levels is a critical strategy in helping NJ to achieve its MCH outcomes. FHS has several initiatives to build and strengthen family/consumer partnerships for all MCH populations, to assure cultural and linguistic competence and to promote health equity in the work of NJ's Title V program.

Efforts to support Family/Consumer Partnerships, including family/consumer engagement, are in the following strategies and activities:
• Advisory Committees;
• Strategic and Program Planning;
• Quality Improvement;
• Workforce Development;
• Block Grant Development and Review;
• Materials Development; and
• Advocacy.

This section summarizes the relevant family/consumer and organizational relationships which serve the MCH populations and expand the capacity and reach of the state Title V MCH and CYSHCN programs. **Table 1f** - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination (See Supporting Document #1) summarizes the partnerships, collaborations, and cross-program coordination established by the state Title V program with public and private sector entities; federal, state and local government programs; families/consumers; primary care associations; tertiary care facilities; academia; and other primary and public health organizations across the state that address the priority needs of the MCH population but are not funded by the state Title V program.

The public health issues affecting MCH outcomes generally affect low-income and minority populations disproportionately and is influenced by the physical, social and economic environments in which people live. To address these complex health issues effectively, the FHS/Title V program recognizes that a spectrum of strategies to build community capacity and promote community health must include parents and consumers representing the affected populations as integral partners in all activities in order to have full community engagement and successful programs. In order to carry out these functions and address the public health disparities affecting NJs maternal child health population, the FHS/Title V program has incorporated consumer/family involvement in as many programs and activities as appropriate.

NJ has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. Partially funded by FHS, the MCHC are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. The three MCHC are located in the northern, central and southern regions of the state. It is a requirement of the statute governing the MCHC that 50% of their Board of Directors be comprised of consumers representing the diverse population groups being serviced by their organizations.

Recognizing the importance that parent/consumer involvement has in the design and implementation of a program to address issues related to preterm births and infant mortality, the MCH Program incorporated focus groups into several programs under the HWHF initiative including those for doulas, breastfeeding, and addressing disparities. Similarly, the Home Visiting Program (MIECHV) also requires funded grantees to implement County Advisory Boards.

The NJ Title V CYSHCN Program, SCHEIS, partners, collaborates, and coordinates with many different governmental and nongovernmental entities, on federal, state, and local levels, as well as parents, families and caregivers, primary care physicians, specialists, other health care providers, hospitals, advocacy organizations, and many others to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. SCHEIS works with programs within the NJ Departments of Human Services (DHS) and Children and Families (DCF) in addressing many needs facing CYSHCN

including medical, dental, developmental, rehabilitative, mental health, and social services. DHS administers Title XIX and Title XX services and provides critical supports for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children's Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare Program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need. SCHEIS utilizes patient satisfaction survey as a means to improve and refine. All trainings provided to grantees are also open to parents/consumers as either participants or speakers. All CYSHCNs educational materials and informational brochures receive input and are reviewed by parents/consumers for health literacy and cultural competence.

SCHEIS collaborates with many offices and programs in DHS to develop and implement policy that will ensure that children referred into the SCHS CMUs and their families are screened appropriately for healthcare service entitlements and waivered services. SCHEIS programs including case management, specialized pediatrics, and Ryan White Part D, screen all referrals for insurance and potential eligibility for Medicaid programs, counsel referrals on how to access Medicaid, NJ FamilyCare, Advantage, and waiver programs, and link families with their county-based Boards of Social Services and Medicaid Assistance Customer Care Centers. Program data including insurance status is collected into a report that is compared with Medicaid data in determining CYSHCN need. Referrals are made to Boards of Social Services, NJ Family Care, Advantage, Charity Care, Department of Banking and Insurance, and Disability Rights NJ for support and advocacy.

The Early Hearing Detection and Identification (EHDI) program within the SCHEIS also recognizes the pivotal role that consumers and parents play in the effective administration of the program. EHDI has an Advisory Council composed of parents of Deaf and hard of hearing children and consumers who themselves are Deaf or hard of hearing. Participants on the council take part in literature reviews, advise the NJDOH regarding innovations in the programmatic area and assist in the review of operations of the program.

In accordance with the 1993 Family Support Act the NJ CDD established the Regional Family Support Planning Councils (RFSPCs) to provide a way for parents and family members of people with developmental disabilities to come together to exchange knowledge and information about family support services and to advocate for families and individuals with developmental disabilities at the local and state level on issues that directly impact their lives. They also collaborate with the state Division of Developmental Disabilities (DDD) on how to better serve individuals and their families.

The Medical Assistance Advisory Committee (MAAC) operates pursuant to 42 CFR 446.10 of the Social Security Act. The 15-member Committee is comprised of governmental, advocacy, and family representatives and is responsible for analyzing and developing programs of medical care and coordination. State SCHEIS staffs participate at MAAC meetings and share information on access to care through Medicaid managed care with Committee members as well as with SCHEIS programs. Likewise, information shared by the MAAC is incorporated into SCHEIS program planning to better assure coordination of resources, services, and supports for CYSHCN across systems. The quarterly MAAC meetings continue to provide a public forum for the discussion of systems changes in DHS's Medicaid program as well as invite collaboration across State programs. Updates keep stakeholders including the public and providers informed of NJ's progress in implementation of Managed Long Term Services and Supports (MLTSS), and the restructuring of services to children and youth with the developmental disabilities through DDD, DCF, DOE and DOL, Vocational Rehabilitation.

The SPAN Parent Advocacy Network, and the NJAAP are key partners with the Title V Program in NJ in many initiatives and projects to better serve CYSHCN and empower families. The Statewide Community of Care Consortium (COCC), a leadership group of SPAN, dedicated to improving NJ's performance on the six core outcomes for CYSHCN and their families, includes three co-conveners from Title V, SPAN and NJAAP. This group also includes DHS, DCF, the NJ Primary Care Association, and over 60 statewide participating stakeholder organizations. The COCC partners are continuing to work to improve the access of children with mental health challenges to needed care, and to improve the capacity of primary care providers to address mental health issues within their practice. A Family Guide to Integrating Mental Health and Pediatric Primary Care has been developed and shared with families. COCC co-conveners continue to meet with NJ's child protection agency, DCF Division of Protection and Child Permanency, about addressing challenges for children with mental health needs under their care. As an organization consisting of parents or families of CYSHCN, SPAN's guides, publications and presentations are consistently developed, by design, with family and consumer involvement.

As evidenced by the multitude of advisory council, consumer groups, coalitions, interdepartmental work groups, and committees, the NJDOH places a great emphasis on the active and meaningful participation of parents and consumers in the development, design and implementation and evaluation of Title V programs. This is a core strength of the NJDOH Title V programs.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

The findings from the Five-Year Needs Assessment drive the identification of MCH priority needs for the five-year reporting cycle consistent with Figure 4 of the MCH Block Grant Logic Model. The selected priorities reflect the unique needs of NJ and address the defined MCH population groups and cross-cutting/ systems building areas. In addition, the identified priority needs address areas for which targeted interventions will result in needed improvements to its health care delivery systems. The identified priority needs have informed the selection of nine NPMs, one in each of the MCH population health domains, and the development of 4 SPMs. Collectively, the NPMs and SPMs address the state's identified priority needs. The narrative discussion organized by NPMs supplements the listing of the final priority needs by providing a rationale for how the priority needs were determined and how they link with the selected national and state performance measures. The selected state priority needs drive the selection of NPMS and the development of SPMs which align the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). Table 1a - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model (see page 49 and Supporting Document #1) summarizes the process of identifying priority needs and linking them to performance measures.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,500,000	$10,341,324	$11,500,000	$8,075,934
State Funds	$116,248,000	$141,274,423	$146,102,727	$158,134,800
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$127,748,000	$151,615,747	$157,602,727	$166,210,734
Other Federal Funds	$67,172,292	$65,734,645	$70,030,826	$172,666,279
Total	$194,920,292	$217,350,392	$227,633,553	$338,877,013

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,500,000	$0	$11,500,000	
State Funds	$158,057,356		$170,054,602	
Local Funds	$0		$0	
Other Funds	$0		$0	
Program Funds	$0		$0	
SubTotal	$169,557,356		$181,554,602	
Other Federal Funds	$65,719,932		$0	
Total	$235,277,288		$181,554,602	

	2022	
	Budgeted	Expended
Federal Allocation	$0	
State Funds	$0	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$0	
Other Federal Funds	$0	
Total	$0	

III.D.1. Expenditures

IIID Financial Narrative Expenditures (in process of being updated as of 7/29/21)

NJ expenditures demonstrate the Federal/State partnership and how federal support (Form 2, Line 1, $11,500,000) complements the NJ total State MCH investment (Form 2, line 3, $158,134,800). NJ monitors the MCH Block Grant expenditures bi-annually to ensure compliance with the federal Title V legislative financial requirements. NJ's compliance with the required 30%-30%-10% distribution is documented on Form 2, Line 1 A-C with a population group distribution of 45.5% for Preventive and Primary Care for Children, 45.8% for Children with Special Health Care Needs, and 8.7% for Title V Administrative Costs. The required distribution of more than 30% of Title V funds for
Preventive and Primary Care for Children is still met at 37.7% in FY21. NJ performed very well on the total number and percentage of the MCH population who are served by Title V, as reported on Form 5 by population group (Pregnant Women, Infants <1 Year Old, and Children 1 through 21 Years of Age). NJ is improving its efforts to expand its reach to CSHCN through case management and coordination with Medicaid Managed Care Organizations.

Funds for the reporting year (FFY19) have not been fully expended at the time of the Application/Annual Report submission in Sept 2020. The most recent expenditure data for SFY19 is being reported in this submission.

NJ reports the federal and non-federal MCH Block Grant expenditures separately on the budget/expenditure forms (Forms 2 & 3). Federal MCH Services Title V Block Grant expenditures are reported on Form 2, Lines 1A-1C (Federal Allocation). State MCH funds are reported on Form 2, Line 3 (State MCH Funds). Other non-Title V Federal Funds related to MCH are listed on Form 2, Line 10 (Other Federal Funds).

NJ recognizes that Title V is the payer of last resort and MCH Services Title V Block Grant funds cannot be used to reimburse a claim for a service that is otherwise covered under Medicaid. Service providers receiving MCH Block Grant funds must seek payment from other public and private insurance providers when applicable. Services in NJ supported by the MCH Block Grant reflect services that were not covered or reimbursed through the Medicaid program or another provider.

III.D.2. Budget

IIID2FinancialBudget Update needed

NJ's proposed budget plan (Form 2, FY19 Application Budgeted) presents how MCH Block Grant funds will be allocated across the population groups to address the state's priority needs, improve performance related to the targeted MCH outcomes and expand its systems of care for both the MCH and CSHCN populations. The proposed budget plan assures NJ's commitment to complying with the legislative financial requirements (30%-30%-10% requirements) and program regulations.

The proposed budget plan, like the reported expenditures, demonstrates the federal-state partnership and how federal MCH Block Grant support are utilized to complement the state's planned total match (Form 2, Lines 3-11) for the Application year. The proposed budget plan includes Table A (State Funding Level for MCH Programs and Services, below) and aligns with the identified MCH/CSHCN priorities. NJ combines federal and non-federal MCH Block Grant funds to support the activities that are described in the State Action Plan for the upcoming budget period. State appropriations support a number of maternal and child health programs. In the State Fiscal Year 2020 budget most programs and services are maintained at the SFY 2018 levels. Based on the critical nature of the budget deficit in the state the proposed budget demonstrates an ongoing commitment on the part of the State to support to the best of its ability services to the maternal and child health population. The following are the state funding levels for programs and services for SFY 2018, SFY 2019 and SFY 2020 that reach maternal and child health populations in NJ:

State Budgeted Funding Levels for Programs and Services	SFY 2018	SFY 2019	SFY 2020
Birth Defects Registry	$ 744,000	$ 744,000	
Cleft Lip and Palate Projects	$ 690,000	$ 690,000	
Infant Mortality Reduction	$ 2,000,000	$ 2,000,000	
Sudden Infant Death Syndrome	$ 221,000	$ 221,000	
Newborn Screening	$ 4,593,550**	$ 4,872,875	
Postpartum Depression Screening and Referral	$ 1,900,000	$ 1,900,000	
Early Intervention for Developmental Delay/Disabilities	$ 104,225,357	$ 116,900,661	
Hemophilia services	$ 1,245,000	$ 1,245,000	
Catastrophic Illness in Children Relief Fund	$ 1,700,000	$ 1,700,000	
Handicapped Children's Fund, which is used to support subspecialty care and case management services	$ 4,592,200	$ 4,592,200	
Fetal Alcohol Syndrome	$ 989,000	$ 989,000	
MCH Services	$ 1,740,000	$ 1,740,000	
Council Physical Fitness and Sports	$ 50,000	$ 50,000	
Autism Registry	$ 750,000	$ 750,000	
Family Planning	$ 7,453,000	$ 7,453,000	
Opioid Education for Obstetricians	$ 1,000,000	$ 0	

*This amount applies to NBSGSP (not Hearing and CCHD).
**Note: This amount includes carry over funds.

NJ has used the allocation for the current fiscal year (FY20) as a basis for determining the proposed budget plan for federal and non-federal MCH Block Grant funds in the Application year (FY21). The final federal MCH Block Grant allocation for FY20 is not yet known.

Sources of other federal MCH dollars (Form 2, Line 9) and other state matching funds (Table A, State Funding Level for MCH Programs and Services) are used by NJ to meet its MCH Title V programming needs. The distribution of funding to support services for the 3 legislatively defined populations of the Title V MCH Services Block Grant Pyramid is summarized on Form 2, Line 1 A-C. Planned MCH Block Grant funding will support the budget estimates for individuals served within the 5 population groups (Pregnant Women, Infants < 1 Year, Children 1 through 21 Years, CSHCN, and All Others) on Form 5a and within the 3 types of services (Direct Services, Enabling Services, and Public Health Services and Systems) on Form 3b, Line IIA, 1-4. NJ does not provide any direct MCH services with federal Title V funding.

NJ monitors the Federal/State match requirements, which includes a $3 match in non-federal funds for every $4 of federal MCH Block Grant funds expended and the maintenance of effort from 1989. In FY18 NJ exceeded the Federal/State match ($3/$4) by matching $158,057,356 in non-federal funds to the $11,500,000 federal MCH Block Grant funds. NJ's non-federal State match far exceeded the required maintenance of effort amount of $9,419,570 from 1989.

III.E. Five-Year State Action Plan

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

State: New Jersey

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

IIIE2a – State Title V Program Purpose and Design

New Jersey's Title V Program is uniquely positioned through its leadership and many partnerships with families, professionals, health care organizations, local, state, and federal agencies, and stakeholders to address health care needs of mothers, children and adolescents, including those with special health care needs, at-risk populations, and families and to reduce disparities in health outcomes. In concert with the New Jersey Department of Health State Health Assessment, State Health Improvement Plan, the Nurture NJ Strategic Plan, and Healthy NJ2030 planning documents, the New Jersey Title V program which includes Maternal and Child Health and Special Child Health and Early Intervention Services, works to address selected state priority needs through strategies as noted in the State Action Plan Table.

New Jersey Title V, as a leader, facilitates collaboration and partnership with many agencies and organizations including the Statewide Parent Advocacy Network, the New Jersey Chapter, American Academy of Pediatrics, the New Jersey Hospital Association, state Maternal and Child Health Consortia, and other State agencies to advance and address the needs of MCH populations. Title V programs continually undergo evaluation of individual program success, ongoing challenges and emerging issues. New Jersey Title V is committed to providing a foundation for family and community health across the state and works to assure access to the delivery of quality health services for mothers, infants, and children, including children with special health care needs. New Jersey Title V supports the life course model in approaching maternal and child health, where the full spectrum of factors that impact health are considered, including social, economic, and environmental factors which can contribute to underlying causes of persistent disparities in health.

The New Jersey Title V program is a convener, collaborator, and partner in addressing MCH issues. New Jersey has the third-highest Black maternal mortality rate in the country. Alarming disparities have persisted despite programs designed to improve maternal outcomes. Through the NJ Title V program, initiatives were developed to determine and address the root causes of adverse health outcomes. One of the initiatives currently underway is the Healthy Women, Healthy Families (HWHF) Initiative. The HWHF initiative works toward improving maternal and infant health outcomes for women of childbearing age and their families while reducing racial, ethnic, and economic disparities in those outcomes through a collaborative, coordinated community-drive approach. This coordinated approach uses Community Health Workers (to complete clinical and social needs assessments) and Central Intake Hubs, or county-specific "points of entry" for clinical assessments. Referrals and tracking occur through a central data management platform called "NJCHART." Through this Initiative, New Jersey Title V serves as convener, collaborator and partner to not only traditional health partners, but also to non-traditional, community-based partners such as faith-based organizations that specifically address social determinants of health that lie outside the scope of health. These partnerships are essential in improving pregnancy outcomes, especially among high-risk populations, addressing health disparities and structural racism, and reducing Black Infant Mortality. Utilizing innovative and evidence-based approaches to address cross-cutting issues that impact the health status of the most vulnerable populations is a critical piece of the newly developed HWHF.

The launch of the Governor and First Lady's many maternal health initiatives including Nurture NJ, have enabled Title V to convene, collaborate, and partner with other public and private agencies, families and stakeholders to perform a comprehensive and maternal morbidity and mortality environmental scan to develop a needs assessment with goals to address NJ's maternal health crisis.

NJ Title V partners with the NJ Maternal Health Innovation Team, also at NJDOH, to address maternal health. Health care leaders also engaged include the New Jersey Maternal Mortality Review Committee; New Jersey 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 New Jersey Perinatal Quality Collaborative (NJPQC); the New Jersey Health Care Quality Institute (NJHCQI); Federally Qualified Health Centers; hospital associations; regional New Jersey maternal child health consortia; foundations; and birthing hospital facility Chief Executive Officers, maternal health and quality improvement experts.

Coordinated, comprehensive, culturally and linguistically competent, family centered systems of care are available in Title V's Special Child Health Case Management System, which includes the implementation of AMCHP's National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs.

The core public health functions of assessment, assurance and policy development through program efforts are all supported through the MCH Block Grant.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

3.E.2.b.1 MCH Workforce Development

NJDOH has identified through the State Health Assessment, the State Health Improvement Plan and the Departments' 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 is also a priority for the Division of Family Health Services (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 an experienced and trained staff, the FHS has taken action to improve the capacity of the MCH workforce despite a long-standing hiring freeze.

The FHS implemented the development of succession planning to assure essential functions were considered in long-term planning. During this past fiscal year, cross-training of staff was implemented to assure the ability to maintain key roles in the event of short-term staffing shortages. Changes in the workforce funded by Title V have been quite minimal, reflecting the long-standing MCH priorities and core functions of staff.

The majority of FHS staff concurred there was a need for training to help them effectively conduct return on investment (ROI) analyses of MCH programs. As a result of the NJDOH's paradigm shift toward results-based accountability, additional training is needed for staff to become skilled in collecting data appropriate for accountability documentation and to develop accountability metrics to better calculate the ROI for MCH programs tied to public health outcomes. FHS also 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.

Given the diversity of our state, cultural competency trainings continue to be provided to staff as an essential component of their continuing education activities. Other available opportunities have been pursued through trainings 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 Title V Program staff are ongoing goals of NJ Title V. New Jersey remains in a hiring freeze with exemptions made for critically needed positions, including those within Title V.

MCH Workforce Training and COVID-19

The NJDOH has created a vulnerable populations plan, which encompasses epidemiology on high need areas, areas where individuals are more susceptible to contracting COVID-19. Additionally, the NJ COVID-19 vulnerable populations plan includes a list of populations deemed vulnerable to COVID-19, that includes racial and ethnic populations, immigrants, limited English proficient, homebound, seniors, homeless, disabled populations, migrant workers, Orthodox Jewish populations, pregnant and nursing mothers, underinsured and uninsured, undocumented workers and substance abusers. Many of these vulnerable populations face increased risk of exposure to COVID-19 as many experience higher rates of unemployment; are more likely to work in essential, low-income jobs that do not allow telework; and do not have health insurance or paid sick leave through employers. Racial and ethnic minority groups, seniors, people with low socioeconomic status, the homeless, those with substance use disorders, pregnant women, and/or those with certain underlying medical conditions such as heart disease, diabetes, obesity, and smoking are also at increased risk of contracting COVID-19 and/or experiencing severe illness from COVID-19. Other populations such as immigrants, migrant workers, undocumented workers, limited English proficient, homebound, and disabled populations traditionally do not access health care on a routine basis, thereby increasing their risk for severe disease. In addition, distrust of medical and governmental entities, anti-vaccination sentiments (particularly in Orthodox Jewish populations), and disparities in vaccine coverage may impact achievement of high COVID-19 vaccination rates in these population groups.

Often members of the communities they serve, Community Health Workers (CHWs) are frontline public health workers who because of their intimate understanding of the cultures, languages, and challenges of their neighborhoods are trusted by the people they serve. A base of evidence has long pointed to the effectiveness of CHWs, but over the past few years a marked increase in studies has demonstrated their value in improving health outcomes, lowering healthcare costs, and reducing inequities[1].

Guided by this evidence, NJDOH in recent years has made the expansion of CHWs in New Jersey a strategy to address inequities in our healthcare system. One of the ways The New Jersey Department of Health has worked over the past several years to improve the health of vulnerable populations within the state is to support and help sustain initiatives that involve Community Health Workers. This work has

included efforts to establish a standardized training, build CHW capacity and expand the number of CHWs statewide. We plan to use this same strategy of training, deploying and engaging CHWs to respond to COVID-19 in vulnerable populations. We will expand outreach within the NJDOH and also in the field to include other social service providers, community-based organizations (CBOs) and faith-based organizations (FBOs) partners, using a regional field team structure.

CHWs reach out to vulnerable populations, educate them on services available and make critical linkages to additional social supports, activities that will be implemented as part of the COVID-19 response. Many CHWs are involved in case management as well. Knowing the value of CHWs along with their long-term use in NJDOH programming, their limited training, lack of a standardized curriculum, and difficulty recruiting, retaining and advancing in their careers, NJDOH made the decision to invest, establish and build the *NJDOH Colette Lamothe-Galette Community Health Worker Institute,* https://www.nj.gov/health/clgi.

Colette Lamothe Galette Community Health Worker Institute Background

In May 2020, NJDOH created the Colette Lamothe-Galette Community Health Worker Institute (CLG-CHWI), a program to train and certify CHWs. The NJDOH secured a grant from the New Jersey Department of Labor's Growing Apprenticeship in Non-Traditional Sectors (GAINS) Program, which is the Institute's primary funder. The Institute is named in honor of Colette Lamothe-Galette, the former NJDOH's 1st Population Health Director, who went on to the Nicholson Foundation, where she served as a Senior Program Officer and led The Nicholson Foundation's CHW efforts until she passed away from COVID-19 on April 4, 2020.

Through the CLG-CHWI, CHWs are hired as apprentices, allowing them to experience both classroom and on the job training. Training includes 144 hours of related classroom technical instruction covering 13 core competencies supplemented by 1000 to 2000 on the job hours, with reflective supervision. This CHW apprentice occupation is registered with the USDOL.

Community Problem and Response

COVID-19 is disproportionately impacting some communities. These vulnerable populations often have underlying medical conditions, co-morbidities, living and work conditions that make them more susceptible to COVID-19 exposure and death. CHWs often come from the communities they serve and can educate individuals on how to protect themselves, mitigate the risks of COVID-19 exposure and access the many social supports available to these vulnerable populations. To address these social needs, CHWs will be trained in COVID-19 related competencies and social supports.

We propose building on the CLG-CHWI to train, deploy and engage more CHWs. We will do this by expanding CHW core competencies to include mental health & substance use disorder (SUD) , adding new CHW specialized tracks in the form of additional training on primary actions of state and/or local public health led efforts to address underlying conditions such as chronic disease. We will integrate CHWs in novel settings that include prisoner re-entry programs, mental health and substance use disorders, Certified Community Behavioral Health Clinics (CCBHCs) and FQHCs who have never utilized CHWs. These novel settings have been selected due to the challenges facing these vulnerable populations. These novel settings will be a part of innovative demonstration projects where we test the Return on Investment (ROI) of CHWs and explore sustainable funding strategies with Medicaid.

Preventive and Primary Care for Children with Special Health Care Needs

NJ maintains a comprehensive system to promote and support access to preventive and primary care for CYSHCN through early identification, linkage to care, and family support. Title V partially supports this safety net that is comprised of pediatric specialty and sub-specialty providers, case management, and family support agencies that provide in-state regionalized and/or county-based services. It is designed to provide family-centered, culturally competent, community-based services for CYSHCN age birth through 21 years of age, and to enhance access to medical home services, facilitate transition to adult systems, and ensure health insurance coverage. The Specialized Pediatric Services Programs (SPSP) agencies are a significant resource of pediatric specialty and subspecialty care in NJ and are used widely by CYSHCN including Medicaid recipients. Although clients are screened for their ability to pay for clinical services, the support provided by Title V enables all CYSHCN to be served regardless of their ability to pay. There is no charge for SCHS CM and family support. The system is operated by 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, one Autism Spectrum Disorder Support Service project multiple SPSP health service grants and a small State operated Fee-for-Service program. State and federal collaborations among the FCCS programs and non-Title V funded programs such as the Ryan White Part D Family Centered HIV Care Network (RWPD), Early Intervention System (EIS), Federally Qualified Health Centers (FQHC), medical home initiatives, Supplemental Security Income (SSI), Catastrophic Illness in Children Relief Fund (CICRF) and other community-based initiatives extend the safety net through which Title V links CYSHCN with preventive and primary care.

State Title V staff, SCHS CMUs and SPSP providers, receive training from State agencies such as the NJ Department of Human Services, and the Department of Children and Families to become Informal Application Assistors for Medicaid/NJ FamilyCare programs as well as to learn about Managed Long Term Services and Supports (MLTSS), how to obtain care through the Marketplace, and behavioral services through PerformCare. These trainings build capacity among Title V agency providers to enhance access to primary and preventive care for

CYSCHN. For example, an SCHS CM reported being able to assist a parent to problem solve a denial of home health aide services for a 12-year-old with autism and significant developmental delays by advocating on the mother's behalf with PerformCare, her child's school district, and her Family Support Organization. Repeated phone calls, home visits, and written appeals by the SCHS CM supported the mother's efforts to clarify the missing information and resolve her child's needs.

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[1] Payne, J., Razi, S., Emery, K. *et al.* Integrating Community Health Workers (CHWs) into Health Care Organizations. *J Community Health* **42,** 983–990 (2017). https://doi.org/10.1007/s10900-017-0345-4

III.E.2.b.ii. Family Partnership

IIIE2bii Family Partnership

Building the capacity of women, children and youth, including those with special health care needs, and families to partner in decision making with Title V programs at the federal, state and community levels is a critical strategy in helping NJ to achieve its MCH outcomes. FHS has several initiatives to build and strengthen family/consumer partnerships for all MCH populations, to assure cultural and linguistic competence and to promote health equity in the work of NJ's Title V program.

Efforts to support Family/Consumer Partnerships, including family/consumer engagement, are in the following strategies and activities:
• Advisory Committees;
• Strategic and Program Planning;
• Quality Improvement;
• Workforce Development;
• Block Grant Development and Review;
• Materials Development; and
• Advocacy.

This section summarizes the relevant family/consumer and organizational relationships which serve the MCH populations and expand the capacity and reach of the state Title V MCH and CYSHCN programs. **Table 1f** - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination (See Supporting Document #1) summarizes the partnerships, collaborations, and cross-program coordination established by the state Title V program with public and private sector entities; federal, state and local government programs; families/consumers; primary care associations; tertiary care facilities; academia; and other primary and public health organizations across the state that address the priority needs of the MCH population but are not funded by the state Title V program.

The public health issues affecting MCH outcomes generally affect low-income and minority populations disproportionately and is influenced by the physical, social and economic environments in which people live. To address these complex health issues effectively, the FHS/Title V program recognizes that a spectrum of strategies to build community capacity and promote community health must include parents and consumers representing the affected populations as integral partners in all activities in order to have full community engagement and successful programs. In order to carry out these functions and address the public health disparities affecting NJs maternal child health population, the FHS/Title V program has incorporated consumer/family involvement in as many programs and activities as appropriate.

NJ has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. Partially funded by FHS, the MCHC are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. The three MCHC are located in the northern, central and southern regions of the state. It is a requirement of the statute governing the MCHC that 50% of their Board of Directors be comprised of consumers representing the diverse population groups being serviced by their organizations.

Recognizing the importance that parent/consumer involvement has in the design and implementation of a program to address issues related to preterm births and infant mortality, the MCH Program incorporated focus groups into several programs under the HWHF initiative including those for doulas, breastfeeding, and addressing disparities. Community Advisory Boards have also been established by the HWHF grantees with an emphasis on recruiting new and nontraditional partners. Similarly, the Home Visiting Program (MIEC-HV) also requires funded grantees to implement County Advisory Boards.

The NJ Title V CYSHCN Program, also referred to as Special Child Health and Early Intervention Services (SCHEIS), partners, collaborates, and coordinates with many different governmental and nongovernmental entities, on federal, state, and local levels, as well as with parents, families and caregivers, primary care physicians, specialists, other health care providers, hospitals, advocacy organizations, and many others to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. SCHEIS works with programs within the NJ Departments of Human Services (DHS) and Children and Families (DCF) in addressing many needs facing CYSHCN including medical, dental, developmental, rehabilitative, mental health, and social services. DHS administers Title XIX and Title XX services and provides critical supports for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children’s Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare Program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need. SCHEIS utilizes patient satisfaction survey as a means to improve and refine. All trainings provided to grantees are also open to parents/consumers as either participants or speakers. All CYSHCNs educational materials and informational brochures receive input and are reviewed by parents/consumers for health literacy and cultural competence.

SCHEIS collaborates with many offices and programs in DHS to develop and implement policy that will ensure that children referred into the SCHS CMUs and their families are screened appropriately for healthcare service entitlements and waivered services. SCHEIS programs including case management, specialized pediatrics, and Ryan White Part D, screen all referrals for insurance and potential eligibility for Medicaid programs, counsel referrals on how to access Medicaid, NJ FamilyCare, Advantage, and waiver programs, and link families with their county-based Boards of Social Services and Medicaid Assistance Customer Care Centers. Program data including insurance status is collected into a report that is compared with Medicaid data in determining CYSHCN need. Referrals are made to Boards of Social Services, NJ Family Care, Advantage, Charity Care, Department of Banking and Insurance, and Disability Rights NJ for support and advocacy.

Both the Early Hearing Detection and Identification (EHDI) and the Newborn Screening and Genetic Services (NSGS) Programs within the SCHEIS also recognize the pivotal role that consumers and parents play in the effective administration of their programs. EHDI has an Advisory Council composed of parents of Deaf and hard of hearing children and consumers who themselves are Deaf or hard of hearing. Participants on the council take part in literature reviews, advise the NJDOH regarding innovations in the programmatic area and assist in the review of operations of the program. NSGS meets and communicates regularly with several advisory panels composed of parents of special needs children, physicians, specialists, and others to ensure NJ’s program is state-of-the-art in terms of screening technologies, operations, and responsive to any current concerns regarding newborn screening.

In accordance with the 1993 Family Support Act the NJ Council for Developmental Disabilities (CDD) established the Regional Family Support Planning Councils (RFSPCs) to provide a way for parents and family members of people with developmental disabilities to come together to exchange knowledge and information about family support services and to advocate for families and individuals with developmental disabilities at the local and state level on issues that directly impact their lives. They also collaborate with the state Division of Developmental Disabilities (DDD) on how to better serve individuals and their families.

The Medical Assistance Advisory Committee (MAAC) operates pursuant to 42 CFR 446.10 of the Social Security Act. The 15-member Committee is comprised of governmental, advocacy, and family representatives and is responsible for analyzing and developing programs of medical care and coordination. State SCHEIS staff participate at MAAC meetings and share information on access to care through Medicaid managed care with Committee members as well as with SCHEIS programs. Likewise, information shared by the MAAC is incorporated into SCHEIS program planning to better assure coordination of resources, services, and supports for CYSHCN across systems. The quarterly MAAC meetings continue to provide a public forum for the discussion of systems changes in DHS's Medicaid program as well as invite collaboration across State programs. Updates keep stakeholders including the public and providers informed of NJ's progress in implementation of Managed Long-Term Services and Supports (MLTSS), and the restructuring of services to children and youth with the developmental disabilities through DDD, DCF, DOE and DVRS.

The SPAN Parent Advocacy Network, Autism NJ and the NJAAP are key partners with the Title V Program in NJ for many initiatives and projects to better serve CYSHCN and empower families. The Statewide Community of Care Consortium (COCC), a leadership group of SPAN, dedicated to improving NJ’s performance on the six core outcomes for CYSHCN and their families, includes three co-conveners from Title V, SPAN and NJAAP. This group also includes DHS, DCF, the NJ Primary Care Association, and over 60 statewide participating stakeholder organizations. The COCC partners are continuing to work to improve the access of children with mental health challenges to needed care, and to improve the capacity of primary care providers to address mental health issues within their practice. A Family Guide to Integrating Mental Health and Pediatric Primary Care has been developed and shared with families. COCC co-conveners continue to meet with NJ's child protection agency, DCF Division of Child Protection and Permanency, about addressing challenges for children with mental health needs under their care. As an organization consisting of parents or families of CYSHCN, SPAN’s guides, publications and presentations are consistently developed, by design, with family and consumer involvement.

As evidenced by the multitude of advisory council, consumer groups, coalitions, interdepartmental work groups, and committees, the NJDOH places a great emphasis on the active and meaningful participation of parents and

consumers in the development, design and implementation and evaluation of Title V programs. This is a core strength of the NJDOH Title V programs.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

The MCH Epidemiology program is housed within the Maternal Child Health Services (MCHS) Unit of the NJDOH, Division of Family Health Services and currently falls under the supervision of the MCHS Medical Director, Marilyn Gorney-Daley, DO, MPH. Dr. Gorney-Daley serves as the Project Director for the NJ Pregnancy Risk Assessment Monitoring System (PRAMS) and oversees all MCH Epidemiology activities. There is currently one full time Research Scientist II responsible for managing/analyzing MCH data and two FTE vacancies. MCH Epidemiology positions are funded by the Title V, MCH Block Grant and the SSDI grant.

The Research Scientist II has an MPH in Epidemiology and serves as the Project Director for the State Systems Development Initiative (SSDI) and the NJ PRAMS Coordinator. Her responsibilities include: completing all SSDI required progress reports and continuation applications; responding to internal and external data requests; providing overall coordination of the PRAMS project; organizing PRAMS Steering Committee meetings; assuring compliance with the PRAMS protocol; coordinating the dissemination of PRAMS data and the development of PRAMS data briefs, topic reports, and the NJ State Health Assessment Data (NJSHAD) system PRAMS data query; and completing all PRAMS progress reports and continuation applications.

The MCH Epidemiology program is currently in the process of hiring a Research Scientist 1 and an Analyst 1, Research and Evaluation. A highly qualified candidate for the Research Scientist 1 position has been selected and paperwork is currently going through the approval process to hire. The Research Scientist 1 will be responsible for research, design, coordination and implementation of all programs and activities within the MCH Epidemiology program. Duties include: serving as the PRAMS Project Director; designing and developing research protocols and data evaluation for the Healthy Women, Healthy Families initiative; preparing technical reports and needs assessments for programs, including the 5-year needs assessment for the MCH Block Grant; developing, reviewing and analyzing publications and other documents pertaining to current MCH research developments; disseminating information to internal and external professional staff; and serving as the SSDI Project Director.

The Analyst 1, Research and Evaluation, will promote the health of pregnant women, infants and children through the analysis of trends in MCH data and facilitate efforts aimed at developing strategies to improve MCH outcomes. Duties include: linking and analyzing data and conducting applied research projects to provide information about improving health outcomes; linking PRAMS data to birth certificate and/or other data sources and conducting analysis, creating and updating PRAMS-related data for briefs and other reports annually; participating in the routine reporting of MCH indicators and birth outcomes research by demographic indicators, geography and hospital; conducting data linkages and analysis for SSDI; and responding to internal and external data requests. Interviews for this position have been conducted, however, a candidate has not been identified to hire. This position may be reposted as a Research Scientist III to broaden the pool of applicants.

Due to staffing changes within the MCH Epidemiology program, assistance with data analysis has been provided by an MCH Epidemiologist in the NJDOH, Office of Population Health. The Epidemiologist linked PRAMS data to birth certificate data and conducted analyses on pre-pregnancy maternal morbidity, marijuana use, and adverse birth outcomes due to smoking which were presented at the 2021 NJ PRAMS Steering Committee Meeting. The Epidemiologist has also assisted with requests for PRAMS data and will be available for future data needs.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

Evaluating services for New Jersey mothers, infants and children is an important part of improving access to health services and reducing disparities in health outcomes. The lack of comprehensive and timely data can limit the ability to make decisions supported by data. The Maternal and Child Health Epidemiology (MCH Epi) Program provides MCH surveillance and evaluation support to Maternal and Child Health Services (MCHS). The State Systems Development Initiative (SSDI) project resides in the MCH Epi Program and focuses on improving the exchange of data for linkages within the department and between other agencies.

Data exchanges occur currently between MCH Epi, Vital Statistics, Pregnancy Risk Assessment and Monitoring System (PRAMS; also housed in the MCH Epi Program) and Centers for Health Statistics. Using birth data retrieved monthly and death data and hospital discharge data retrieved when the latest files are available, MCH Epi has expanded the use of recent provisional data for analysis, decision making, resource allocation and evaluation of New Jersey's MCH Title V activities. Partial funding of PRAMS is supported through the SSDI grant to ensure the availability of PRAMS data for linkage.

SSDI supported the use of vital statistics data and hospital discharge data to identify cases of maternal deaths that are then used by New Jersey's Maternal Mortality Review Committee to identify pregnancy-related deaths and make recommendations so that such deaths can be prevented for other women. SSDI staff has also been a participant in the State's Strategic Plan to Reduce Maternal Mortality. This participation involved providing data support as well as making recommendations for future surveillance and reporting on maternal mortality by sociodemographic characteristics, causes of death, and timing of death in the form of an annual maternal mortality report.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

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, updating annual reports related to breastfeeding and c-section rates, 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 Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is housed within the MCH Epi program and is a crucial surveillance tool necessary to improve the health of NJ mothers and infants. MCH Epi staff conduct analysis of PRAMS data, develop PRAMS data briefs and topic reports, and provide data to internal and external MCH programs to inform program planning and evaluation. In addition, 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 NJ State Health Assessment Data (NJSHAD) system on the NJDOH website. MCH Epi staff update the PRAMS data query annually. Several CDC survey supplements have been included in the NJ PRAMS survey to collect data on emerging MCH issues. For example, a survey supplement on Zika was included from July 2016 to October 2017, and a supplement on marijuana and opioid was included from July 2018 to March 2020. Results from the Zika supplement were presented at the 2018 PRAMS National Meeting, and the drug use data was recently analyzed and presented at the 2021 NJ PRAMS Steering Committee Meeting. In response to the COVID-19 pandemic, a COVID-19 supplement was added to NJ PRAMS in October 2020, and a COVID-19 vaccine supplement was added in April 2021. Both supplements will be included in PRAMS through March 2022. NJ PRAMS is also participating in the Postpartum Assessment of Women Survey (PAWS), a follow-up survey being led by researchers at Columbia University. The purpose of PAWS is to conduct surveillance of women's health needs, health insurance status, health care utilization, and social determinants of health in the year following childbirth. The PAWS data will be linked to the PRAMS data, and analysis will be conducted. Data from this effort will inform the development of programs and policies to mitigate maternal morbidity and mortality in the extended postpartum period. Staffing of analytical positions remains a key challenge in NJ's efforts to improve the use of MCH data. MCH Epi has been collaborating with staff from the NJDOH, Office of Population Health to respond to data needs.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

MCH Emergency Planning and Preparedness

https://mchb.tvisdata.hrsa.gov/uploadedfiles/TvisWebReports/Documents/blockgrantguidance.pdf

page:

The Family Centered Care Program in Special Child Health and Early Intervention Services, is in the process of up-grading out the current case management system to enable us to quickly reach out to all of our families with children with special health care needs. This system includes an “exceptional events” module that was developed in response to Superstorm Sandy. This module will be redesigned to allow more flexibility of collecting what the family needs are and how they can best be serviced during an emergency situation.

Pregnant women, infants and children have unique risks with public health emergencies. Gaps in emergency preparedness and response planning can leave MCH populations especially vulnerable. The COVID-19 pandemic necessitated immediate response to address the needs of MCH populations. Services and resources were quickly transitioned into remote access when possible. NJDOH was awarded CDC funding for an Epidemiology and Laboratory Capacity (ELC) grant to enable enhanced detection. The ELC scope of work in MCH was prioritized under the umbrella of the Colette Lamothe-Galette Community Health Worker (CLG-CHW) Institute. The ELC focused on developing CHW to assist in contact tracing efforts; assisting with the surveillance of vulnerable populations; implementing prevention strategies with vulnerable, diverse populations; and providing alternative testing and vaccine sites for COVID-19. DOH established three statewide regional grantees to work closely with over 35 subgrantees, including both traditional partners (Healthy Women Healthy Families grantees/subgrantees) and nontraditional partners (FQHCs, food banks, faith-based and local community organizations).

CDC’s new initiative “Surveillance for Emerging Threats to Mothers and Babies,” is enabling investing in public health data systems to better monitor and respond to the unique risks and needs of pregnant women, infants, and children during public health emergencies. Through this initiative, in which NJ Title V is participating, the effects of new health threats such as COVID-19, on pregnant women and their babies can be detected by collecting data from pregnancy through childhood. The initiative enables the use of evidence-based, actionable information to help save and improve the lives of mothers and babies.

The NJDOH has partnered with CDC to help protect mothers and babies from the consequences of public health emergencies. As we continue to have limited information from published scientific reports regarding pregnant women and their risks with COVID-19, NJDOH with CDC, is monitoring pregnant women who test positive for COVID-19 through the end of their pregnancy as well as monitoring birth outcomes of their infant(s), and follow-up of those infants at 2 and 6 months.

By collecting existing laboratory and clinical information on these mothers and infants, we will be able to characterize the spectrum of health effects associated with COVID-19 infection during pregnancy to inform clinical guidance, programs, and services. DOH staff are working with hospital Health Information Management Departments and are currently abstracting data from medical records for cases where delivery has already occurred. Through this initiative, the data may be used to monitor and improve the health of pregnant women and infants; link families to medical and social services to get recommended care; strengthen laboratory and clinical testing to find emerging health threats quickly; and ensure public health is ready and prepared to meet the needs of pregnant women and infants during emergencies.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Public and Private Partnerships

The NJDOH collaborates with many other federal, state, and non-governmental partners to complement Title V program efforts to provide a systems approach to ensure access to quality care and needed services for the MCH population.

Through the First Lady's Nurture NJ, a statewide awareness campaign committed to reducing maternal and infant mortality and ensuring equitable care among women and children of all races and ethnicities, the NJDOH has partnered with other state departments and agencies, health systems, physicians, doulas, community organizations, and most importantly mothers and their families to make a transformational change in a system that has historically failed mothers and babies. From this campaign the Nurture NJ Strategic Plan, which was released in January 2021, requires all sectors, including health and Title V, as well as education housing, business, government, justice and others to contribute. This Strategic Plan was developed to reduce New Jersey's maternal mortality by 50% over a five year period and eliminate racial disparities in birth outcomes. This plan is the culmination of over a year of in-person and virtual meetings with over 100 critical stakeholders, including national public health experts, New Jersey state departments and agencies, health systems, physicians, doulas, community organizations, and mothers and families. The plan seeks to reduce maternal mortality and eliminate racial disparities by: ensuring all women are healthy and have access to care before pregnancy; building a safe, high-quality equitable system of care for all women prenatally through postpartum care; and ensuring supportive community environments during every other part of a woman's life, so that conditions and opportunities for health are always available.

Nine action areas for the Nurture NJ Strategic plan are as follows:

1. Build racial equity 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 New Jersey;
6. Generate and more widely disseminate data and information for improved decision-making;
7. Change institutional structures to accommodate innovation and transformative action;
8. Address the social determinants of health; and
9. Improve the quality of care and service delivery to individuals.

In June 2021, NJDOH launched the New Jersey Maternal Care Quality Collaborative (NJMCQC), a 34-member legislated State Maternal Health Task Force formed to improve maternal health outcomes by catalyzing multidisciplinary collaboration, collecting and analyzing maternal health data, while promoting and executing innovation in maternal health service delivery. The NJMCQC will coordinate all efforts and strategies aimed at reducing maternal mortality, morbidity, and racial and ethnic disparities within the state. The NJMCQC will work collaboratively with current organizations such as the Perinatal Quality Collaborative and many others, that are developing and implementing maternal mortality and morbidity reduction strategies within the state. The New Jersey Maternal Care Quality Collaborative also known as the State Maternal Health Task Force will convene quarterly to: Promote buy-in, Implement the Nurture NJ Strategic Plan, Translate data into action, Strategize on future activities, and Solicit funding opportunities. The vision to make New Jersey the safest and most equitable place in the nation to give birth and raise a baby is at the forefront of the work of the NJMCQC. The NJMCQC is part of the HRSA-funded State Maternal Health Innovation program (SMHIP), a selective innovation program made to complement ongoing Title V programs across the country.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

III.E.2.c State Action Plan Narrative by Domain

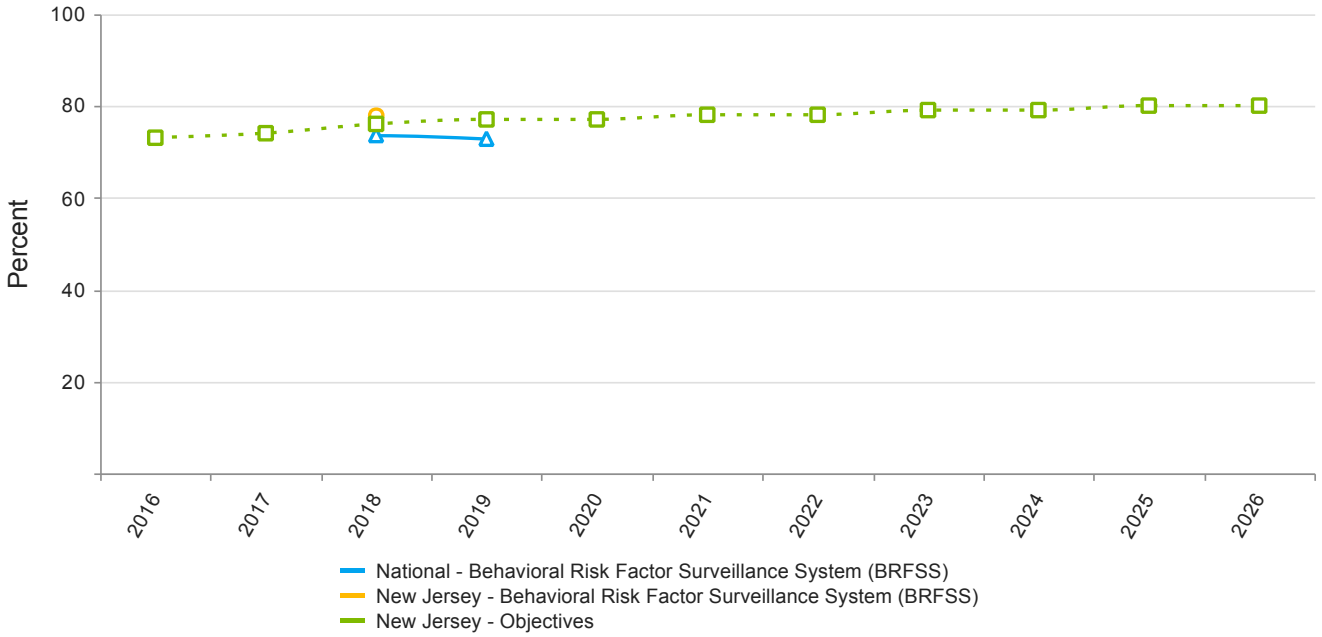
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	81.4	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	20.3	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	7.9 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	9.6 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	25.8 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	4.9	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	3.8	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	2.6	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.2	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	142.3	NPM 1 NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	51.4	NPM 14.1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	10.1 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	6.2	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	93.2 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	10.0	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	10.4 %	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					77
Annual Indicator				77.9	77.9
Numerator				1,186,086	1,186,086
Denominator				1,522,317	1,522,317
Data Source				BRFSS	BRFSS
Data Source Year				2018	2018

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

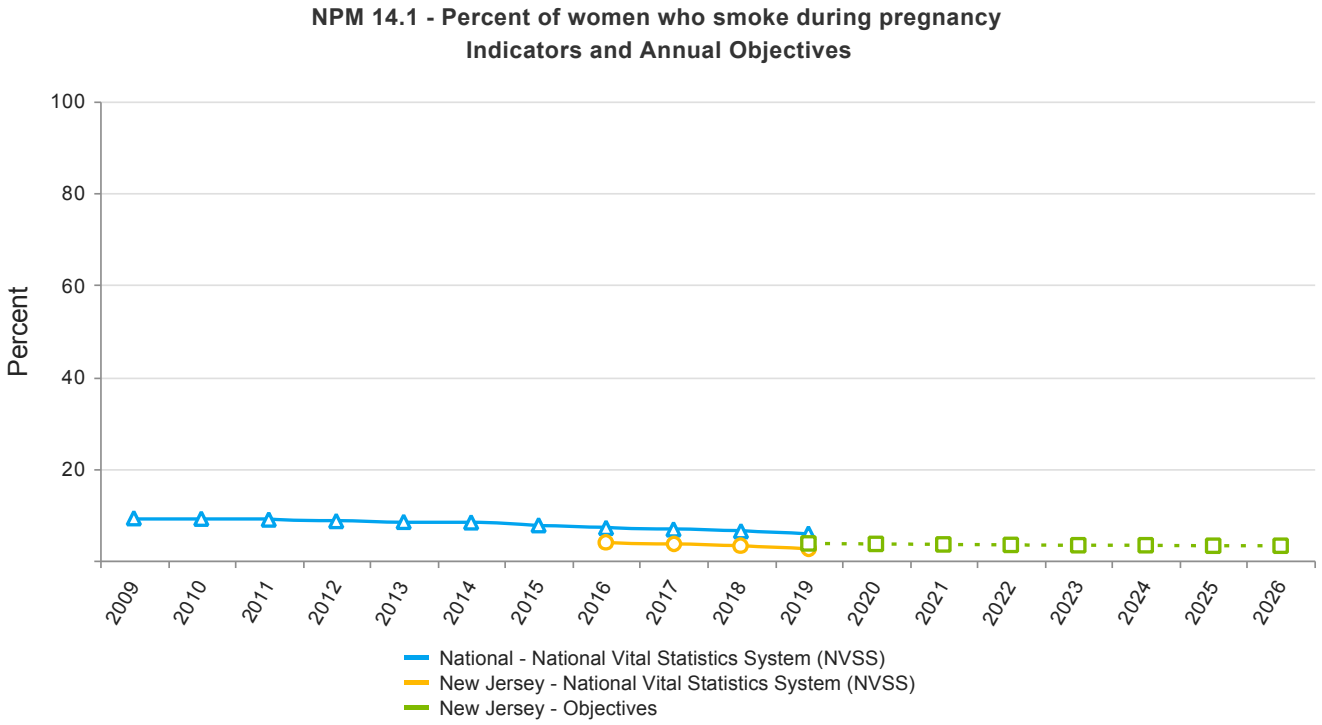
Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	78.0	78.0	79.0	79.0	80.0	80.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Increase first trimester prenatal care rate

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		74	75	75	76
Annual Indicator	72.3	74.7	74.7	73.2	74.6
Numerator	73,862	75,582	75,582	74,081	74,047
Denominator	102,200	101,159	101,159	101,171	99,305
Data Source	Birth Certificate data	Birth Certificate data	Birth Certificate data	Birth Certificate Data - NJ SHAD website	Birth Certificate Data - NJ SHAD website
Data Source Year	2016	2017	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	76.0	77.0	77.5	78.0	78.0	78.0



Federally Available Data				
Data Source: National Vital Statistics System (NVSS)				
	2017	**2018**	**2019**	**2020**
Annual Objective			3.8	3.7
Annual Indicator	3.9	3.7	3.2	2.8
Numerator	3,952	3,690	3,235	2,740
Denominator	102,002	100,785	100,785	98,840
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2016	2017	2018	2019

State Provided Data				
	2017	2018	2019	2020
Annual Objective			3.8	3.7
Annual Indicator	4.4	4.4		
Numerator	4,208	4,208		
Denominator	95,288	95,288		
Data Source	NJ PRAMS	NJ PRAMS		
Data Source Year	2016	2016		
Provisional or Final ?	Provisional	Provisional		

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3.6	3.5	3.4	3.4	3.3	3.3

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - Increase referrals of pregnant women to Mom's Quit Connection.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			5	575
Annual Indicator			575	618
Numerator				
Denominator				
Data Source			Number of PRA referrals to MQC	Number of PRA and self/site referrals to MQC
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	580.0	585.0	590.0	595.0	600.0	605.0

State Action Plan Table

State Action Plan Table (New Jersey) - Women/Maternal Health - Entry 1	
Priority Need	
Increasing equity in healthy births.	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
Increase the percent of women, ages 18 to 44, with a preventive medical visit in the past year by 1% per year by 2022.	
Strategies	
Promote evidence-based strategies to increase preventive medical visits for women (ages 18 - 44 yrs) such as the Community Health Worker model in the Healthy Women, Healthy Families Initiative and the Maternal, Infant and Early Childhood Home Visiting Program.	
ESMs	Status
ESM 1.1 - Increase first trimester prenatal care rate	Active

NOMs

NOM 2 - Rate of 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 (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus 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 women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (New Jersey) - Women/Maternal Health - Entry 2

Priority Need

Smoking Prevention

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

Reduce the percent of women who smoke during pregancy by 2% per year by 2022.

Strategies

Increase smoking screening and referrals of pregnant women to Mom's Quit Connection.

ESMs	Status
ESM 14.1.1 - Increase referrals of pregnant women to Mom's Quit Connection.	Active

NOMs

NOM 2 - Rate of 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 (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus 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 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Women/Maternal Health - Annual Report

Improving the domain of Women's/Maternal Health is crucial to the State Priority Increasing Equity in Healthy Births (SPN #1) and the National Outcomes Measures (NOMs) related to decreasing infant mortality. The selection of NPM #1 (Well Women Visits) 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 to conceptualizing health care needs and services evolved from research documenting the important role early life events play 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 had a long-standing priority of improving the health of women and has utilized several evidence-based strategies to increase preventive medical visits (NPM #1) including: the Healthy Women Healthy Families (HWFH), Maternal and Early Childhood (MIEC) Home Visiting, Fetal Infant Mortality Review (FIMR), and Maternal Mortality Review. Additional emphasis has been placed by the Governor and the First Lady on reducing maternal mortality and morbidity through the Nurture NJ Initiative.

3.e.2.c.2.a - Annual Report - NPM #1 (Percent of women with a past year preventive medical visit)

	2012	2013	2014	2015	2016	2017
Percent of women with a past year preventive medical visit	77.7	77.3	78.8	79.8	80.5	77.0

Data Source: Behavioral Risk Factor Surveillance System (BRFSS) in NJSHAD. Visited a Doctor for a Routine Checkup in the past year (age-adjusted).

The HWHF initiative is a five-year state-wide grantee program implemented on July 1, 2018 and includes six community-based grantees in 12 regions; HWHF is focused on improving birth outcomes and reducing black infant mortality. Specific black infant mortality reduction activities in 8 municipalities (Atlantic City, Camden, East Orange, Irvington, Jersey City, Newark, Paterson, and Trenton) include breastfeeding, centering, fatherhood initiatives, and doulas.

HWHF's use of Community Health Workers and Central Intake Hubs is focused on improving maternal and infant health outcomes including women's health with preventive medical visits, preconception care, prenatal care, interconception care, preterm birth, low birth weight, and infant mortality. This has been coordinated with existing federal and state-funded initiatives including Healthy Start, MIEC Home Visiting, Strong Start, Title X Family Planning, Perinatal Addictions Prevention, Postpartum Mood Disorders, Coordinated School Health, WIC, Federally Qualified Health Centers (FQHCs).

Through use of Community Health Workers and Central Intake the HWHF initiative targets limited public health resources to populations and communities with the highest need where impact will be greatest to improve population health outcomes and reduce health disparities. The newly designed HWHF Initiative addresses the disparities in birth outcomes through case management and assures that appropriate referrals are made and tracked including medical care referrals to promote NPM #1 (Well Women Visits).

Evidence-Based Informed Strategy Measure (ESM) 1.1 (Increase First Trimester Prenatal Care) was selected for its positive impact on National Performance Measure (NPM) #1 (Well Women Care) and State Performance Measure (SPM) #1 (Increasing Healthy Births).

Included in improving NPM #1 is a focus 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 for 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.

Efforts to improve access to early prenatal care must address the factors related to unintended pregnancy and lack of early pregnancy awareness by focusing on women before they become pregnant. Preconception care is a critical component of prenatal care and health care for all women of reproductive age. 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 NPM #1 (Well Women Visits).

Through its collaboration with the NJDOH Office of Population Health and the Population Health in Action Teams, FHS has established linkages with sister agencies (Department of Labor, Department of Education, Department of Transportation, etc.) to address some of the barriers that exist in the scope of Social Determinants of Health (SDOH). The DOH Title V Program and Office of Population Health continue to work with national maternal health experts to develop a strategic plan to promote maternal health and reduce maternal morbidity and mortality as well as develop the activities for the Maternal Health Innovations Program and expanded Maternal Mortality

Review Commission.

The (HWHF) implemented in 2018 is designed to improve pregnancy outcomes and intentionally focuses on reducing disparities. HWHF includes supporting organizations in targeted high BIM cities to implement evidence-based programs like Centering (a type of group prenatal care), doulas, breastfeeding, and fatherhood initiatives. More than 30,000 women have been screened since July 2018 and over 16,000 were connected to programs such as Home Visiting and Healthy Start.

Additional efforts to reduce maternal mortality and morbidity have been and continue to be developed under First Lady Tammy Murphy's Nurture NJ Initiative whose goal is to "make New Jersey the safest place to give birth in the country".

The state Legislature is also focused on the problem of maternal mortality and morbidity with a diverse package of more than a dozen maternal-care related bills. The bill for Medicaid to provide coverage for doula services has been signed into law.

The regional quality improvement activities within each of the three Maternal Child Health Consortia (MCHCs) coordinated by RPHS include the regular monitoring of indicators of perinatal and pediatric statistics, fetal-infant mortality review, maternal mortality review, and maternity services reporting through the Vital Information Platform (VIP). Regional quality improvement activities include regular monitoring of indicators of perinatal and pediatric statistics and pathology, including 1) transports with death; 2) non-compliance with rules regarding birth weight and gestational age; 3) cases in which no prenatal care was received; 4) all maternal deaths; 5) all fetal deaths over 2,500 grams not diagnosed as having known lethal anomalies; 6) selected pediatric deaths and/or adverse outcomes; 7) immunizations of children 2 years of age; and 8) admissions for ambulatory care sensitive diagnoses in children.

Quality improvement is accomplished through the FIMR and Maternal Mortality Review systems, as well as analyzing data collected through electronically submitted birth certificates. The TQI Committee reviews the data and makes recommendations to address either provider specific issues or broad system issues that address multiple providers or consumer groups within each Consortium region.

Maternal and Child Health Services has a long history of efforts to combat persistent perinatal health disparities. Despite years of improving pregnancy outcomes programs and appointments of task forces dedicated to addressing disparities in healthcare, these disparities continue.

The First Lady launched Nurture NJ, a multi-pronged, multi-agency campaign focused on reducing maternal and infant mortality and morbidity and ensuring equitable maternal and infant care among women and children of all races and ethnicities. The Nurture NJ campaign is dedicated to ensuring equitable maternal and infant care among women and children of all races and ethnicities. This past January 2021, the Nurture NJ 2021 Strategic Plan was unveiled with a goal of reducing New Jersey's maternal mortality by 50% over the next five years and eliminate racial disparities in birth outcomes. This strategic plan supports the First Lady's platform to make New Jersey "the safest and most equitable place in the nation to deliver and raise a baby".

Through the Healthy Women Healthy Families (HWHF) Initiative, implemented in July 2018, efforts continue to be targeted to reduce the Black Infant Mortality (BIM) Rate in New Jersey. Specific BIM reducing activities including Centering Pregnancy and Centering Parenting programs, Doula, breastfeeding support and Fatherhood initiatives are being implemented in the cities with the highest BIM rates in NJ. Centering groups faced an initial pause due to in-person restrictions, but within a few months many groups were able to resume using a virtual platform. After pandemic restrictions were modified, in-person groups also resumed following certain guidelines. The Doula Pilot Program was a three year state-wide program that ended June 2021, which included the three community-based grantees working in 12 regions. Additionally through this program, doula care proves to reduce black infant mortality in 8 municipalities (Atlantic City, Camden, East Orange, Irvington, Jersey City, Newark, Paterson, and Trenton). The bridge funding will provide support to the community doulas trained through the Doula Pilot Programs as they transition and enroll in NJ FamilyCare Medicaid fee-for-service and the Manage Care Organization's process to become Medicaid providers. A RFA was issued for the creation of a Doula Learning Collaborative (DLC), which was awarded to Health Connect One. The focus of the DLC is to reduce maternal and infant mortality and eliminate racial disparities in health outcomes by providing training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to grow the community doula workforce. Community Health Workers and supervisors are receiving breastfeeding education through an initiative by the NJDOH. Fatherhood success continues with a total of 207 fathers graduating from the program since inception three years ago, with alumni still staying involved.

The Colette Lamothe-Galette (CLG) Community Health Worker Institute was established through a NJ Department of Labor Apprenticeship program to create a standardized community health worker training and certification program, resulting in a robust CHW workforce. This has allowed the state to educate an emerging and critical component of its workforce – creating a needed infrastructure to support CHWs and 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.

In collaboration with the CLG-CHW Institute, the Epidemiology Laboratory and Capacity (ELC) grant emphasizes the prevention of disease and enhanced detection for COVID19. The ELC focused on hiring and training CHWs to assist in contact tracing efforts; assisting with the surveillance of vulnerable populations; implementing prevention strategies with vulnerable, diverse populations; and providing alternative testing and vaccine sites for COVID-19. The COVID Community Corps and Vaccine Ambassador Programs also support these efforts.

Women/Maternal Health - Application Year

Plans for the coming year to promote NPM 1 (Well Women Care) will include the continued implementation of HWHF and collaboration with families, partners, and stakeholders in the newly implemented State Maternal Health Innovation Program.

The activities of the HWHF initiative and BIM reducing activities of breastfeeding and fatherhood support, as well as the expansion of Centering Programs and the doula pilot program continue to be implemented. Due to COVID19, progress of the Centering Programs (which are types of group prenatal and parenting care) has been on a pause with individual telehealth sessions continuing. Telehealth mini-grants have been awarded from the Centering Healthcare Institute to New Jersey's Centering programs. Virtual group visits are also being established and help to connect pregnant women and new parents who are likely more isolated due to the COVID19 crisis. Doula visits have transitioned into virtual visits including virtual doula support through the birth as needed and possible. At least 79 doulas have received their training in the Uzazi Village model and are serving women. HWHF Doulas will continue to participate in Medicaid's Doula Stakeholder meetings. The Fatherhood initiative has been tremendously successful in northern New Jersey with over 84 men having attended an evidence-based curriculum in 24/7 Dad. A statewide Breastfeeding Strategic plan is also being developed for DOH review.

The MIEC Home Visiting Programs and Healthy Start Programs will continue to case manage mothers and assure preventive medical visits through the monitoring of benchmarks which include a reproductive life plan, medical home and well women visits.

The DOH, FHS and the Office of Population Health will continue to focus on improving women's and maternal health through the development and implementation of a maternal mortality and morbidity strategic plan. The Department is joining efforts with First Lady Tammy Murphy's Nurture NJ Initiative and the legislature which has proposed a package of maternal health related bills. NJ Governor Murphy has directed the implementation of many legislative mandates to promote maternal health. These mandates include the development of annual report care of hospital maternal care, the establishment of the NJ Maternal Data Center, the NJ Maternal Mortality Review Committee, and the NJ Maternal Quality Collaborative; Medicaid coverage for doula care, a perinatal episode of care pilot program in Medicaid, and a shared decision-making pilot program.

The Nurture NJ 2021 Strategic Plan will continue to set the standard for the First Lady's mission of reducing New Jersey's maternal mortality by 50% over the next five years and eliminate racial disparities in birth outcomes, supporting the First Lady's platform to make New Jersey "the safest and most equitable place in the nation to deliver and raise a baby". In collaboration with the Maternal Health Innovation (MHI) team and NJ Maternal Quality Care Collaborative (NJMCQC) MCH continues to prioritize this goal to improve outcomes for women and infants. The Department's focus on improving women's and maternal health through the development and implementation of a maternal mortality and morbidity strategic plan will have a positive impact on reducing black maternal mortality and black non-Hispanic preterm births.

The Healthy Women Healthy Families (HWHF) Initiative will continue to develop partnerships with community-based maternal and child health 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. Support for Black Infant Mortality (BIM) reduction programs in targeted BIM regions will continue to evolve. Support programs for breastfeeding and fathers will continue to be developed and evaluated. The Doula Bridge funding will provide support to the community doulas trained through the Doula Pilot Programs as they transition and enroll in NJ FamilyCare Medicaid fee-for-service and the Manage Care Organization's process to become Medicaid providers. The newly initiated Doula Learning Collaborative (DLC) goal is to reduce maternal and infant mortality and eliminate racial disparities in health outcomes by providing training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ. Centering programs continue with both in-person and virtual groups and will focus on sustainability of the programs. The Burke Foundation has also launched an initiative of expanding centering pregnancy and parenting in NJ over the next 5 years, awarding funding for 5 sites each for implementation and training through the evidenced -based program of the Centering Healthcare Institute (CHI).

The goal of the HWHF Initiative continues to be to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes through a collaborative coordinated community-driven approach. County-based consumer-driven advisory boards will continue to contribute to the direction and progress of the HWHF initiative and the Central Intake Hubs will meet quarterly to build partnerships and local referral systems. Rebranding of Central Intake is currently in progress to find a more appealing and trusted name that welcomes participants for referrals and services.

The CLG-CHW Training Institute will continue to enhance the professional development of CHWs and allow for a stronger workforce. The CLG-CHWI continues to expand its programs through state funding and now will include apprenticeships for perinatal CHWs, an initiative which will assist in improving maternal child health outcomes and Certified Nurse Assistants (CNAs). The ELC will continue to collaborate with the CLG-CHW Training Institute, focusing on the prevention of disease and enhanced detection for COVID19, focusing on vulnerable populations.

Perinatal/Infant Health

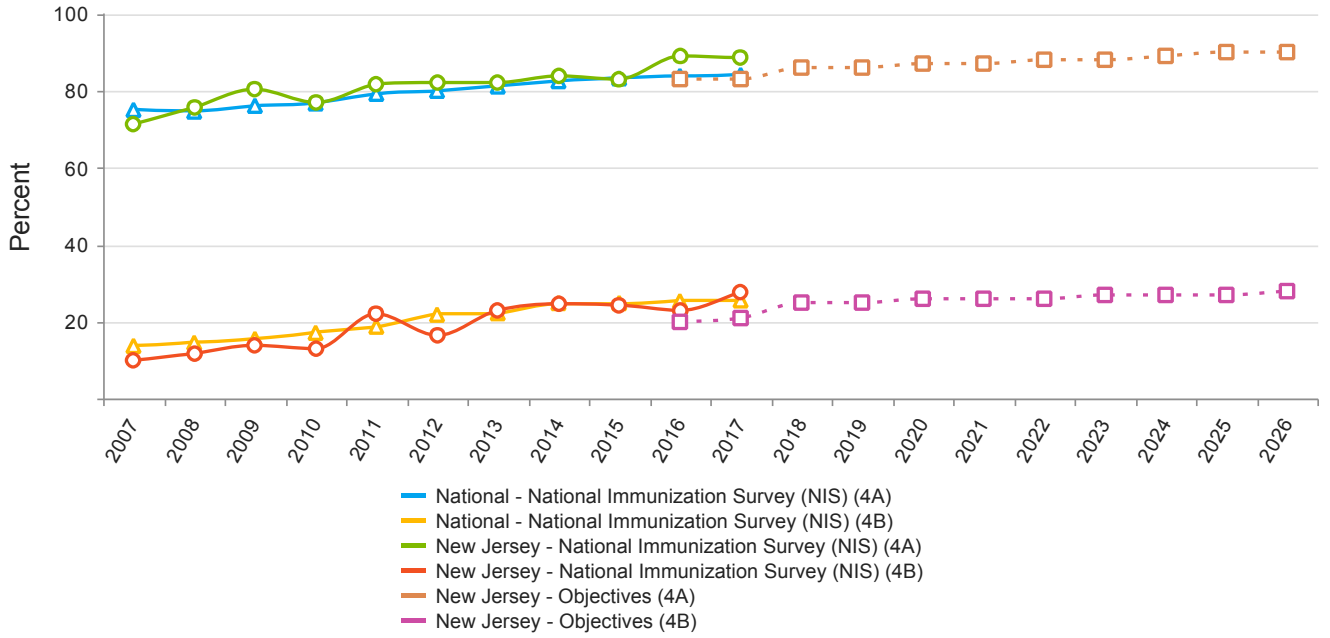
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	3.8	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.2	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	51.4	NPM 4 NPM 5

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	83	83	86	86	87
Annual Indicator	82.0	83.9	82.8	88.8	88.7
Numerator	80,278	85,949	78,449	88,793	82,802
Denominator	97,849	102,457	94,703	100,033	93,345
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	83	83	86	86	87
Annual Indicator	85.8	85.8	85.8	89.8	89.4
Numerator	1,132	1,132	1,132	1,053	79,628
Denominator	1,319	1,319	1,319	1,173	89,080
Data Source	New Jersey PRAMS	New Jersey PRAMS	New Jersey PRAMS	NJ PRAMS	NJ PRAMS
Data Source Year	2016	2016	2016	2018	2019
Provisional or Final ?	Final	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	87.0	88.0	88.0	89.0	90.0	90.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	20	21	25	25	26
Annual Indicator	23.1	24.8	24.4	22.8	27.7
Numerator	21,220	24,771	22,262	22,315	24,921
Denominator	92,052	100,086	91,389	97,759	90,129
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	26.0	26.0	27.0	27.0	27.0	28.0

Evidence-Based or –Informed Strategy Measures

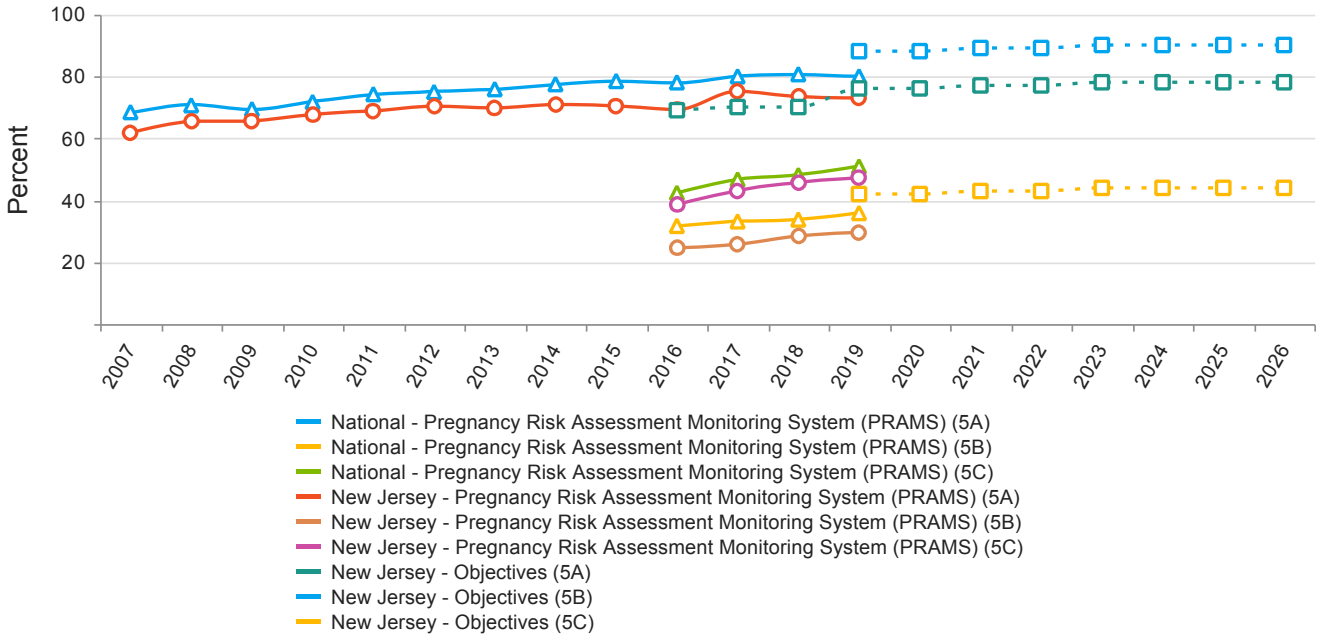
ESM 4.1 - Increase the Percentage of Births in Baby Friendly Hospitals

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		16	20	20	22
Annual Indicator	18.1	19	19	29.1	27.6
Numerator	19,071	18,089	18,089	28,224	26,253
Denominator	105,385	95,065	95,065	96,908	95,275
Data Source	NJ Birth Certificate Data	NJ Birth Certificate Data	NJ Birth Certificate Data	NJ Birth Certificate Database	NJ Birth Certificate Database
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.0	24.0	24.0	25.0	26.0	27.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	69	70	70	76	76
Annual Indicator	69.5	70.5	75.0	73.4	73.0
Numerator	43,610	66,406	68,365	66,608	64,315
Denominator	62,769	94,153	91,207	90,735	88,060
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2017	2018	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	69	70	70	76	76
Annual Indicator	69.4	75	75		
Numerator	64,111	68,365	68,365		
Denominator	92,428	91,207	91,207		
Data Source	NJ PRAMS	NJ PRAMS	NJ PRAMS		
Data Source Year	2016	2017	2017		
Provisional or Final ?	Final	Final	Provisional		

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	77.0	77.0	78.0	78.0	78.0	78.0

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		88	88
Annual Indicator	25.8	28.6	29.7
Numerator	22,403	24,865	24,716
Denominator	86,724	86,846	83,326
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			88	88
Annual Indicator	89.9	89.9		
Numerator	77,962	77,962		
Denominator	86,721	86,721		
Data Source	NJ PRAMS	NJ PRAMS		
Data Source Year	2016	2017		
Provisional or Final ?	Provisional	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	89.0	89.0	90.0	90.0	90.0	90.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		42	42
Annual Indicator	43.1	45.8	47.5
Numerator	37,032	40,078	39,288
Denominator	85,971	87,507	82,694
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			42	42
Annual Indicator	41.3	41.3		
Numerator	37,644	37,644		
Denominator	91,170	91,170		
Data Source	NJ PRAMS	NJ PRAMS		
Data Source Year	2017	2017		
Provisional or Final ?	Final	Provisional		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	43.0	43.0	44.0	44.0	44.0	44.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Promote the complete Infant Safe Sleep Environment (no co-sleeping, on back, and no soft bedding)

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		30	22	23	23
Annual Indicator	21.7	22.1	22.1	22.1	42.8
Numerator	20,743	18,024	18,024	18,024	39,479
Denominator	95,391	81,480	81,480	81,480	92,262
Data Source	NJ PRAMS	NJ PRAMS	NJ PRAMS	NJ PRAMS	NJ PRAMS
Data Source Year	2016	2017	2017	2017	2019
Provisional or Final ?	Final	Final	Provisional	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.0	24.0	24.5	24.5	25.0	25.5

State Action Plan Table

State Action Plan Table (New Jersey) - Perinatal/Infant Health - Entry 1	
Priority Need	
Reducing Black Maternal and Infant Mortality.	
NPM	
NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	
Objectives	
Increase infant safe sleep by 1% per year by 2022	
Strategies	
Increase infant safe sleep practices as reported by the PRAMS survey (on back, no co-sleeping, no soft bedding).	
ESMs	**Status**
ESM 5.1 - Promote the complete Infant Safe Sleep Environment (no co-sleeping, on back, and no soft bedding)	Active
NOMs	
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 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

State Action Plan Table (New Jersey) - Perinatal/Infant Health - Entry 2

Priority Need

Improving Nutrition & Physical Activity.

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

Increase births in Baby Friendly hospitals by 2% per year by 2022.

Strategies

Increase births in Baby Friendly hospitals by promoting certification of hospitals and sharing breastfeeding data (birth certificate data and mPINC).

ESMs	Status
ESM 4.1 - Increase the Percentage of Births in Baby Friendly Hospitals	Active

NOMs

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 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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 State Priority Need (SPN) of Reducing Black Infant Mortality and selected the related NPMs 4 (Breastfeeding) and 5 (Infant Safe Sleep) as a result of the Five-Year Needs Assessment process. NJ has implemented several evidence-based strategies related to NPM 4 & 5 which in turn will impact on several NOMs (1, 2, 3, 4, 5, 6, 8, 9, 9.5). Evidence-based strategies related to NPM 4 & 5 are listed in the Logic Model.

3.E.2.c.2.a - Annual Report - NPM 4:
4A) Percent of infants who are ever breastfed and
4B) 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. 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.

WIC's 2019 Strategic Plan includes facilitating the creation of the New Jersey Breastfeeding Strategic Plan (NJBSP) with the NJ Breastfeeding Coalition (NJBC). The final report was scheduled to be released 2020 but due to the pandemic the plan had to be redrafted to include breastfeeding in COVID-19. NJBSP with recommendations of short- and long-term goals, objectives and strategies will be released in 2021 for review.

According to the Centers for Disease Control and Prevention (CDC) 2020 National Immunization Survey Breastfeeding Rate Report Card, New Jersey rates stayed about the same for newborns ever breastfed at 88.8% in 2016 and 88.7% in 2017 (NPM 4A), Breastfeeding rates increased in four categories from 2016 to 2017: exclusive breastfeeding at 3 months increased from 43.7% to 46.9%; breastfeeding at 6 months increased from 60.2% to 63.5%; exclusive breastfeeding at 6 months increased from 22.8% to 27.7% (NPM 4b); and breastfeeding at 12 months increased from 38% to 38.6%.

Table NPM #4	Born in 2010	Born in 2011	Born in 2012	Born in 2013	Born in 2014	Born in 2015	Born in 2016	Born in 2017
Percent of infants who ever breastfed	77.1	81.6	82.0	82.0	83.9	82.8	88.8	88.7
Percent of infants breastfed exclusively through 6 months	13.0	22.3	16.7	23.1	24.8	24.4	22.8	27.7

Notes - Source – the CDC's National Immunization Survey.
http://www.cdc.gov/breastfeeding/data/NIS_data/

FHS has supported Baby-Friendly™ designation through training, technical assistance and mini-grants. The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by the World Health Organization and the United Nations Children's Fund to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. BFHI recognizes and awards birthing facilities who successfully implement the Ten Steps to Successful Breastfeeding (i) and follow the International Code of Marketing of Breast-milk Substitutes (ii). Fourteen NJ hospitals have earned the "Baby-Friendly" designation. Two "Baby-Friendly" hospitals were added in NJ in 2019.

NJ hospitals participate in the Maternity Practices in Infant Nutrition and Care (mPINC) survey, which is a national survey of maternity care practices and policies conducted by the CDC every two years, beginning in 2007. In 2018, 42 of 50 (84%) eligible hospitals participated in the mPINC Survey and the total score was 80 (above the national score of 79). NJ tied with two other states, ranking 18 out of 53 in 2018. The 2020 mPINC survey results have been collected and state reports will be released by the CDC when the data is finalized.

Breastfeeding rates on discharge (alone or in combination with supplemental formula) varied with the racial and ethnic composition of mothers. In 2019 Asian non-Hispanic women were most likely to breastfeed (76.4%) while black non-Hispanic women were least likely to breastfeed (67.1%). White non-Hispanic and Hispanic women initiated breastfeeding at 75.0% and 78.6% respectively.

The exclusive rates for 2019 were 41.9% for white non-Hispanic women, 29.8% for Asian non-Hispanic women, 25.1% for Hispanic women, and 24.4% for Black non-Hispanic women. These statistics underscore the importance of comprehensively evaluating and addressing

healthcare delivery, access, culturally appropriate support and community involvement to combat disparities.

Further examination of the disparity in these rates will require State leadership in enforcement of hospital regulations regarding breastfeeding and in providing support for information of locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services

WIC Services provide breastfeeding promotion and support services for WIC participants through grants to all 16 local WIC agencies. International Board Certified Lactation Consultants 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 Peer Counseling Breastfeeding Program. WIC breastfeeding staff conducts professional outreach in their communities and education to healthcare providers who serve WIC participants.

Existing FHS programs that promote breastfeeding and include performance measures for increasing breastfeeding include the Healthy Women, Healthy Families (HWHF) Initiative and the MIEC Home Visiting Program. The newly designed Healthy Women Healthy Families Initiative will include as one of its outcomes increasing exclusive breastfeeding. Additionally, in an effort to address the racial/ethnic disparity in breastfeeding rates, one of the interventions/strategies that will be a requirement in targeted municipalities include breastfeeding support groups for Black, non-Hispanic, women.

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.

Throughout 2019 and early 2020, the New Jersey Breastfeeding Strategic Plan Steering Committee, consisting of NJDOH and Title V staff, with representatives from the New Jersey Breastfeeding Coalition and the Central Jersey Family Health Consortium met monthly to provide guidance and monitor the progress of the development of a statewide strategic breastfeeding plan. This project included completion of a statewide environmental scan of literature, laws, policies, data, trends, disparities and practices in the state that support or create barriers to breastfeeding initiation, duration, and exclusivity, especially with regard to WIC and SNAP participants. The project also included development and dissemination of surveys to pediatricians, obstetricians, family practice physicians, midwives, perinatal nurses, lactation consultants, childbirth educators, staff of Healthy Women Healthy Families, and analysis of the resulting data. Eight consumer focus groups were organized and facilitated in Atlantic City, Camden, Newark, New Brunswick, Phillipsburg, Trenton, Union City and Vineland to explore factors that support, influence or discourage breastfeeding among NJ families, especially persons of color and marginalized groups, including the WIC and SNAP populations. A diverse stakeholder group was created that included over seventy traditional and non-traditional partners in government, business, insurance, education, community organizations, and healthcare and across agencies and departments that met periodically to recommend policy environmental and system changes. Interviews of key informants and state experts was undertaken. Utilization of the data created by the above activities to inform a needs assessment and SWOT analysis of strengths, weaknesses, opportunities and threats regarding breastfeeding/lactation in the state. Recommendation of short and long term goals, objectives and strategies to accomplish the NJBSP mission. The final report was submitted in April 2020 for review by DOH. A section on COVID-19 and breastfeeding was then added and submitted to the DOH in August 2020. The DOH plans to formally release the NJBSP in August 2021 for National Breastfeeding Month.

In January 2017, the State finalized new Hospital Licensing Standards that require hospitals to develop and implement evidence-based written policies and procedures for obstetrics, perinatal and postpartum patient services, newborn care, the normal newborn nursery, and emergency departments that address breastfeeding and supporting the needs of a breastfeeding mother and child from the point of entry into the facility through discharge. These Standards support the Ten Steps to Successful Breastfeeding and need strong enforcement.

The NJDOH will call attention to NJ's 23.3% rate for hospitals supplementing breastfed infants with formula before two days of life; this is above the national average of 19.2% (with a Healthy People 2020 Target of 14.2%) and ranks NJ 46 out of 52 states (CDC's Breastfeeding Report Card, 2020). In 2018 NJ was ranked 3rd worst out of 54 states. The Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding (PC-05a) was retired in recognition of the decision some women make to not exclusively breastfeed despite recommendations. PC-05 continues as an accountability measure that is publicly reported on The Joint Commission's Quality Check® website.

ESM 4.1 (Increase the Percentage of Births in Baby Friendly Hospitals) was selected for its positive impact on NPM #4 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.

Annual Report NPM #5 (infant safe sleep)

Promoting infant safe sleep was selected as NPM #5 during the Five-Year Needs Assessment process for its importance in reducing often preventable infant deaths and its potential impact on improving NPMs 1, 2, 3, 4, 5, and 6. Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUID includes Sudden Infant Death Syndrome (SIDS), accidental suffocation and strangulation in bed and ill-defined and unknown causes. Due to 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, which has been called of the seven leading research findings in pediatrics in the last 40 years (Goldstein & Ostfeld, Pediatrics, 2017). Although, by definition, SIDS and ill-defined and unknown causes refer to deaths whose etiology has not been identified, the conditions that elevate risk are known. In 2011 and 2016, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Additional recommendations include breastfeeding and avoidance of overheating and of smoke exposure during pregnancy and after birth. These expanded, 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 that of the SIDS Center of New Jersey whose research contributed to the safe sleep policies of the AAP.

The selection of ESM 5.1 (Promote Infant Safe Sleep Environments) monitors and focuses attention on the complete safe sleep environment (Healthy Sleep) including back to sleep, no co-sleeping, and no soft bedding. Over a 10-year period there has been an upward trend in the use of back to sleep placement.

Table NPM #5

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Percent of infants placed to sleep on their backs	65.7	67.4	68.9	70.1	69.5	70.8	70.5	69.4	75	73.4*	73.0*

*In 2017 the percent of infants placed on their backs surpassed the Health People 2020 NJ target of 74.1. The percentages for 2018 and 2019 fall within the standard error of measurement for 2017 and thus are comparable to 2017.

Notes - Source – NJ PRAMS.

https://www26.state.nj.us/doh-shad/query/selection/prams/PRAMSSelection.html

To promote infant safe sleep (NPM #5), NJDOH has supported the evidence-based strategies of the American Academy of Pediatrics, the NICHD's Safe to Sleep Campaign, the activities of the SIDS Center of New Jersey https://www.facebook.com/SID CenterNJ/, and www.rwjms.rutgers.edu/sids, and the work of the Sudden Unexpected Infant Death Case Review Workgroup. To improve the surveillance of infant safe sleep practices, Family Health Services conducts the PRAMS survey which includes questions on infant safe sleep and participates on the SUID-CR Workgroup.

The SIDS Center of New Jersey (SCNJ) is a program funded by a NJDOH health services grant to Robert Wood Johnson Medical School (RWJMS), a part of Rutgers, The State University of New Jersey, New Brunswick and is based both at RWJMS and the Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center, Hackensack. SCNJ was established in 1988 through the SIDS Assistance Act. The SCNJ missions are to: 1) provide public health education to reduce the risk of sudden infant death, 2) offer emotional support to bereaved families, and 3) participate in efforts to learn about possible causes of and risk factors associated with sudden unexpected infant deaths, and best practices for providing safe sleep education. Research by SCNJ faculty has contributed to the identification of risk factors and risk-reducing strategies.

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, schools, social service agencies, home visiting programs, doulas, and faith-based communities. It works with state, federal and national organizations to reduce infant mortality, the racial and ethnic disparities associated with SUID and the adverse antecedent social and health determinants that increase the vulnerability of infants to unsafe sleep environments. These factors include smoke exposure, preterm birth, the absence of breastfeeding, poverty, lifespan health, and implicit bias. The SCNJ's Infant's Bill of Rights supports collaboration among the many public health programs that address these issues and the shared goal of reducing infant mortality. SCNJ follows the guidelines of the AAP when providing risk reduction education. The Safe Infant Sleep guidelines of the AAP are intended to help families reduce the situational risks that are associated with Sudden Unexpected Infant Deaths. Research conducted by the SCNJ contributed to these recommendations and informs its safe sleep education programs. With the goal of changing behavior as well as knowledge, the SCNJ also evaluates educational methodologies and barriers to compliance and develops interventions designed to be respectful of generational, cultural and community concerns. NJ rates of SUID are

among the lowest in the US. In 2018, New Jersey's SUID rate was 0.5 per 1000 live births, in contrast to the national rate of 0.9 and was third lowest among states. (CDC WONDER linked birth/infant death file). Provisional New Jersey data for 2019 is on track to be similar.

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. NJDOH 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 Department of Children and Families 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, The SIDS Center of New Jersey developed a unique and free app, SIDS Info, for ioS and android devices, with the goal of enhancing the education of parents and providers about safe infant sleep and enabling parents and others to have direct access to this information. This novel and interactive tool contains graphics, English and Spanish text and voiceovers to eliminate language and literacy challenges, and a menu of additional resources. It gives nurses, physicians, childcare specialists, case workers and other providers a new way of reviewing the information with parents. Providers also help families download the app to their phone, ubiquitous in all population groups, to serve as an enduring resource for a generation of parents familiar with accessing information in this manner. The app can reduce the need for print material, can be automatically updated, and is more accessible and enduring than flyers. It can be shared remotely with others caring for an infant. Under a "Keep It Up!" strategy, pediatricians also are encouraged to review the app with families at well-baby visits to compensate for a decline in compliance over time. Rural communities and others with limited access to health resources, and parents concerned about visiting health care providers during the COVID-19 pandemic, are able to access this tool directly. SIDS Info, which received a Public Health innovation Award from the NJDOH, has been accepted as a resource by the NICHD Safe to Sleep Campaign® and as an Emerging Practice in the Innovation Hub of the Association of Maternal and Child Health Programs. In 2019, faculty of the SCNJ announced release of a second app, Baby Be Well®, developed in a collaboration of Rutgers University and volunteers of Microsoft. It is intended to extend interest in accessing the information throughout the first year, through multiple design strategies, providing an additional resource to compensate for reductions in compliance over time. These tools are now widely used in NJ and other states. Other educational strategies used by the SCNJ include webinars in English and Spanish specific to provider groups, grandparent education through faith-based community programs, hospital-based staff education through its "Nurses LEAD the Way!" initiative and tool kit, a high-school education program with established efficacy to create trusted student ambassadors who inform their community, and participation in the community-based outreach programs of Nurture NJ. To make its flyers, other resources and live and on-demand webinars directly accessible to the public, the SCNJ posts them on its social media platform: https://www.facebook.com/SIDSCenterNJ/ and its website: www.rwjms.rutgers.edu/sids.

Through the multiple evidence-based strategies in NJ to promote infant safe sleep and the consistent message to place infants to sleep on their backs, according to NJ PRAMS, NPM #5 has been slowly improving from 60.6% in 2004 to 75% in 2017 which exceeded the NJ Healthy People 2020 goal of 74.1%. At 73%, the data for 2019 falls within the standard error of measurement of 2017 and thus is comparable to the previous year, The NJ SUID rate has also declined from 1.13 per 1000 live births in 1990-1992 to 0.5 per 1000 live births in 2018, according to NJSHAD and NCHS. The NJ SUID rate falls well below the national rate of 0.9 and is among the lowest in the US. Racial and ethnic disparities in NPM 5 persist throughout the US and are being addressed through more targeted educational messages using home visitor staff in DCF and the MIEC Home Visiting Program. The SCNJ provides safe sleep education to these programs and also addresses racial disparity in the application of safe sleep practices and in the adverse antecedent social and health risk factors that affect SUID.

Annual Report – SPM #1 (*The percentage of Black non-Hispanic preterm births in NJ)*

The selection of SPM #1 (The percentage of Black non-Hispanic preterm births in NJ) during the Five-Year Needs Assessment process recognizes the persistence of racial/ethnic disparities in healthy birth outcomes in NJ. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Annual Indicator	14.0	13.2	13.0	12.7	12.8	13.3	13.3	13.6	13.1	13.5	13.8
Numerator	2,298	2,105	2,021	1,986	1,930	1,983	1,879	1,852	1,774	1,835	1,803
Denominator	16,402	15,945	15,586	15,692	15,064	14,864	14,169	13,634	13,530	13,643	13,043

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

See Chart 5 Low Birthweight by Race/Ethnicity attached as Supporting Document #3.

Maternal and Child Health Services has a long history of efforts to combat persistent perinatal health disparities. Despite years of improving pregnancy outcomes programs and appointments of task forces dedicated to addressing disparities in healthcare, these disparities continue.

First Lady Tammy Murphy has made reducing black infant mortality a top priority, committing to improving the well-being of women and infants. The First Lady has traversed the state over the past three years meeting with stakeholders to better understand the depth of the crisis, and to raise awareness that New Jersey's black infants are three times more likely than white infants to die before their first birthday. The First Lady launched Nurture NJ, a multi-pronged, multi-agency campaign focused on reducing maternal and infant mortality and morbidity and ensuring equitable maternal and infant care among women and children of all races and ethnicities. The Nurture NJ campaign is dedicated to ensuring equitable maternal and infant care among women and children of all races and ethnicities. This past January 2021, the Nurture NJ 2021 Strategic Plan was unveiled with a goal of reducing New Jersey's maternal mortality by 50% over the next five years and eliminate racial disparities in birth outcomes. This strategic plan supports the First Lady's platform to make New Jersey "the safest and most equitable place in the nation to deliver and raise a baby".

Through the Healthy Women Healthy Families (HWHF) Initiative, implemented in July 2018, efforts continue to be targeted to reduce the Black Infant Mortality (BIM) Rate in New Jersey. Specific BIM reducing activities including Centering Pregnancy and Centering Parenting programs, Doula, breastfeeding support and Fatherhood initiatives are being implemented in the cities with the highest BIM rates in NJ. Centering groups faced an initial pause due to in-person restrictions, but within a few months many groups were able to resume using a virtual platform. After pandemic restrictions were modified, in-person groups also resumed following certain guidelines. The Doula Pilot Program was a three year state-wide program that ended June 2021, which included the three community-based grantees working in 12 regions. Additionally through this program, doula care proves to reduce black infant mortality in 8 municipalities (Atlantic City, Camden, East Orange, Irvington, Jersey City, Newark, Paterson, and Trenton). The bridge funding will provide support to the community doulas trained through the Doula Pilot Programs as they transition and enroll in NJ FamilyCare Medicaid fee-for-service and the Manage Care Organization's process to become Medicaid providers. A RFA was issued for the creation of a Doula Learning Collaborative (DLC), which was awarded to Health Connect One. The focus of the DLC is to reduce maternal and infant mortality and eliminate racial disparities in health outcomes by providing training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to grow the community doula workforce. Community Health Workers and supervisors are receiving breastfeeding education through an initiative by the NJDOH. The" Breastfeeding in Color" training focuses on women of color and was developed to address issues of disparities, focusing on reproductive justice and addressing inequities in human lactation. Fatherhood success continues with a total of 207 fathers graduating from the program since inception three years ago, with alumni still staying involved.

The Colette Lamothe-Galette (CLG) Community Health Worker Institute was established through a NJ Department of Labor Apprenticeship program to create a standardized community health worker training and certification program, resulting in a robust CHW workforce. This has allowed the state to educate an emerging and critical component of its workforce – creating a needed infrastructure to support CHWs and 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.

In collaboration with the CLG-CHW Institute, the Epidemiology Laboratory and Capacity (ELC) grant emphasizes the prevention of disease and enhanced detection for COVID19. The ELC focused on hiring and training CHWs to assist in contact tracing efforts; assisting with the surveillance of vulnerable populations; implementing prevention strategies with vulnerable, diverse populations; and providing alternative testing and vaccine sites for COVID-19. The COVID Community Corps and Vaccine Ambassador Programs also support these efforts.

Efforts for safe sleep education and practices continue through the SIDS Center of NJ and Rutgers State University involving a) outreach and education, and b) providing linkages that will address some of the social determinants that literature and research as well as focus groups conducted by FHS have identified as contributors to mortality. Intentional focus continues on municipalities that were identified as having the highest Black Infant Mortality Rates as well as high proportion of Black, NH women in need of these services.

Perinatal/Infant Health - Application Year

Plan for the Application Year - NPM 4:
A) Percent of infants who are ever breastfed and
B) Percent of infants breastfed exclusively through 6 months

Efforts to promote Baby Friendly Hospital Initiative (BFHI) designation through training, technical assistance, and mini-grants will continue to promote NPM 4A & B. The 14th NJ hospital to earn the “Baby-Friendly” designation was JFK University Medical Center in July 2019. Surveillance through the Birth Certificate file and the mPINC survey will continue to identify areas of potential improvement.

The selection of ESM 4.1 (Increase Births in Baby Friendly Hospitals) will monitor progress on promoting breastfeeding policies and practices in hospitals which should lead to an increase in NPM #4 (Breastfeeding). Many hospitals employ International Board Certified Lactation Consultants who provide early support and information to breastfeeding mothers, however it requires a commitment from the entire organization to implement breastfeeding supportive policies and practices.

WIC’s 2019 Strategic Plan includes facilitating the creation of the New Jersey Breastfeeding Strategic Plan (NJBSP) with the NJ Breastfeeding Coalition (NJBC). The final report was scheduled to be released 2020 but due to the pandemic the plan had to be redrafted to include breastfeeding in COVID-19. NJBSP with recommendations of short- and long-term goals, objectives and strategies will be released in 2021 for review.

WIC will continue to provide breastfeeding promotion and support services to pregnant and breastfeeding women who participate in the Program.

Existing FHS programs that promote breastfeeding and include performance measures for increasing breastfeeding include the HWHF Initiative and the MIEC Home Visiting Program which now serve all 21 counties and target high-need communities. With the new HWHF initiative and its focus on addressing BIM rates, programs to support breastfeeding among Black non-Hispanic women will be made available in targeted municipalities. A Breastfeeding indicator, increase over time in the proportion of mothers who breastfeed their 6-week-old infants, is included in the MIECHV and Healthy Start performance benchmarks.

Healthy Women Healthy Families breastfeeding program seeks to decreases black infant mortality rates. This initiative consists of education of breastfeeding to birthing/new parents and assistance/supports to increase breastfeeding success. The goal of the initiative is to increase the rates of breastfeeding 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. Community Health Workers (CHWs) are key stakeholders in educating birthing and new parents on breastfeeding.

NJDOH has implemented a breastfeeding training in partnership with the Perinatal Foundation to educate CHWs on the history of breastfeeding and how various groups have been affected. 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 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 Black Breastfeeding Experience, Global Health, Influence of Formula, Lactation Landscape and Feeding Choice.

Plan for the Application Year - NPM 5: (Percent of infants placed to sleep on their backs)

Plans for the coming year to promote safe infant sleep include continued safe sleep education through the SIDS Center of NJ (SCNJ), MIEC Home Visiting Program and the Sudden Unexpected Infant Death Case Review Workgroup which includes representation by the SCNJ. Staff from the MIEC Home Visiting Program have all been trained by the SCNJ and will promote the infant safe sleep message during their visits to over 7,000 families annually in NJ. The SCNJ will continue to identify and address community-level risk factors and barriers to compliance and present a range of current and new education programs and interventions that address provider knowledge of safe sleep practices, education skills, an understanding of the impact of adverse social and health determinants and implicit bias in elevating the risk of SUID and of racial disparity in these and other causes of infant mortality, and an understanding of how to identify and address barriers that prevent well-established knowledge of safe sleep from translating into practice. When addressing the adverse social and health risk factors of smoking, absence of breastfeeding, or preterm birth, the SCNJ works closely with relevant public health, social

service and healthcare systems and programs such as the NJ Perinatal Quality Collaborative Health Disparities Work Group to develop additional strategies. The SCNJ also will continue to develop methods for direct public education such as through the free apps and social media platform. The SCNJ's educational tools, including the free safe sleep mobile phone apps, on-demand and live webinars, educational material in multiple languages, and baby clothing adorned with safe sleep messaging will continue to be disseminated. The SCNJ also will disseminate the anticipated 2021 updates to the AAP guidelines. The SCNJ also identifies risks 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 week of life, and creates programs to highlight and address these. SCNJ programs are directed to intuitions (i.e., schools, hospitals, clinics, public health programs, including the NJDCF Division of Child Protection and Permanency), organizations (i.e., WIC, HWHF grantees, AAP-NJ, Maternal and Child Health Consortia), providers (i.e., pediatricians, obstetricians, nurses, social service providers, home visitors, clergy, community workers, doulas, first responders), and the public (i.e., baby fairs, Nurture NJ programs).

The SIDS Center of New Jersey (SCNJ) educates hospital nurses, who play an important role in modeling and teaching about safe sleep, by providing its on-site program, Nurses LEAD the Way, by presenting at regional nursing conferences, and by communicating through other venues such as listservs, live and on-demand webinars and e-blasts. In addition to providing education, the SCNJ makes available educational scripts, hospital safe sleep audit protocols, approaches to identifying and addressing potential barriers to compliance, and educational materials in electronic and hard copy, using content developed by SCNJ and translated into English, Spanish, Haitian-Creole, Farsi, Arabic and Portuguese. The free safe sleep apps provide an additional resource supporting the nurse, physician, and others. Many of the SCNJ resources, including live and on-demand webinars, Frequently Asked Questions, a short video, information about its free safe sleep apps and flyers in multiple language are tools that can be accessed from the SCNJ social media site: https://www.facebook.com/SIDSCenterNJ/ and website: www.rwjms.rutgers.edu/sids

The SCNJ's resources are also disseminated through collaboration with its many partners. These include the New Jersey Chapter of the AAP, the Grand Rounds lecture programs for hospital Departments of Pediatrics and Obstetrics, primary care centers, the New Jersey Hospital Association and the maternal and child health consortia.

In 2018 to make it easier for hospitals to carry out safe sleep education, SCNJ developed a cost-free, educational app, SIDS Info, in English and Spanish. This app provides nurses with an interactive educational tool to help them share the information with families. Graphics and voice-overs in both languages overcome language or literacy barriers. The menu provides nurses with additional tools to support their own knowledge. Provider's help interested families download this free resource to their cell phones for future reference. It is also a tool that the public can download directly, providing a resource to those with limited access to healthcare. Funding for this app was derived from a health services grant from the NJ Department of Health to the SCNJ. In 2019, a second free educational app, Baby Be Well®, was developed by faculty via a collaboration between Rutgers University and volunteers of Microsoft Corporation and designed to stimulate return visits throughout the first year of life to compensate for a decline in the use of safe sleep over time.

Through grant funding from NJDOH, the SCNJ provides public health interventions to birthing hospitals, as part of the Nurses LEAD the Way initiative, to the Division of Child Protection and Permanency and to a wide range of public health, social service, home visiting, community, medical, faith-based, first responder and childcare systems. The SCNJ provides education to both obstetricians and pediatricians who, in turn, raise awareness among their patients. With respect to obstetrician-gynecologists, this information is also shared with older generations. The wide-ranging outreach, available tools, and broad focus on risk reducing behaviors such as safe sleep, smoke avoidance and breastfeeding as well as antecedent social and health determinants, implicit bias, and education strategies contribute to New Jersey's low SUID rate.

There are racial and ethnic disparities in antecedent factors that raise the risk of SIDS as well as of lifespan health issues, and these contribute to disparities in rates. Such factors include disparities in preterm births, access to care, poverty, neighborhood crime, and exposure to second-hand smoke, a major contributing factor rising to the level of causality, and other unsafe environmental conditions. In addition, implicit bias is an independent contributor to disparity, raising stress levels and reducing participation in health care. The SCNJ has long focused on these broader issues that create a more vulnerable infant because safe infant sleep practices alone, though compensatory, do not reliably predict SUID rates across states. The SCNJ has studied population groups with poorer compliance with safe sleep practices but fewer social and health risk factors and found them to have among the lowest rates of SUID. SCNJ activities therefore include participation in the implicit bias initiative of the NJ Perinatal Quality Collaborative Committee on Racial Disparities, Nurture NJ, and Family Festivals held in high-risk communities as well as education programs for home visitors, doulas and community health workers in underserved communities. In higher risk communities, a high-school student ambassador for safe sleep program was found effective, thus supporting future plans for broader adoption. In higher risk communities, parent education will be accompanied by baby clothing adorned

with safe sleep guidance. The SCNJ also released an Infant's Bill of Rights to serve as a framework by which to work toward addressing the risk factors beyond safe sleep that contribute to SUID and to disparity in rates.

Plan for the Application Year SPM 1: (*The percentage of Black non-Hispanic preterm births in NJ)*

The Nurture NJ 2021 Strategic Plan will continue to set the standard for the First Lady's mission of reducing New Jersey's maternal mortality by 50% over the next five years and eliminate racial disparities in birth outcomes, supporting the First Lady's platform to make New Jersey "the safest and most equitable place in the nation to deliver and raise a baby". In collaboration with the Maternal Health Innovation (MHI) team and NJ Maternal Quality Care Collaborative (NJMCQC) MCH continues to prioritize this goal to improve outcomes for women and infants. The Department's focus on improving women's and maternal health through the development and implementation of a maternal mortality and morbidity strategic plan will have a positive impact on reducing black maternal mortality and black non-Hispanic preterm births.

The Healthy Women Healthy Families (HWHF) Initiative will continue to develop partnerships with community-based maternal and child health 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. Support for Black Infant Mortality (BIM) reduction programs in targeted BIM regions will continue to evolve. Support programs for breastfeeding and fathers will continue to be developed and evaluated. The Doula Bridge funding will provide support to the community doulas trained through the Doula Pilot Programs as they transition and enroll in NJ FamilyCare Medicaid fee-for-service and the Manage Care Organization's process to become Medicaid providers. The newly initiated Doula Learning Collaborative (DLC) goal is to reduce maternal and infant mortality and eliminate racial disparities in health outcomes by providing training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ. Centering programs continue with both in-person and virtual groups and will focus on sustainability of the programs. The Burke Foundation has also launched an initiative of expanding centering pregnancy and parenting in NJ over the next 5 years, awarding funding for 5 sites each for implementation and training through the evidenced -based program of the Centering Healthcare Institute (CHI).

The goal of the HWHF Initiative continues to be to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes through a collaborative coordinated community-driven approach. County-based consumer-driven advisory boards will continue to contribute to the direction and progress of the HWHF initiative and the Central Intake Hubs will meet quarterly to build partnerships and local referral systems. Rebranding of Central Intake is currently in progress to find a more appealing and trusted name that welcomes participants for referrals and services.

The CLG-CHW Training Institute will continue to enhance the professional development of CHWs and allow for a stronger workforce. The CLG-CHWI continues to expand its programs through state funding and now will include apprenticeships for perinatal CHWs, an initiative which will assist in improving maternal child health outcomes and Certified Nurse Assistants (CNAs). The ELC will continue to collaborate with the CLG-CHW Training Institute, focusing on the prevention of disease and enhanced detection for COVID19, focusing on vulnerable populations.

Safe sleep education will continue thru the SIDS Center of NJ, continuing with initiatives to address disparities and the social determinants of health.

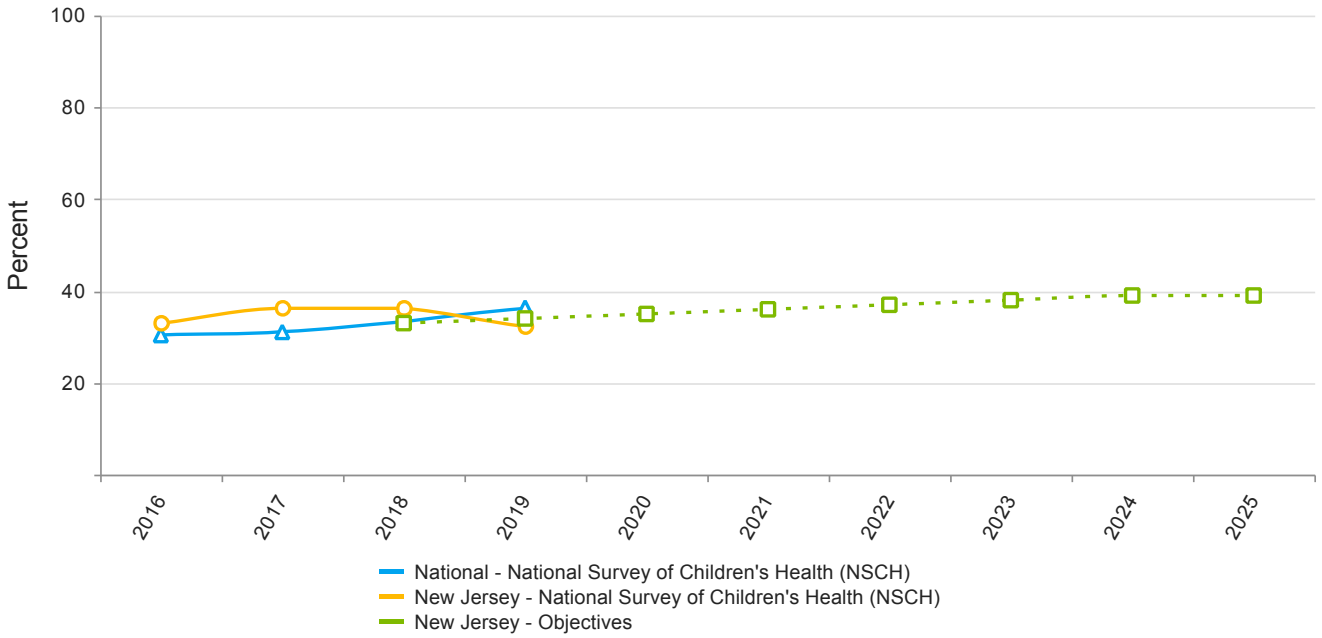
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	11.4 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	13.3 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	93.2 %	NPM 6 NPM 8.1 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	14.0 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	14.9 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	11.9 %	NPM 8.1

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			33	34	35
Annual Indicator		32.9	36.3	36.1	32.2
Numerator		65,432	77,344	68,548	50,931
Denominator		198,930	213,230	189,731	157,934
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

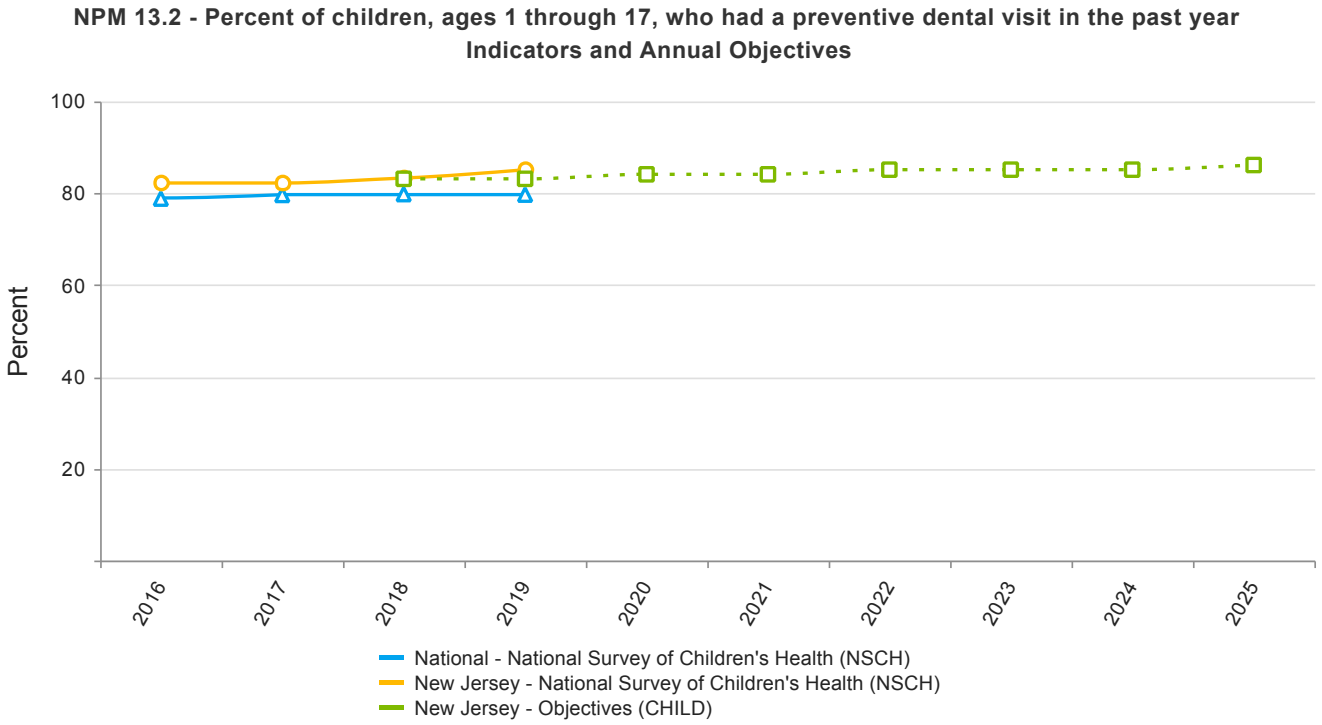
Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	36.0	37.0	38.0	39.0	39.0	39.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Promote parent-completed early childhood developmental screening using an online ASQ screening tool.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		200	300	600	2,000
Annual Indicator	200	200	200	241	914
Numerator					
Denominator					
Data Source	DCF ECCS Impact Program	DCF ECCS Impact Program	DCF ECCS Impact Program	DCF ECCS Impact Program	DCF ECCS Impact Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	3,000.0	4,000.0	5,000.0	5,000.0	5,000.0	5,000.0



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			83	83	84
Annual Indicator		82.1	82.0	83.2	84.9
Numerator		1,534,885	1,510,657	1,530,393	1,594,112
Denominator		1,868,922	1,842,384	1,839,454	1,877,182
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	84.0	85.0	85.0	85.0	86.0	86.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416)

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		50	51	53	54
Annual Indicator	49.5	50.9	52.3	50.5	41.5
Numerator	404,579	407,596	419,284	429,996	345,790
Denominator	816,685	801,375	801,940	852,219	833,312
Data Source	CMS-416 form from DHS	CMS-416 form from DHS	CMS-416 form from DHS	CMS-416 form from DHS	CMS-416 form from DHS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	55.0	56.0	57.0	58.0	59.0	59.0

State Performance Measures

SPM 2 - The percentage of children (≤6 years of age) with elevated blood lead levels (≥10 ug/dL).

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		0.5	0.5	0.5	0.5
Annual Indicator	0.5	0.5	0.5	0.4	0.5
Numerator	889	882	882	757	660
Denominator	174,114	172,217	172,217	174,734	144,753
Data Source	Childhood Lead Information database, MCHS, FHS	Childhood Lead Information database, MCHS, FHS	Childhood Lead Information database	Childhood Lead Information Database	Childhood Lead Information Database
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.4	0.4	0.4	0.4	0.4	0.4

State Action Plan Table

State Action Plan Table (New Jersey) - Child Health - Entry 1	
Priority Need	
Promoting Youth Development Programs.	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
Increase developmental screening among children, ages 9 - 3 months, by 2 percentage points per year by 2022.	
Strategies	
Increase completed ASQ developmental screens online as part of ECCS Impact Program.	
ESMs	**Status**
ESM 6.1 - Promote parent-completed early childhood developmental screening using an online ASQ screening tool.	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

State Action Plan Table (New Jersey) - Child Health - Entry 2

Priority Need

Promoting Youth Development Programs.

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

Increase the percentage of children, ages 1 - 17, who had a preventive dental visit in the past year by 2% by 2022.

Strategies

Increase awareness of the importance of early preventive dental care and increase referrals to dentists

ESMs	Status
ESM 13.2.1 - Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416)	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New Jersey) - Child Health - Entry 3

Priority Need

Promoting Youth Development Programs.

SPM

SPM 2 - The percentage of children (≤6 years of age) with elevated blood lead levels (≥10 ug/dL).

Objectives

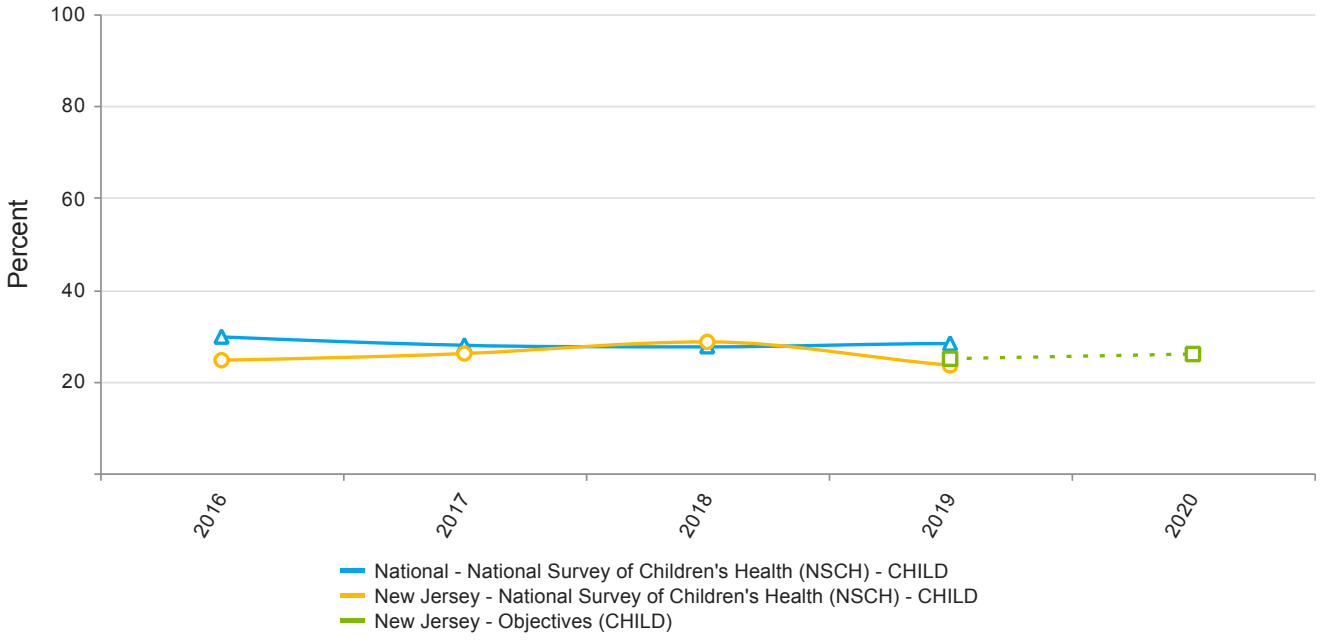
Decrease the number of elevated blood lead level screening tests (>=10ug/dL) by 4% by 2022.

Strategies

The percentage of children that have had at least one test by 26 months of age.

2016-2020: National Performance Measures

2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2017	**2018**	**2019**	**2020**
Annual Objective			25	26
Annual Indicator	24.7	26.1	28.6	23.4
Numerator	145,670	169,894	195,766	150,823
Denominator	589,709	651,892	684,924	644,939
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2016	2016_2017	2017_2018	2018_2019

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 8.1.1 - Number of schools participating in an activity (training, professional development, policy development, technical assistance) to improve physical activity among children (6-17).

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			140	145
Annual Indicator			6	
Numerator				
Denominator				
Data Source			Needs data source (DOE)	
Data Source Year			2019	
Provisional or Final ?			Provisional	

The domain of Child Health includes the State Priority Needs of #3 Improving Nutrition and Physical Activity and the selected National Performance Measures of #6 Developmental Screening. NPMs #6 was selected during the Five-Year Needs Assessment process for their impact on overall child health and wellness and for the evidence-based strategies implemented by NJDOH and its partnerships.

Child Health – Annual Report

Annual Report - NPM #6: *(*Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)

Increasing NPM #6 is an important focus in the domain of Child Health 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 percent 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.

	2007	2011-2012	2016	2017-2018	2018-2019	2019
6: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	12.67	25.02	32.9	36.1	36.4	37.7

Source – National Survey of Children's Health (NSCH) https://www.childhealthdata.org/browse/survey

Developmental screening is a required benchmark performance measure for the NJ MIEC Home Visiting Program and improving developmental screening practices and policies is a current focus on HV evaluation and continuous quality improvement. The NJ MIEC Home Visiting Program promotes and monitors parent completed child development screening tools (ASQ and ASQ: SE). In SFY 2020 6303 families with young children participated across all 21 NJ counties. 6272 Developmental screenings were completed through NJ MIEC Home Visiting programs.

The NJDOH is an active interdepartmental partner with the NJ Council for Young Children (NJCYC), the Preschool Development Grant: Birth to five (PDG B-5)and CDC's NJ "Learn the Signs. Act Early." (LTSAE) Ambassador.. The NJCYC, Infant Child Health Committee has established a priority of improving system connections for children and families with health care providers, community services, early intervention, child care, home visiting to expand screening (prenatal & child development) in health care and early care & education settings. Through the NJ ECCS CoIIN work improvements on early childhood systems continued with a focus on creating universal access to evidence- based developmental screening through the early childhood central Intake system (Help Me Grow Central Access point) that supports linkages and access to programs and services for families within their community. NJ's LTSAE Ambassador and the LTSAE COVID Response Project activities focus on promoting parent-engaged developmental monitoring and screening, and referral and connection to services through trainings, presentations, and materials distribution across the state. As the State Parent Lead for the ECCS Impact CoIIN and MIEC Home Visiting programs, the LTSAE Ambassador also supports the teams with accessing LTSAE materials and with family-engagement activities. NJ's Child Developmental Passport, created in collaboration between the LTSAE Ambassador and the ECCS CoIIN team (available in English & Spanish) includes a developmental tracker to empowers parents to track their child's developmental screening information. In addition, the CDC's Milestone Tracker App is embedded in the NJ WIC Shopper App to support monitoring of children receiving WIC 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 with the expectation that 90% of high needs infants and children participating in GNJK will receive developmental screening with an emphasis on using the parent

completed child monitoring system Ages and Stages Questionnaires (ASQ and ASQ: SE) screening tools.

Additionally, SPAN is collaborating with the NJ Chapter of the American Academy of Pediatrics on the Early Identification and Referral for Autism (EIRA) ECHO project to provide education to pediatric practices on the early identification, referral and care coordination of children with ASD. SPAN is also collaborating on a project with the NJ site for the Autism & Developmental Disabilities Monitoring (ADDM) Network to promote awareness about the importance of parent-engaged developmental monitoring and the early identification of ASD using a validated screening tool in the Newark area,

NJ is part of a national Project LAUNCH initiative funded by HRSA that is designed to promote the wellness of young children ages birth to 8 and to reduce racial and ethnic disparities including an emphasis on routine developmental screening. NJ Project LAUNCH is targeting urban Essex County and is using a Help Me Grow systems approach to strengthen the connections between physicians, parents/families, and community providers to addresses the physical, social, emotional, cognitive, and behavioral aspects of child development. Project LAUNCH ensures that parents/families have access to a continuum of community-based evidence-based programs (EBP) that support parent-child interaction and young child development across a range of settings—health care, home visiting, child care, Early Head Start/Head Start, preschool/school to promote early identification of health and developmental issues that impact child wellness. In FY18, the NJ Project Launch grant ended, however many of the activities to the NJ Project Launch Essex County team aligned with Central Intake, the Help Me Grow System and ECCS Impact continued, which include the reach and linkage of families with young children to services and programs that support family and child well-being; inclusive of developmental health promotion and screening.

The selected ESM 6.1 will monitor progress on increasing the use of parent-completed early childhood developmental screening using an online ASQ screening tool and 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 #6 (Developmental Screening). NJ DCF implements the ECCS Impact grant in 5 communities to promote parent-completed early childhood developmental screenings in children less than 3 years old. ASQ Enterprise software (Brookes Publishing) is being utilized to add a parent/family portal for easy access to developmental screening and links screening to Central Intake hubs. NJ's expanded data system will link developmental screenings with current Central Intake assessments to enhance engagement of families not connected to early childhood services/programs that could potentially be engaged and linked for additional services and supports as identified, including developmental needs as determined by the completed ASQ and in partnership with the parent regarding their child's developmental milestones. Families will be supported in linking with pediatric primary care and/or other systems partners that include at a minimum Home Visiting; and may extend to quality Child Care, Early Head Start/Head Start, and Preschool programs. In FY18, the Project Launch/ECCS Team for Essex County (EPPC) begin a pilot in testing the implementation of the ASQ Family Access online portal within their Central Intake system. They developed, implemented and tested policies and procedures on the use and experience of the Family Access Portal by parents, as well as outreach and engagement strategies. EPPC was able to provide no cost development screening to 32 children/families, they provide appropriate follow-up and linkage, as well as education to parents on monitoring their child's developmental milestones and activities parents can do to support their child's developmental progress. EPPC led the way to the infusion of the ASQ Family Access Portal with the statewide Central Intake System, which led to the 4 additional ECCS Placed Based Communities (PBC's) to join in the implementation in FY19.

In FY19 Plans for statewide expansion of screening to the additional 16 counties were slated and implementation begin in FY 20 with the expansion of Early Childhood Specialist staffed within all 21 Central Intake hubs. In FY20 EC Specialist received ASQ training, developed and activated the additional 16 ASQ Family Access portals. Outreach begin in the communities through in-person community events and via telephone. Once the Covid-19 pandemic hit all services were remote and/or virtual. Through the pandemic engagement of families continued through social media platforms, virtual events and outreach through existing community partners (eg. WIC, Family Success Centers, etc; In FY20 the CI/EC Specialist network completed (N=1,108) parent led developmental screens through the ASQ Family Access Portal. Age breakdown is as follows:

ASQ- Family Access Portal Screens completed	FY 20 N =1,108
Age of Child	**%**
2-12MO	35%
13-24MO	18%
25-38MO	16%
39-50MO	20%
51-66MO	11%

In FY2020, the 1,029 children (ages 10 – 71 months) receiving an ASQ developmental screening through the ECCS Impact grant through the NJ Home Visiting Program and Central Intake (ASQ Family Access Portal).

SPN #3: Improving Nutrition and Physical Activity

Annual Report: The New Jersey Supplemental Nutrition Assistance Program-Education (NJ SNAP-Ed) in FHS is a federally funded nutrition and physical activity program that aims to improve the likelihood that persons eligible for SNAP will make healthy food and lifestyle choices that prevent obesity. NJ SNAP-Ed provides behavior-focused educational classes for all ages, including specialized workshops to meet the needs of children. The Cooking Matters for Kids curricula, developed by Share Our Strengths, is a 6-lesson series designed for children, 3rd through 5th grades. The classes teach how to prepare healthy meals and snacks and to make healthier choices – whether at school, home, the store, or out to eat. Cooking Matters for Kids (CMK) recorded a total of 2071 total participants reached in five elementary schools prior to March 2020 when COVID19 disrupted lesson delivery for all direct education interventions. The proportion of female students was higher (55%) than males (45%).

Child Health - Application Year

Plan for the Application Year - NPM #6: *(*Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)

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) and CDC's NJ "Learn the Signs. Act Early." (LTSAE)Team. The NJCYC Infant Child Health Committee has established a priority of improving system connections for children and families with health care providers, community services, early intervention, child care, and home visiting to expand screening (prenatal and child development) in health care and early care and education settings. Through the NJ ECCS Impact CoIIN work, improvements on early childhood systems continued with a focus on creating universal access to evidence-based developmental screening through the early childhood central Intake system (Help Me Grow Central Access Point) that supports linkages and access to programs and services for families within their community. NJ's LTSAE Ambassador and the LTSAE COVID Response Project activities focus on promoting parent-engaged developmental monitoring and screening, and referral and connection to services through trainings, presentations, and materials distribution across the state. As the State Parent Lead for the ECCS Impact CoIIN and MIEC Home Visiting programs, the LTSAE Ambassador also supports the teams with accessing LTSAE materials and with family-engagement activities. NJ's Child Developmental Passport, created in collaboration between the LTSAE Ambassador and the ECCS CoIIN team (available in English & Spanish) includes a developmental tracker to empowers parents to track their child's developmental screening information. In addition, the CDC's Milestone Tracker App is embedded in the NJ WIC Shopper App to support monitoring of children receiving WIC services. The Boggs Center on Developmental Disabilities, NJ's federally-designated University Center of Excellence on Developmental Disabilities, and the Statewide Parent Advocacy Network (SPAN), the state's federally-designated Parent Training and Information Center (PTI) and Family to Family Health Information Center (F2F) and the Boggs Center on Developmental Disabilities, NJ's federally-designated University Center of Excellence on Developmental Disabilities collaborated on the Act Early State Systems Grant with the shared goal ofLTSAE COVID Response Project with the goals to:

a) Bolster the 4 steps of early identification of developmental delays and disabilities: 1) Parent-engaged Developmental Monitoring 2) General developmental and autism screening 3) Referral for early intervention services 4) Receipt of early intervention services for children birth to 5

b) Advance the promotion and distribution of existing, relevant tools, materials, and programs to improve resiliency among families with young children during COVID-19 response and mitigation efforts.

Additionally, SPAN is collaborating with the NJ Chapter of the American Academy of Pediatrics on the Early Identification and Referral for Autism (EIRA) ECHO project to provide education to pediatric practices on the early identification, referral and care coordination of children with ASD. SPAN is also collaborating on a project with the NJ site for the Autism & Developmental Disabilities Monitoring (ADDM) Network to promote awareness about the importance of parent-engaged developmental monitoring and the early identification of ASD using a validated screening tool in the Newark area,

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 with the expectation that 90% of high needs infants and children participating in GNJK will receive developmental screening by 2019 with an emphasis on using the parent completed child monitoring system Ages and Stages Questionnaires (ASQ and ASQ: SE) screening tools. Implementation of a parent/family portal for easy access to parent-completed early childhood developmental screenings in children < 3 years old (Ages and Stages Questionnaire) through the ECCS Impact grant will permit monitoring of ESM 6.1 (Promote parent-completed early childhood developmental screening) and promote improvement in NPM #6.

The MIEC Home Visiting Program will continue to promote and monitor parent completed child development screening tools (ASQ and ASQ: SE). In SFY 2020 6,303 families with young children participated across all 21 NJ counties. Developmental screening is a required benchmark performance measure and improving developmental screening practices and policies is a current focus on HV evaluation and continuous quality improvement.

Plans for additional expansion of parent completed child development screening (ASQ and ASQ: SE) to all 21 NJ counties occurred in FY20 with the expansion of Early Childhood Specialists staffed within all 21 Central Intake hubs. In FY20, 1108 children were reached

through the state wide Central Intake system – ASQ Family Access Portal for access to evidence-based developmental screening.

NJ has completed a significant amount of work to create an aligned system of early education data through the NJ-EASEL (NJ Enterprise Analysis System for Early Learning). The NJ-EASEL project will link DOE's Statewide Longitudinal Data System (NJ SMART), DCF's Licensing System, DHS's Workforce Registry (NJ Registry for Childhood Professionals, a component of the Grow NJ Kids data system), DHS's child care system (CASS), DCF's foster care system (NJ SPIRIT), DOH's Early Intervention System (NJEIS), DCF's Home Visiting system, Head Start/Early Head Start program data systems, and other state early learning and development data collections within the parameters of state and federal privacy laws. NJ-EASEL project is designed to be able to measure outcome objectives of the initially started through the Race to the Top Early Learning Challenge RTTT-ELC, now sustained through PDG B-5,including being able to show that early developmental screening has a direct impact on identifying children and referring them to needed services resulting in positive outcomes for children. The NJ-EASEL data warehouse will serve as the repository through which collected data informs the quality improvement and outreach activities "managed" by GNJK.

Plan for the Application Year – SPN #3: Improving Nutrition and Physical Activity

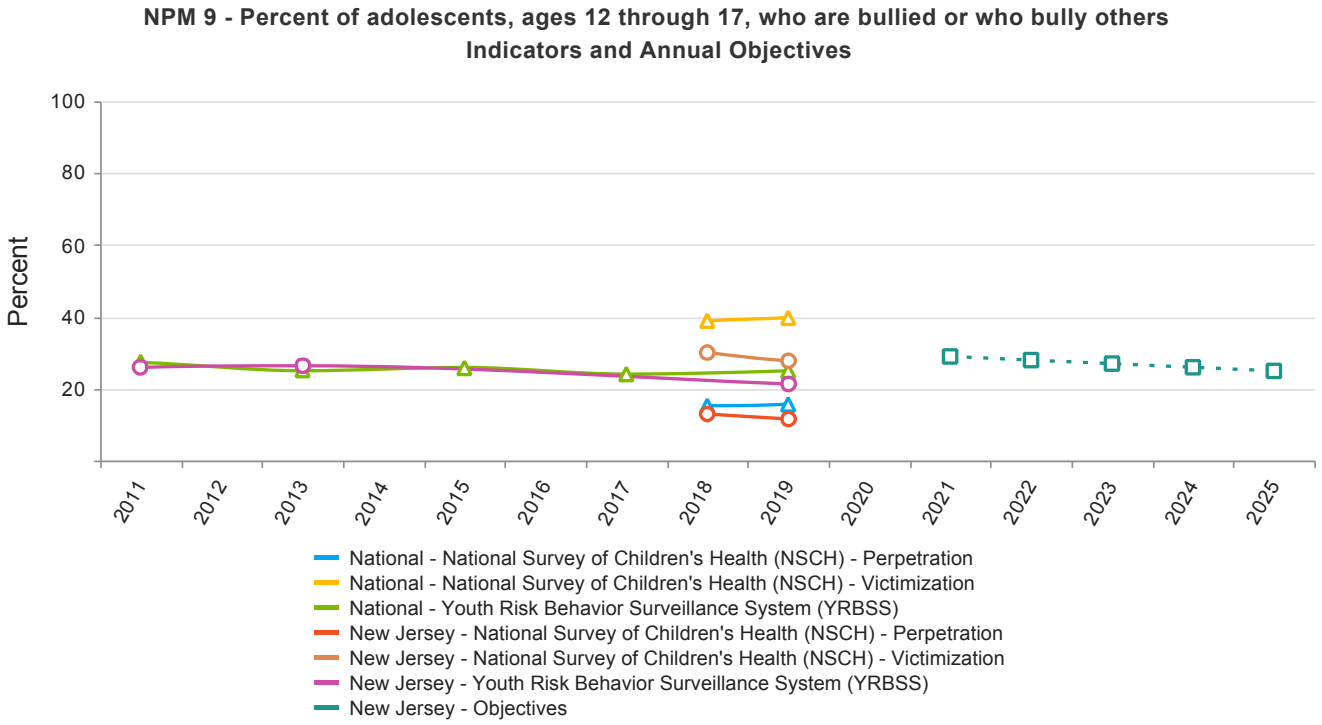
NJ SNAP-Ed will continue implementation of behavior-focused nutrition and physical education classes so children can make healthy food and lifestyle choices to prevent obesity. NJ SNAP-Ed and the CAHP's WSCC School Health NJ project will meet throughout the upcoming year to coordinate and collaborate on improving nutrition and physical activity in New Jersey's public schools.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	22.0	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	5.5	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	5.4	NPM 9 NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	13.3 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	62.2 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	93.2 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	14.0 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	14.9 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	11.9 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	72.3 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	67.1 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	89.0 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	90.6 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	10.0	NPM 10

National Performance Measures



Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2019	**2020**
Annual Objective		
Annual Indicator	26.6	21.5
Numerator	104,200	82,289
Denominator	391,821	383,470
Data Source	YRBSS	YRBSS
Data Source Year	2013	2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Perpetration		
	2019	**2020**
Annual Objective		
Annual Indicator	13.1	11.6
Numerator	89,695	78,725
Denominator	684,057	680,984
Data Source	NSCHP	NSCHP
Data Source Year	2018	2018_2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Victimization		
	2019	**2020**
Annual Objective		
Annual Indicator	29.9	27.7
Numerator	204,274	188,436
Denominator	684,057	681,427
Data Source	NSCHV	NSCHV
Data Source Year	2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	29.0	28.0	27.0	26.0	25.0	25.0

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Reduce the percentage of high school students who are electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media).

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	13.8	
Numerator		
Denominator		
Data Source	CDC High School YRBS	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.0	12.0	11.0	10.0	9.0	

ESM 9.2 - Reduce the percentage of high school students who are bullied on school property.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	16.4	
Numerator		
Denominator		
Data Source	CDC High School YRBS	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	16.0	15.0	14.0	13.0	12.0	

State Performance Measures

SPM 6 - Increase the percentage of students completing the TOP program, Reducing the Risk, and Teen PEP per year.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	57.9	84
Numerator	1,129	2,025
Denominator	1,950	2,411
Data Source	Child and Adolescent Health program	Child and Adolescent Health program
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	75.0	75.0	75.0	75.0	75.0

State Action Plan Table

State Action Plan Table (New Jersey) - Adolescent Health - Entry 1	
Priority Need	
Promoting Youth Development Programs.	
NPM	
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others	
Objectives	
Increase the number of adolescents participating in a bullying awareness and prevention program	
Strategies	
Number of bullying/suicide prevention presentations delivered by or supported by NJDOH Title V	
ESMs	**Status**
ESM 9.1 - Reduce the percentage of high school students who are electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media).	Active
ESM 9.2 - Reduce the percentage of high school students who are bullied on school property.	Active
NOMs	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

State Action Plan Table (New Jersey) - Adolescent Health - Entry 2

Priority Need

Reducing Teen Pregnancy

SPM

SPM 6 - Increase the percentage of students completing the TOP program, Reducing the Risk, and Teen PEP per year.

Objectives

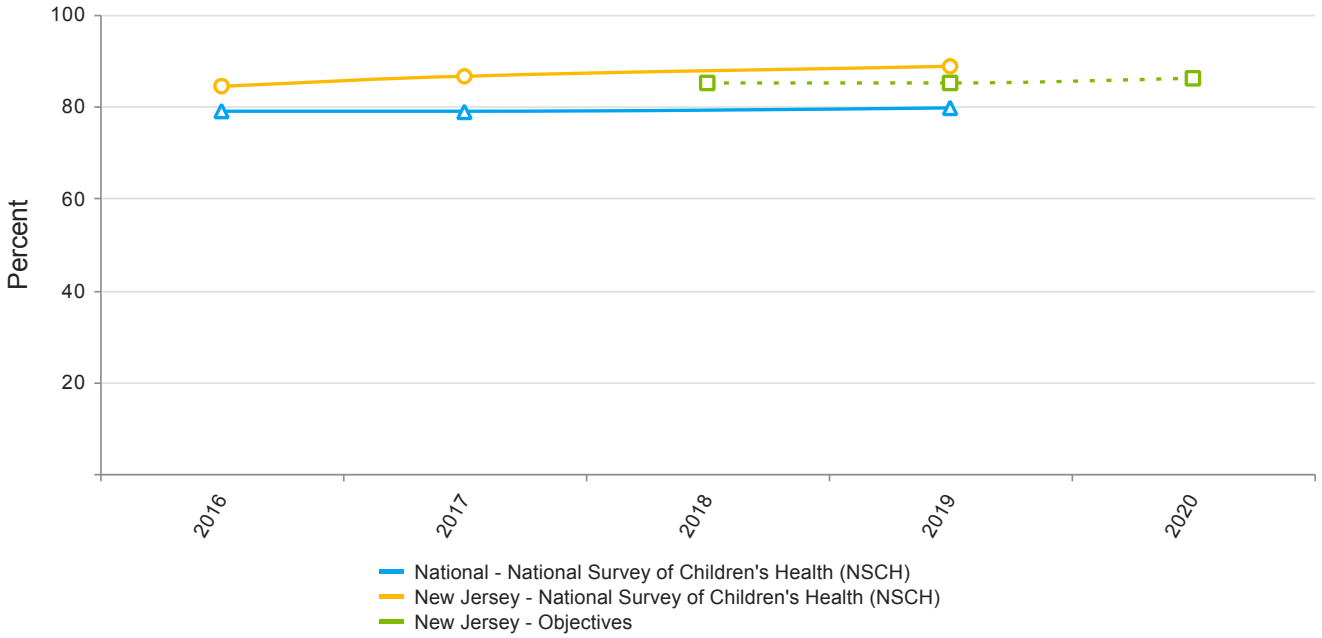
Reduce reproductive health disparities of women before and between pregnancies by decreasing births to African American and Hispanic teens aged 15-19 by .5% by 2022.

Strategies

Implement evidence based Teen Pregnancy Prevention models in high need areas with African American and Hispanic teens aged 15-19.

2016-2020: National Performance Measures

2016-2020: NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			85	85	86
Annual Indicator		84.4	86.5	86.5	88.7
Numerator		626,832	589,243	589,243	635,009
Denominator		742,521	681,414	681,414	716,126
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 10.1 - Number of pediatric patients served in practices participating in the Medical Home Technical Assistance Program in the last year.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		128,500	128,500	129,000	130,000
Annual Indicator	128,500	128,500	128,500	128,500	
Numerator					
Denominator					
Data Source	Medical Home Technical Assistance Program	Medical Home Technical Assistance Program	Medical Home Technical Assistance Program	Medical Home	
Data Source Year	2016	2017	2018	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	

Adolescent Health - Annual Report

Adolescent Health Annual Report

Adolescent/ Young Adult Health

The domain of Adolescent/Young Adult Health includes focuses on NPM #9: Bullying (Percent of 9-12th graders who reported being bullied on school property or electronically bullied), NPM #11 (Percent of children with and without special health care needs having a medical home) and NPM #12 (Percent of children with and without special health care needs who received services necessary to make transitions to adult health care). Because reporting on NPM #11 and #12 overlap the two domains of Adolescent/Young Adult Health and SCHCN, the narrative for NPM #11 and #12 will be presented in this Adolescent/Young Adult Health section and not repeated in the CYSHCN Section. This section serves as the state's narrative plan for the Annual Report and as the Application year. Planned activities for the Application year are described and programmatic efforts summarized that have been undertaken for the Annual Report year, with primary emphasis placed on the performance impacts that have been achieved. The strategies and activities to address the identified priorities from the Needs Assessment Summary are further described.

Annual Report - NPM #9: Bullying

Improving NPM #9 (Bullying) is an important measure on the domain of Adolescent/Young Adult Health (AYAH) and is related to SPN #4 Promoting Youth Development and SPN #5 Preventing Teen Pregnancy. 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.[1]. Teens who are bullied are at increased risk for mental health problems, have problems adjusting to school and is connected to absenteeism.[2] Bullying also can cause long-term damage to self-esteem.[3]

Through the CAHP multiple efforts are made to decrease bullying in schools and build the social emotional learning (SEL) competencies of both youth who are bullies and are bullied. Building youth capacity for self-awareness, social awareness, self-management, relationships and decision-making helps build the core skills that teens need to refrain from bullying others and bounce back when they are bullied. According to 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; to have meaningful interactions with others who are socially and emotionally competent; and to receive positive and specific guidance.

The Teen Outreach Program (TOP®), a nationally replicated SEL program evidenced to reduce teen pregnancy, school suspension and cutting class while increasing academic success, life skills and civic responsibility is replicated in over 50 schools throughout NJ and on CASEL's list of supported SEL programs. From 10/1/20 – 9/30/21 TOP® will engage at least 1,000 NJ youth and complete 20,000 hours of community service learning. TOP® links teens from diverse backgrounds and groupings within schools and facilitates dialogues that promote teens to be introspective, connect with their peers, partner with adults and participate in bettering their communities. Because TOP® is an evidence based program, data is collected via pre and post surveys delivered to participants that measure in particular to bullying: teens connectedness (empathy, self-awareness and social awareness) and resiliency (emotion management, self-efficacy and self-management) which lead to improved decision making and relationships. Thus far, implemented in NJ since 2012, TOP® has shown to improve connectedness and resiliency in NJ teens.

Bullying is a learned behavior which often starts at home, learned from older siblings, extended family and parents and then transferred to school behaviors. Youth who are bullies are at increased risk for substance use, academic problems, and violence to others later in life; and teens who are both bullies and victims of bullying suffer the most serious effects of bullying and are at greater risk for mental and behavioral problems than those who are only bullied or who are only bullies.[2] To impact this, CAHP implements multiple parent engagement programs that help parents better understand and support their teens. Connection to a supportive adult has been associated with decreased drug use, delayed initiation of sex, and fewer suicide attempts in teens. Key risk factors for teen decision-making include family-related protective factors such as positive values and norms expressed and modeled by family members and other trusted adults and feelings of connection to groups that encourage responsible behaviors. 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 pre surveys, polls during lessons and a post retrospective survey. Since 9/30/20 CAHP grantees have offered 5 cohorts of Teen Speak engaging over 50 parents and caregivers with plans to offer another 6-10 cohorts through the Spring and Summer. CAHP plans to expand

Teen Speak in 2021 to 3 additional grantees with the goal of reaching 500 parents and caregivers in 2022.

In addition to engaging teens and parents directly, in order for more teens to be positively impacted, youth serving professional capacity must be improved at the school and community-based level. We know 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.[4] 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 the youth who bully them.[5] 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. Read more about these findings in the NICHD news release: Depression High Among Youth Victims of School Cyberbullying, NIH Researchers Report.

To address this comprehensively, CAHP staff and CAHP grantee staff have been trained in multiple approaches to working our most vulnerable youth. This has included comprehensive training in suicide prevention and safe messaging, mindfulness, youth mentoring, youth-adult partnering, cyber-bullying, effective use of social media, LGBTIAQ inclusivity training and an intensive Transgender 101 train the trainer, social and emotional learning (SEL) and trauma informed care (TIC). Training and TA occurs on a quarterly basis and is required for all PREP and SRAE program grantees but is open to all CAH Programs and Program Partners including schools and community-based organizations where CAH programs operate. In January of 2021, all CAHP grantee staff were offered training on Teaching Students to Use Tech Safely and Wisely, which will be incorporated into their program sessions with youth.

Through a comprehensive approach aimed at building 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.

Annual Report - NPM #11: 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 that should be delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are 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 the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. The Maternal and Child Health Bureau uses the AAP definition of medical home. State staff continues to develop refined techniques within the electronic reporting system (i.e., CMRS) that will include all seven qualities essential to medical home care.

CYSHCN with a medical home has been a priority for the SCHEIS program and has been supported by several partnerships and collaboratives. Having a primary care physician service identified in a child's Individual Service Plan (ISP) developed with a SCHS CM served as a medical home proxy beginning with 2014 reporting. As part of the Medical Home grant, FCCS and its partners developed a Shared Plan of Care (SPoC), a document meant to increase care coordination for CYSHCN. This additional component was added to the medical home proxy with 2017 reporting continued in 2018 and has continued for ESM 11.1. It is acknowledged that a medical home is more comprehensive than just having a primary care physician. In part, it is also imperative for a child to have consistent health insurance to increase access to said provider. Of the 20,342children age 0 to 18 years served in FFY 2020, 6,775 (approximately 33.3%) had a primary care physician and/or SPoC documented, and of those children approximately 57.1% had insurance identified in their ISP. The percent of CYSHCN ages 0-18 years served by SCHS CMUs with a primary care physician and/or SPoC has been selected as ESM 11.1, which should increase NPM #11 (Children with and without special health care needs having a medical home). Table NPM 11 - Percent of children with and without special health care needs having a medical home

	2007	2011-2012	2016-2017	2017-2018	2018-2019
Percent of children with special health care needs having a medical home	51.8	42.2	35.2	35.6	40.6
Percent of children without special health care needs having a medical home	57.8	55.4	51.7	52.5	49.0

Data Source: National Survey of Children's Health (NSCH)
https://www.childhealthdata.org/browse/survey

For many CYSHCN, a specialty provider often comes to be a child's usual source of care where coordination of care becomes vital to ensure primary care services are not overlooked. Past chart reviews have shown greater than 90% of CYSHCN, 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 goals and objectives. The Title V SCHS CMUs and pediatric specialty providers will continue to provide a safety net for families of CYSHCN.

In March 2020, staff reached out to the 16 SPSP health service grantees to understand the impact of COVID-19 at each center. While all (100%) of the centers were able to successfully accommodate in-office visits, in compliance with the CDC recommendations, many offered alternate options. Some physicians were able to schedule patients at their private offices, while the centers (hospital/ambulatory based offices) were able to provide alternative methods of evaluation, care and treatment, such as: telehealth platforms, letters, phone calls, etc. An overwhelming 85% of the grantees expressed that the response to telehealth/telemedicine visits from patients and families with CYSHCN were positive.

Despite the COVID-19 pandemic, the number of CYSHCN captured through quarterly statistics collected from the 16 SPSP health service grantees show continued growth in the utilization of specialized pediatric services. In SFY20, services were provided to approximately 132,864 children, up from 120,323 children served in SFY19. The increase in the number of patients seen in SFY20 may largely be because many agencies adjusted to telehealth/telemedicine platforms. Centers were able to coordinate continuous and comprehensive services for patients in a more individualistic approach. CYSHCN were to able access their team of providers independently, accounting for more appointments.

Recognizing that there have been many changes in staff throughout the grant programs and internally at the NJ DOH, the program is working on updating the data collection process. The program is in the process of revising the data collection sheets to be more standardized across grant programs and on establishing a database to house all the data and run reports. This will enable the SPSP to establish a new baseline and better capture changes.

The SPSP continues to monitor the wait times at each grant funded site for both initial and follow-up appointments. With the start of the pandemic, grantees were asked to report out on the status of their operations such as, utilization of telehealth and in-person appointments. The grantees were very forthcoming with sharing their experiences in real time in addition to their quarterly reports. A survey was also sent out to all SPSP health service grantees to assess for wait times and to examine factors that may have affected wait times at each agency. Questions asked in the survey were as follows: current wait time for an initial and follow-up appointment, if COVID-19 had affected wait times, any staffing changes that may have occurred within the last 12 months, and if a wait time policy was established. Responses varied with each agency.

Of the responses from the CECs, the average current wait time for an initial appointment ranged from 2 weeks to 12 months. Such appointments varied based on specialty (psychiatry, developmental pediatrics, neurology); however, the majority of the wait times were 2-3 months. Wait times for follow-up appointments varied between no wait to 2-3 months. Many of the CECs cited that they are able to schedule follow-up appointments right away for their patients. COVID-19 has affected each center both positively and negatively. Some centers stated that due to the pandemic, they were able to see more patients through telehealth/telemedicine platforms while others have shared that many families wanted to wait for an in-person visit and therefore the wait list grew longer. During the pandemic, a handful of grantees experienced staffing changings as a result of retirement and leave, thus affecting the wait times at each respective center.

In the same wait list survey, the responses provided by the CLCPC Centers showed that wait times for an initial appointment were significantly shorter for these services compared to CECs. Many of the CLCPC Centers indicated that they could see patients immediately while some expressed that wait times vary depending on the reason for the visit with the longest wait to be 4-6 weeks. PTC centers include many different specialty and subspecialty programs. The wait time varies by specialty; as well as by, diagnosis, age, and medical condition. The average wait time for initial appointments for the majority of pediatric specialties is 1 - 2 weeks with the longest wait time being for genetics appointments, which averages three months.

As explained in the MCH Block Narrative from last year, each SPSP grantee faces a different set of challenges that contribute to prolonged wait times. It is also clear that one single approach will not effectively reduce wait times for all centers in the SPSP network. Moving forward, as each agency adjusts to providing services post COVID-19, the DOH will collaborate with grantees to monitor progress towards reducing wait times for initial appointments and on identifying new

challenges as they arise.

Title V is committed to collaboration with the DHS Office of Medicaid Managed Care, the COCC, SPAN, and the NJAAP, and other community-based partners to engage in medical home initiatives to reinforce linkage of CYSHCN with comprehensive community providers. ISG projects are ongoing and have built upon one another. In July 2009 Title V, in partnership with the NJAAP and SPAN, implemented HRSA's Integrated Systems Grant (ISG) to improve access to quality, culturally competent, family-centered systems of service for children, especially children with special health care needs. This project enabled NJAAP to work with over 30 practices in 13 counties across the State in the development of practice teams and use of the model for improvement to strengthen patient-centered medical homes. The ISG program success was measured using evaluation of the Medical Home Index (a nationally validated self-assessment tool for measuring "Medical Homeness" that each practice must complete pre- and post-program participation). Results for participating practices showed an overall increase from pre- to post, representing an increase in their overall "Medical Homeness." Receiving recognition for their degree or "Level" of Medical Homeness, is for many practices, the next step after participating in NJ AAP's Medical Home Initiative.

With knowledge gained through the Model for Quality Improvement and with the policies, processes and procedural changes that many of the practices implemented throughout their participation in the Initiative, many of the practices were ready to apply for formal recognition, with a goal of payment incentives that will support and sustain financing their Medical Homes. National Center for Quality Assurance (NCQA) recognition as a Patient Centered Medical Home involves a detailed and time-consuming process with many standards and elements, including "Must Pass" elements.

Ongoing improvements to the Case Management Referral System (CMRS) allowed new and different opportunities to track NPM 11 and 12.

Annual Report - NPM #12 (transition to adulthood)

The transition of youth to adulthood has become a priority issue 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 to 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, 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.

Table NPM #12: The percentage of adolescents (12-17)* with (and without) special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2015		2016	2017	2018	2019	2020
Annual NPM #12 Indicator	25.3		41.3	43.0	45.7%	48.1%	45.7%
Numerator	1,101		2,073	2,208	2,027	2,663	1,390
Denominator	4,385		5,017	5,137	4,438	5,534	3,039
Is the Data Provisional or Final?	Final		Final	Final	Final	Final	Provisional

***Notes -** SCHS CMUs serve children with special health care needs up to their 22nd birthday. Children age 12 – 21 are offered &/or provided with transition services.

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; Supplemental Security Income (SSI); SPoC; Exceptional Events documented in the youth's record tied to transition.

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

The SCHS CMUs continue to facilitate transition to adulthood with youth by ensuring a transition to adulthood goal on the ISP. Likewise, exploring youth and their parents' needs to facilitate transition with insurance, education, employment, and housing, and linking them to community-based partners will continue. The quality improvement project that started in 2014 includes transition to adulthood CMRS documentation and NPM #12 proxies described above.

Ongoing Case Management Referral System (CMRS) presentations to the SCHS CMUs stimulate active discussions about how SCHS CM documentation produces system wide data that is used for QI and MCH Title V Block Grant reporting. These presentations also inform FCCS and SCHS CMU staffs on areas for training to more effectively unlearn and relearn documentation methods, to move from a lengthy narrative charting style to the use of drop-down menus supported by brief entries that use shorter and more consistent terminology. The state data/analytical staff collaborate with the Program Officers to review and analyze CMRS data. Monthly meetings are held jointly with FCCS state staff and all 21 CMUs to provide additional QI presentations highlighting progress and additional areas of improvement in documentation on the Core Outcomes.
SCHS CMUs and pediatric specialty providers will refer youth and/or their parents to NJ Council for Developmental Disabilities (NJ CDD) for participation in Partners in Policymaking (PIP) self-advocacy training as well as continue to assist youth and their families to advocate for transitional supports through their individualized education plans and community-based supports. Title V will continue to participate in PIP mock trials to facilitate the development of clients' self-advocacy skills.

Under health care reform, NJ Medicaid eligibility for single adults expanded in 2014 up to 133% FPL. As this population is intended to include a significant percentage of childless adults with incomes below 133% of FPL, it is anticipated that CYSHCN transitioning to adulthood will have expanded opportunity to access health coverage through Medicaid, the insurance exchange, and coverage through their parents' insurance through age 26 (or in certain circumstance till age 31). In addition, it is also possible that some youth/young adults with special needs on Medicaid may experience a shift in eligibility to an insurance exchange. 20.8% of the 12-21-year-old youth who were served by SCHS CMUs in FFY2017 had an insurance service documented. Of those with insurance documented, 52.4% had Medicaid/NJ Family Care specifically

The percent of CYSHCN ages 12-17 years served by SCHS CMUs with at least one transition to adulthood service has been selected as ESM 12.1, which should increase NPM #12 (Transition to Adulthood).

Documentation of transition planning was largely noted by SCHS CMUs to occur on or about age 14. A discussion with parents/youth about transition planning, and the distribution of transition packets were noted. An anecdotal observation by the SCHS CMs noted that families reported that they preferred to receive materials incrementally rather than one very large packet filled with resources. That incremental method provided 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 Department of Children and Family's Children's System of Care Initiative, and others.

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 SCHS CM and SCHS CMs.

Due to the rising percentage of children in NJ diagnosed with ASD, FCCS is excited to partner with Autism New Jersey to provide support to SCHS CMs for children active in SCHS CM who have been diagnosed with ASD as well as other learning disabilities. This agreement will enable SCHS CMs to provide the necessary support to children and their families active in SCHS CM.

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 COCC to medical practices. Community-based partners continue to identify resources and linkages to support transition to adulthood for CYSHCN.

In 2013, services for children and youth with developmental disabilities under age 21 were transitioned from DHS's Division of Developmental Disabilities (DDD) to the DCF's Children's System of Care (CSOC). CSOC is charged with working

collaboratively with the Department of Education (DOE) Offices of Special Education, the DDD and the Division of Vocational Rehabilitation (DVRS) to help facilitate transition to adulthood services. After age 21, developmental disability services are provided by the DDD. Training on these systems for adolescents with developmental disabilities is occurring with regularity among the SCHS 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 appropriate access to services and supports. Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through SCHS CMUs statewide is in process as well. 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 supports is provided. State staff monitor the SCHS CMU's efforts to outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' individual service plans.

Transition planning and implementation will remain a priority throughout SFY22. The adolescent subset of CYSHCN served through Title V remained relatively the same between SFY2019 and SFY2020 and is as follow. In SFY2020, 17% of patients at CECs and 16% of patients at FASD Centers were of youth 14-19 years of age while 9% of CYSHCN of the same age group were served at Cleft Lip Cleft Palate Craniofacial (CLCPC) Centers. In addition, youth between the ages of 14 and 19 comprised 30% of those served at Pediatric Tertiary Care (PTC) Centers. The Specialized Pediatric Services Program (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 CYSHCN to multidisciplinary team members including social work and other community-based systems such as SCHS CM, 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, plans of care and documentation on transition to adult care vary amongst the three SPSP categories: CEC, CLCPC, and PTC Centers. The SPSP plans to collaborate 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.

Aligned with the Title V CYSHCN 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 Family Health Services' Maternal Child Health and CYSHCN's programs, and the Ryan White Part D program to support WICY needs in the community. NJ ranks third in the nation for pediatric cases. Of youth 13-24 years, 432 were living with HIV/AIDS, & of youth 0-12 year, 26 were living with HIV/AIDS in 2020. Through diligent efforts to treat and educate HIV-infected pregnant women, the perinatal transmission rate in NJ remains very low. Intensive case management, coupled with appropriate antiretroviral therapy, enables children with HIV to survive into and successfully transition into adulthood.

Adolescent Health - Application Year

Plan for the Application Year - NPM #9: Bullying
The CAHP will continue to implement SEL and parent engagement programs along with virtual activities that provide youth with opportunities to lead and educate their peers. Evidence based SEL programs to be implemented include: The Teen Outreach Program (TOP®) will be implemented in over 50 schools with at least 1,250 NJ youth and the WSCC model. In addition, the CAHP will provide Teen Speak to approximately 500 parents statewide and Parents as Champions. CAHP will continue to host the NJDOH Voice of Youth Planning Committee as they plan and implement Youth led virtual programs for their peers. 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.

Plan for the Applicant Year - NPM #11: Percent of children with and without special health care needs having a medical home

State SCHEIS staff will continue to refine tracking of Performance Measures in CMRS and provide documentation training to SCHS CMUs to ensure activities related to these Measures are accurately counted. Updates are being 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 CYSHCN. ESM #11.1 provides a baseline for programmatic needs in order to increase the percent of CYSHCN with a primary care physician and identify the 'next steps' needed to establish medical homes for CYSHCN, a medical home webpage on the Department's website, includes a Shared Plan of Care (SPoC, a medical home tool for families).

Plan for the Applicant Year - NPM #12 (transition to adulthood)

Efforts to improve documentation of transition to adulthood activities performed by SCHS CMUs and documented in CMRS will continue. State staff provide ongoing technical assistance and guidance via site visits, desktop audits, and conference calls to improve the data collected and reported on transition to adulthood activities and client outcomes.

Transition to an adult program for CYSCHN is a critical decision and one that must be planned appropriately to ensure continuity of care. Although Title V will continue to assess youth's progress toward transition and linkage with community-based supports, the SCHS CM and SPSP programs are exploring the development of standardized needs assessment and quality indicators to better measure NJ CYSHCN's experiences. The SPSP plans to collaborate 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.

Children with Special Health Care Needs

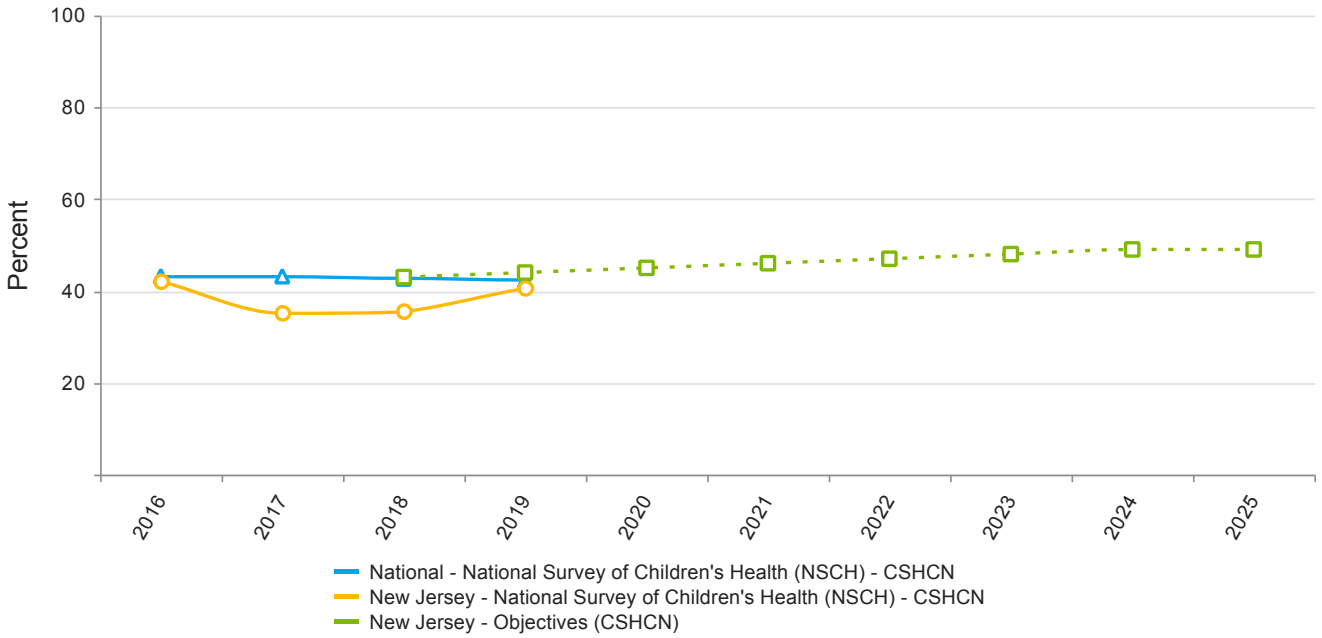
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	13.3 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	62.2 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	93.2 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	2.0 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			43	44	45
Annual Indicator		42.0	35.2	35.6	40.6
Numerator		146,471	117,862	113,515	135,084
Denominator		348,608	334,610	318,461	333,065
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.0	47.0	48.0	49.0	49.0	49.0

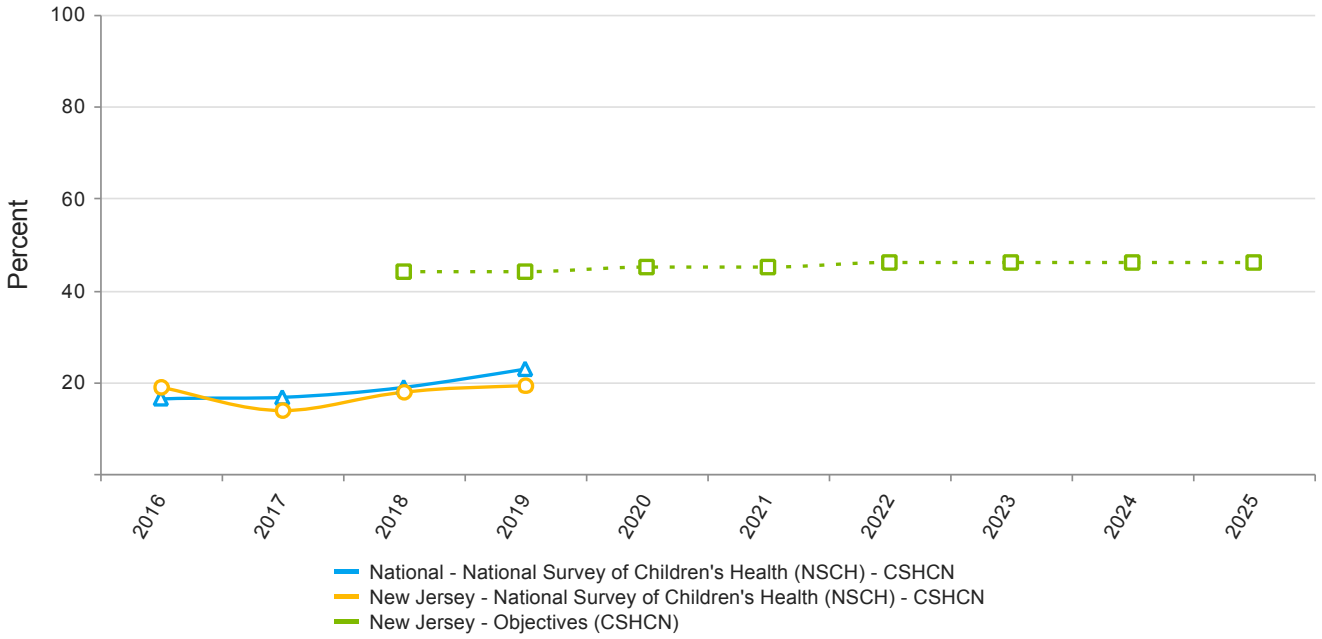
Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units (SCHS CMUs) with a primary care physician and/or Shared Plan of Care (SPoC).

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		35	36	37	38
Annual Indicator	29.6	35.8	35.8	35.5	
Numerator	6,276	7,653	7,653	8,779	
Denominator	21,220	21,354	21,354	24,714	
Data Source	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	
Data Source Year	2016	2017	2018	2019	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	39.0	40.0	41.0	42.0	43.0	

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			44	44	45
Annual Indicator		18.8	13.8	17.9	19.1
Numerator		28,694	18,598	22,805	26,530
Denominator		152,712	135,014	127,305	139,223
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	45.0	46.0	46.0	46.0	46.0	46.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		28	31	34	37
Annual Indicator	41.3	43	43	48.1	
Numerator	2,073	2,208	2,208	2,663	
Denominator	5,017	5,137	5,137	5,534	
Data Source	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	
Data Source Year	2016	2017	2018	2019	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	43.0	46.0	47.0	48.0	

State Performance Measures

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.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		85.8	85.8	86	86.5
Annual Indicator	89	76.7	76.7	82.1	
Numerator	1,833	1,366	1,366	1,334	
Denominator	2,059	1,782	1,782	1,625	
Data Source	Early Hearing Detection and Intervention Program	Early Hearing Detection and Intervention Program	Early Hearing Detection and Intervention Program	Early Hearing Detection and Intervention Program	
Data Source Year	2016	2017	2018	2019	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	87.0	87.5	88.0	88.5	89.0	

SPM 4 - 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 who are receiving services.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		90.4	92	92.2	92.4
Annual Indicator	90.1	91.8	91.8	94.6	
Numerator	13,634	14,011	14,011	13,326	
Denominator	15,135	15,261	15,261	14,093	
Data Source	NJ Case Management Referral System	NJ Case Management Referral System	NJ Case Management Referral System	NJ Case Management Referral System	
Data Source Year	2016	2017	2018	2019	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	92.6	92.8	93.0	93.0	93.2	

SPM 5 - Age of Autism Diagnosis

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		5.3	5.3	5.2	5.1
Annual Indicator	5	5.4	5.4	4.9	
Numerator					
Denominator					
Data Source	NJ Birth Defects and Autism Reporting System	NJ Birth Defects and Autism Reporting System	NJ Birth Defects and Autism Reporting System	NJ Birth Defects and Autism Reporting System	
Data Source Year	2016	2017	2018	2019	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	4.9	4.9	4.8	

State Action Plan Table

State Action Plan Table (New Jersey) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Improving Access to Quality Care for CYSHCN	
NPM	
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	
Objectives	
ESM 12.1: Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service.	
Strategies	
ESM 12.1: Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service.	
ESMs	Status
ESM 12.1 - Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

State Action Plan Table (New Jersey) - Children with Special Health Care Needs - Entry 2

Priority Need

Improving Access to Quality Care for CYSHCN

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

Increase the percentage of children and children with special health care needs, age 0 - 17 years old, who have a medical home by 4 percentage points by 2022.

Strategies

ESM 11.1: Percent of CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units (SCHS CMUs) with a primary care physician and/or Shared Plan of Care (SPoc).

ESMs	Status
ESM 11.1 - Percent of CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units (SCHS CMUs) with a primary care physician and/or Shared Plan of Care (SPoC).	Active

NOMs

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 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (New Jersey) - Children with Special Health Care Needs - Entry 3

Priority Need

Improving & Integrating Information Systems

SPM

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.

Objectives

By the end of the funding period at least 70% of children that are identified as having a permanent hearing loss as a result of newborn hearing screening will be enrolled in Early Intervention services within two months of the diagnosis.

Strategies

Universal newborn hearing screening began largely due to evidence that clearly demonstrated improved language and developmental outcomes in Deaf/hard of hearing children that receive Early Intervention services as soon as possible and ideally before six months of age.

State Action Plan Table (New Jersey) - Children with Special Health Care Needs - Entry 4

Priority Need

Improving Access to Quality Care for CYSHCN

SPM

SPM 4 - 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 who are receiving services.

Objectives

Increase the 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 Units (SCHS CMUs) who are receiving services by 0.5% by 2022.

Strategies

Special Child Health Services Unit Coordinators are expected to assign new BDARS referrals to a case manager for initial outreach within fourteen (14) days of referral. In a random sample of 969 Case Management Referral System (CMRS) records, approximately 57.1% were assigned within the 14 day timeline. To increase the percent of children registered with BDARS who have been referred to SCHS CMUs and subsequently receive services, a second goal has been set to increase the % of BDARS referrals that are assigned to a case manager within 14 days to 60% by 2020.

State Action Plan Table (New Jersey) - Children with Special Health Care Needs - Entry 5

Priority Need

Improving Access to Quality Care for CYSHCN

SPM

SPM 5 - Age of Autism Diagnosis

Objectives

Decrease the age of autism diagnosis by .1 years by 2022.

Strategies

Improve BDARS to reduce the time from referral to autism diagnosis.

E.2.c.v Children with Special Health Care Needs

The population domain of CSHCN includes NPM #11 and #12 which were covered in the previous Adolescent / Young Adult Health domain and SPMs 3, 4 and 5 which impact NOMs 13, 15, 16, 17, 18, 19, 20, 21 and 22.

Annual Report (Last Year's Accomplishments)
State Performance Measure 3:

Provisional data indicates that for 2020, 76.2% of infants not passing initial newborn hearing screening at birthing hospitals had out-patient audiological follow-up documented. Since follow-up exams are still occurring on children born at the end of 2020, we expect that the rate will increase when final data is available. We anticipate the final rate will be level with prior years and will exceed the target.

Table 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.

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Annual SPM#3 Indicator	86.4%	88.2%	85.8%	86.0%	89.0%	87.5%	86.1%	82.6%	76.2%*
Numerator	2131	1945	1821	1869	1833	1570	1571	1362	1394*
Denominator	2467	2205	2122	2173	2059	1798	1824	1648	1830*

*Note – Data for 2020 is incomplete. Follow-up reports are still being received for these children and the final rate is expected to exceed this rate

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

- EHDI trained 3 new users in 2020 on the EHDI reporting module in the NJ Immunization Information System (NJIIS) which is used by audiologists and other practitioners who are conducting hearing follow-up to report outpatient exams. The EHDI program receives approximately 89% of reports entered by providers through this Web-based application and the rest are sent to the program on paper forms.

- NJ DOH continued use of 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 in need of hearing follow-up.

- Continued use of HRSA EHDI grant funding for one of the Early Intervention (EI) program's Regional Early Intervention Collaborative's (REIC) to provide two part-time consultants who specialize in working with Deaf and Hard of Hearing children . They have an initial phone conversation with parents of children who have recently been diagnosed with hearing loss to review EI services and discuss communication options for these children t. The consultants participate in the initial EI family meetings via remote access, using laptops with web-cameras. The consultants served a total of 113 families during this year.

- The EHDI Monthly Reconciliation Report is distributed to individual hospitals detailing children still in need of additional audiological follow-up after not passing inpatient hearing screening. This serves as a notice to hospitals of babies still in need of reminder contact. In addition, a report including statistics comparing the individual hospital to statewide statistical averages is sent annually.

- Continued annual distribution of a report to provide audiology facilities with feedback on the timeliness of follow-up for children seen at their facility after not passing inpatient hearing screening. The report also includes statistics on the timeliness and completeness of the documentation of their results.

- The Hearing Evaluation Council, a Commissioner appointed advisory board to the NJ EHDI program, held three meetings during 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 NJ Stakeholders (NJSH) group, a new HRSA grant initiative, held four meetings this year. The NJSH group is made up of providers who work in the EHDI system and parents of Deaf/Hard of Hearing children, including audiologists, Early Intervention providers, the NJ Part C Coordinator liaison, Teachers for the Deaf/Hard of Hearing, a cochlear implant provider, case managers, and DOH EHDI staff.

- The NJ Statewide Network for Cultural Competency's Annual Conference, entitled 'Building Bridges, Breaking Barriers & Cultivating Cultural Competency with the Diverse Deaf and Hard of Hearing Community' was held in April 2021 and focused on cultural competency services for Deaf and Hard of Hearing people. The target audience for this conference was service providers such as nurses, social workers, and case managers. The conference is supported by SCHEIS and EHDI staff have served as valuable resource in this effort.

- NJ EHDI has entered into a three-year Memorandum of Understanding with the NJ Department of Human Services' Leveling the Playing Field (LTPF) initiative to enhance the NJ EHDI Deaf Mentor Program. Funding for this initiative provides access to appropriate language role models for Deaf and Hard of Hearing children (from birth to age 5) whose families have selected American Sign Language (ASL) as a primary mode of communication. LTPF seeks to enhance New Jersey Early Intervention Services and early childhood education by having ASL fluent paraprofessionals interact with Deaf and Hard of Hearing children in the same way hearing childcare workers are interacting with hearing children in their center. The goal is to provide full access to language throughout the child's day.

Between 2018 and 2019, the EHDI program participated in various activities and collaborations to benefit families and professionals, including a Central Jersey Family Health Consortium project funded by the National CMV Foundation. The Hearing Evaluation Council and the NJ EHDI program advisory board worked with the Consortium to increase awareness of the risk of CMV infection in young children among health professionals, service providers, and parents, and provided prevention education.

Other recent educational programs included a NJ EHDI Pediatric Hearing Health Care webinar entitled "How to Detect Vision Issues in Deaf and Hard of Hearing Children", presented to NJ's audiologists by a Deafblind Specialist with the NJ Center on Deaf-Blindness and a Deaf Sensitivity training for Family Health Services staff. Additionally, a poster presentation entitled "Mother's Place of Birth and Hearing Screening Follow-Up" was given at the 2019 National Early Hearing Detection and Intervention Conference in Chicago, Illinois.

Programs for families included the CARE Project Family Retreat, which hosted more than sixty Deaf and Hard of Hearing children and their families and was co-chaired by the NJ EDHI audiologist; and the first NJ SKI HI training weekend, hosted by SPAN Parent Advocacy Network, for participants of the NJ Deaf Mentor program with grant funds from NJ EHDI.

b. Annual Report (Last Year's Accomplishments)
State Performance Measure 4:

NJ has been very successful in linking children registered with the Birth Defects and Autism Registry (BDAR) (also known as the Special Child Health Services Registry) with services offered through our county-based Special Child Health Services Case Management Units (CMUs). The Case Management Referral System (CMRS) is used by the CMUs to track and monitor services provided to the children and their families. It electronically notifies a CMU when a child living within their county has been registered and released for follow-up. Also included in CMRS is the ability to create and modify an Individual Service Plan (ISP), track services, create a record of each contact with the child and child's family, create standardized quarterly reports and register previously unregistered children.

State Performance Measure 4: 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 are received services.

	2015	2016	2017	2018	2019	2020
Annual Indicator SPM #4	88.9%	90.1%	91.8%	94.9%	94.5%	84.1%
Numerator	13,696	13,634	14,011	12,416	13,326	10,339
Denominator	15,404	15,135	15,261	13,079	14,093	12,288

Note: Beginning in 2014, definitions and inclusion criteria were expanded. The numerator reflects all children whose record has any of the five following criteria for services:
1. Case closed within FFY with a reason of “goals achieved”,
2. Child referred to Early Intervention within FFY,
3. Individual Services documented with a begin and/or end date within FFY,
4. Individual Service Objectives documented with a perform date within FFY, and
5. Case Management Actions (excluding any letter correspondence that is part of an initial letter series) documented with a date performed within FFY.

These children must have received any of these services within a given FFY and registered with the BDARS (registration date not restricted to FFY).

The denominator represents the number of children served by SCHS Case Management in FFY 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 FFY but did not receive services as currently defined.

CMRS allows CMUs to receive registrations in real time, enables faster family contact, and more rapidly assists a registered child in gaining access to appropriate health and education services.

BDAR and FCCS staff collaborate to improve the functionality, ease of use and efficiency of the system.

FCCS staff revised annual site visit audits to include protocol-based review of electronic records in CMRS. In these electronic record reviews, staff assessed key functions and expectations of the CMUs and evaluated Individual Service Plans to assess linkage to services. FCCS 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.

b. Annual Report (Last Year's Accomplishments)
State Performance Measure 5:

State Performance Measure 5: Average age of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

In FY 2020, over 3,400 children with a diagnosis of autism were newly reported to the BDARS. The average age of initial autism diagnosis is 4.9 years old. This indicates a significant decline from the previous four years (SFY2016-2019) when the average ages were approximately 5.2 years. While this indicator considers the age when the child is first diagnosed, it includes all children reported during that year. Since the Registry mandates the reporting of all children through their 22nd birthday, previously diagnosed older children are sometimes registered for the first time. Since the Registry began in 2009, previously diagnosed children are continually being registered by their primary care providers, and newly seen specialist such as behavioral and mental health providers. Therefore, we also calculated the average age of diagnosis for children born between 2006 and 2012. The average age of diagnosis for this group is 4.6. These younger birth cohorts may be getting diagnosed earlier as enhanced screening efforts and public awareness have increased.

Staff has also stressed the importance of quickly reporting children diagnosed as having autism by continuing to provide outreach about the Autism Registry through conference presentations and other meetings. Staff participated in several exhibits including the Annual School Health Conference sponsored by the NJ Chapter of the AAP, the Annual Autism New Jersey Conference and continue to meet with of private pediatric offices newly identified providers. Providers with untimely reporting are contacted and reminded of the mandate to report and the important linkage to SCHS CMUs.

One of the most important changes that occurred this year was a shift in the BDARS which greatly reduced the burden on our reporting agencies and improved the efficiency of the system. The improved system allows providers to verify if a child had already been registered for another provider. This is significant as our mandate requires that all children 0-22 with an ASD are registered. Children see many

health care providers, and each one would need to verify registration or register the child. With the new system, health care providers can simply search the system for a child; thus, greatly reducing the number of duplicate registrations. Moreover, if a child had been registered with non-autism diagnoses, their providers can now just add the new autism diagnosis and review and update the child's current contact information. Additionally, the autism data collection pages have been redesigned to provide more check-off options rather than asking providers to use text fields to provide information about comorbidities, symptoms, and other pertinent information.

CSHCN - Plan for the Application Year

State Performance Measure 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.

An important SPM in the domain of CSHCN is 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) which was selected during the last Five-Year Needs Assessment.

The EHDI program will continue to use HRSA EDHI funding for county-based special health services case managers to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up. The EHDI Program also sends hospital-level surveillance data to New Jersey birthing hospitals. Monthly hospital contacts continue to receive a reconciliation list of children that are still in need of follow-up after missed or referred inpatient hearing screening as this has been shown to improve successful follow up rates. A report with each birthing hospital's overall statistics is sent annually.

The program will continue annual distribution of audiology facility reports to highlight timeliness of follow-up and identify children with incomplete follow-up testing.

The EHDI program plans to continue efforts to work with medical homes to ensure that children are receiving timely and appropriate follow-up after a referred hearing screening or inconclusive follow-up testing. An extract available in the New Jersey Immunization Information System (NIIIS) 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 use this information to send fax-back forms to provider offices to remind them to refer children for additional follow-up as needed.

The program will continue the grant-supported activities including case management outreach to families in need of hearing follow-up and support by the EI Hearing Consultants. In addition, the HRSA EHDI grant-supported Deaf and Hard of Hearing Mentoring and Role Model program for families of children identified with hearing loss has been operational since 2018. The Deaf Mentor program has been enhanced by funding from the NJ Department of Human Services Leveling the Playing Field initiative.

EHDI staff will continue educational presentations to hospital staff, pediatricians, audiologists, Special Child Health Service Case Managers, Early Intervention Service Coordinators, and other health care professionals, focusing on the need to decrease rates of children who are lost to follow-up. The EHDI program frequently uses webinars to make educational outreach efforts more accessible to the target audiences, decrease staff travel time, and improve efficiency while decreasing costs.

NJ EHDI staff will continue to collaborate with the EI Hearing Consultants to coordinate outreach meetings with pediatric audiologists regarding timely referral of children with hearing loss to Early Intervention.

As per the suggestion of the NJ EHDI advisory board, The Hearing Evaluation Council, regarding CMV/pediatric hearing loss awareness/prevention, NJ EHDI has updated their website with public service information in multiple languages geared toward women of childbearing age.

Plan for the Application Year

State Performance Measure 4:
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 who are receiving services.

SPM #4 was chosen to improve the timeliness and effectiveness of using the Birth Defects and Autism Reporting System (BDARS), which 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. In the past, these upgrades have included creating the Pulse Oximetry and Exceptional Events modules and improving functionally to decrease the burden on providers and state staff from unnecessary duplications.

For the coming year, we will be focusing on improving case definition across our case management units. How cases are defined as "active" or "inactive" impacts our ability to appropriately measure such things as length of services and number of children being serviced. Our FCCS program staff have been working intensively to standardize the CMUs definitions, and will be working with our programmers to ensure that case the system is accurately capturing the correct data, provides CMUs with the flexibility they need to provide less intensive cases with quarterly or annual updates, and received provide better.

BDAR staff will continue to provide training, on an as-needed basis, to birthing facilities, autism centers, audiologists, and other agencies in the use of the revised electronic BDARS and its modules. Staff will continue to monitor the use of the electronic BDARS and will assist reporting agencies with concerns. In addition, BDAR staff will continue to review the quality of the data in the BDARS and its modules.

On-site visits will be conducted in each of SCHS CMUs to ensure proper usage of the CMRS as needed, and to strengthen the relations with state FCCS staff. This will allow for more consistent use of the system linking referred families to services. FCCS staff provide ongoing feedback and technical assistance to SCHS CMUs on a statewide, county-level, and individual-level basis.

Plan for the Application Year

State Performance Measure 5: Average age (in years) of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

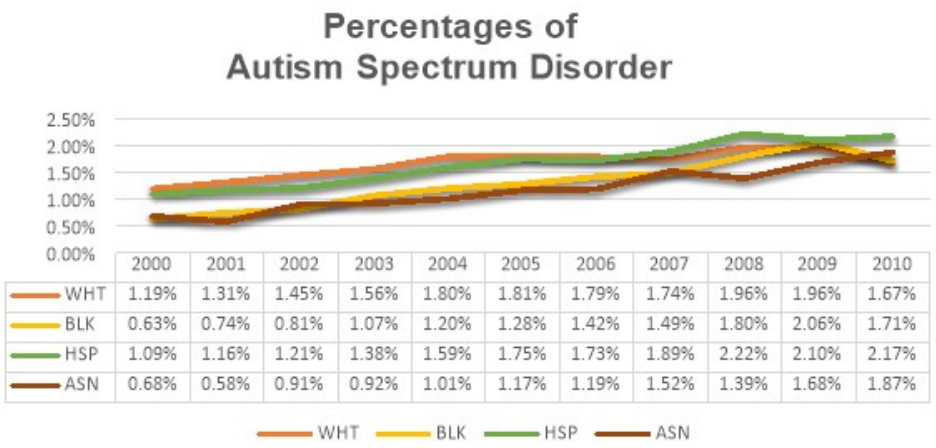
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Annual Indicator SPM #5	4.4	4.3	4.6	4.7	4.9	5.4	5.5	5.2	5.6	5.1	4.9	4.9

SPM #5 was chosen to measure the timeliness of diagnosing autism in children. 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.

For this performance measure to be accurately determined, children are reported to the Autism Registry by licensed health care providers who have either diagnosed them or are providing follow-up care and have the full information regarding the child's date of first diagnosis. The Registry requires all children under 22 to be registered. Although there is currently no timeline for diagnosing autism, the Registry encourages all reporting agents to quickly report children diagnosed with the Autism Spectrum Disorder so that families can be linked to SCHS Case Management. Additionally, new rules are being drafted to require registrations within six months of the diagnosis date or entering the medical practice.

In 2020, 3,131 children were registered, and had an average age of diagnosis of 4.9 years. Over time, the average age of initial Autism Spectrum Disorder diagnosis has decreased from 5.5 in 2015 to 4.9 in 2020. While this measure calculates the average age across birth cohorts, the median age by birth cohort is also considered a useful measure. The CDC reports the median age as just over 4 years of age. The median age for the pooled birth cohorts 2006-2012 is 3.8 years of age. New Jersey's declining average age and median age could be due to increased awareness and screening efforts as well as New Jersey's many diagnosticians and autism centers.

The average age at initial diagnosis is significantly different by race and ethnicity. For the pooled birth cohorts of 2006-2012, the average age for white-non-Hispanic children was 4.7 years. This was significantly different for Hispanic (4.4 years) and Asian (4.1 years) children but not significantly different for black children (4.5 years.) There was also no significant difference between males and females which we might expect since the prevalence is much higher for males and females at 4:1.



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
WHT	1.19%	1.31%	1.45%	1.56%	1.80%	1.81%	1.79%	1.74%	1.96%	1.96%	1.67%
BLK	0.63%	0.74%	0.81%	1.07%	1.20%	1.28%	1.42%	1.49%	1.80%	2.06%	1.71%
HSP	1.09%	1.16%	1.21%	1.38%	1.59%	1.75%	1.73%	1.89%	2.22%	2.10%	2.17%
ASN	0.68%	0.58%	0.91%	0.92%	1.01%	1.17%	1.19%	1.52%	1.39%	1.68%	1.87%

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 have 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 have also trained several psychiatric/behavioral departments located within hospitals. 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 to the BDARS and they continue to retrain new staff within health facilities as needed. Staff have 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 exhibit.

NJDOH 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. In addition, the Governor's Council for Medical Research and Treatment of Autism has funded additional clinical centers in their pursuit to create a NJ Autism Center of Excellence (NJACE).

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - The percentage of Black non-Hispanic preterm births in NJ

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		13	13	13	12.8
Annual Indicator	13.6	13.1	13.1	13.5	13.8
Numerator	1,855	1,774	1,774	1,835	1,803
Denominator	13,657	13,537	13,537	13,643	13,043
Data Source	New Jersey Birth Certificate Database, Office of V	New Jersey Birth Certificate Database, Office of V	New Jersey Birth Certificate Database, Office of V	NJ Birth Certificate Database	NJ Birth Certificate Database
Data Source Year	2016	2017	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	12.8	12.6	12.6	12.5	12.5	12.5

State Action Plan Table

State Action Plan Table (New Jersey) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Increasing equity in healthy births.
SPM
SPM 1 - The percentage of Black non-Hispanic preterm births in NJ
Objectives
Decrease the preterm birth rate for Black non-Hispanic births by 2 percentage points by 2022.
Strategies
Improve First Trimester Prenatal Care Rates for Black non-Hispanic mothers through the implementation of the Healthy Women Healthy Families Program.

Cross-cutting or Systems Building

This section concerning the domain of Life Course includes the SPN #8 Improving Integration of Information Systems and SPN #8 Smoking Prevention and the NPM #13 Oral Health and #14 Household Smoking. SPN #8 was added as a SPN recognizing the adverse impact of smoking on all population domains and many NPMs and NOMs.

Annual Report - NPM #13:

A) Percent of women who had a dental visit during pregnancy and
B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Oral health is an important part of general health. The second selected NPM in the domain of Child Health is NPM #13A (Percent of women who had a dental visit during pregnancy) and #13B (Percent of children, ages 1 through 17, who had a preventive dental visit in the past year). Access to oral health care, good oral hygiene, and adequate nutrition are essential components of oral health that help to ensure children, adolescents, and adults achieve and maintain oral health throughout the lifespan. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to learn. According to the American Dental Association and the American Academy of Pediatric Dentistry, the dental visit should occur within six months after the baby's first tooth appears, but no later than the child's first birthday. Having the first dental visit by age 1 teaches children and families that oral health is important. Children who receive oral health care early in life are more likely to have a positive attitude about oral health professionals and dental exams. Pregnant women who receive oral health care are more likely to take their children for regular dental check-ups.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting good oral health include: providing preventive interventions such as age appropriate oral health education, promoting the application of dental sealants and the use of fluoride, increasing the capacity of state oral health programs to provide preventive services, evaluating and improving methods of monitoring oral disease, and increasing the number of community health centers with an oral health component.

Table NPM #13

	2007	2008	2009	2010	2011-2012	2016	2017	2018	2019
Percent of women who had a dental visit during pregnancy	N/A				N/A	N/A		46.3*	
Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**	78.7				79.9	82.1	81.9	54.5**	85.3

Notes - Source – National Survey of Children's Health (NSCH): 2007-2017

*New Jersey Pregnancy Risk Assessment Monitoring System (PRAMS), Maternal and Child Health Epidemiology, New Jersey Department of Health, NJ SHAD: https://www-doh.state.nj.us/doh-shad/query/result/prams/PRAMS/Teeth.html.

Annual EPSDT Participation Report, CMS-416, 2019: https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html (includes through age 18)

New Jersey has selected the following for ESM #13: preventive and any dental services for children enrolled in Medicaid or CHIP. The ESM was selected since all oral health education activities conducted in the school and community settings serve to improve the oral health status of school age children.

The Children's Oral Health Program (COHP) has provided age-appropriate and developmentally targeted oral health education programs to school-age children covering all 21 counties in the State for over 35 years. It also provides oral health education programs for parenting and community groups and at WIC sites. During the 2019-2020 school year, approximately 39,392 students received oral health and /hygiene

education and oral health personal care items including toothbrushes and floss. School and community presentations are conducted in areas of high-risk for dental disease and high-need of oral health services by Registered Dental Hygienists and Dentists, who provide evidence-based oral health and hygiene information, including the oral disease process, tooth anatomy, healthy food choices, reducing 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. As a result of COVID, the COHP revised their presentation education into online formats beginning in 2020. During the 2020-2021 grant year, schools and community groups have had the option of virtual recorded and virtual live oral health education. The COHP operates under the direction of the State Dental Director, Division of Community Health Services, Oral Health Services Unit.

Special school initiatives include the “Sugar-less Day to Prevent Tooth Decay” poster contest for 4th, 5th and 6th grades, “Project BRUSH” for grades K and 1, and “Project Smile” for grades 2 and 3. Special initiatives are designed to engage the whole school community with positive oral health messages

The “Save Our Smiles, voluntary school-based fluoride mouth rinse (FMR) program had 7,294 student participants in 95 schools during the 2019-2020 school year. Regular use of sodium fluoride mouth rinses in FMR programs have been found to reduce dental decay by up to 35%. Only 14.6% of New Jersey residents have access to CWF. In March 2020, school closures by Executive Order resulted in early discontinuation of the FMR program. This program is now permanently discontinued due to the lack of product needed for the program. The one manufacturer of the Fluoride powder packets and Fluoride unit doses ceased manufacturing of these products in late 2019. This affected 150,000 participants in FMR programs nationwide. A Fluoride Varnish program is being piloted through COHP. Due to lack of access to schools as a result of COVID, only small group programs have been held to date. More programs are anticipated in Spring of 2021 as COVID restrictions ease and school districts re-open.

Interprofessional oral health training programs include “Project PEDs (Pediatricians Eradicating Dental Disease), an introduction to Caries Risk Assessment and the application of fluoride in the pediatric medical setting for physicians, nurses and physician assistants and Project REACH (Reducing Early Childhood Caries Through Access to Care and Health Education, for physicians and obstetric nurses to provide information on the importance of oral health care for pregnant women.

The Home Visitation program, in collaboration with the Division of Children and Families, provides training to Home Visiting staff to encourage families to perform daily dental hygiene and the importance of establishing a dental home. Since its inception in 2014, 7,200 families participating in home visiting programs received oral health information and oral health care kits. This program was updated during the 2020-2021 fiscal year and developed into a series of three one-hour oral health trainings regarding vape/tobacco, diabetes and pregnancy. They were presented in January and February of 2021 and attended by a total of 256 participants. These webinar trainings are now available on the New Jersey Learning Management Network, a portal for public health training. This project is ongoing, with a Home Visiting newsletter slated to be released during Spring 2021, and 1200 oral health kits to be distributed to Home Visitation agencies.

Every 2 years, the NJ Department of Health directs the COHP to survey all State Health Officers and Dental Directors to update the Dental Clinic Directory, “Dial a Smile”. This directory, available online on the Department of Health website, serves as a public resource to identify providers of sliding scale, low-cost and no cost clinical dental services, increase access to care, and assist the public to establish dental homes and decrease Emergency Room visits for dental emergencies. Information about the “Dial A Smile” directory and how to find it online is regularly given to community stakeholders and included in COHP special initiatives, programs, and newsletters. The directory is edited periodically upon request and will be fully updated during the Summer and Fall 2021. It can be found online at: https://www.nj.gov/health/fhs/oral/documents/dental_directory.pdf .

The COHP newsletter, "Miles of Smiles" for school nurses is distributed annually each Fall to school nurses throughout the state. In the 2019-2020 school year, 3,258 were distributed. The "Oral Health Facts for Women, Infants, and Children" newsletter is emailed to State WIC Coordinators each Spring. Both contain timely oral health topics of interest and importance for staff to communicate to the populations they serve. These newsletters and other similar resources will be included on the Oral Health Services Unit webpage. The COHP has an ongoing relationship with WIC offices to provide education to their participants, however, due to COVID, WIC sites were closed. In February 2021, a virtual presentation on oral health and pregnancy was given to WIC staff during their regular staff meeting. COHP has offered virtual education presentation as needed and requested for WIC participants. Despite closures due to COVID, 435 WIC participants received education and oral health supplies during the 2019-2020 grant year.

The Oral Health Nutrition and Obesity Control Program reimburses eight Federally Qualified Health Centers to provide at dental visits, a minimum of three nutrition counseling sessions to Medicaid-eligible or uninsured children ages 6-11 who are determined to be within overweight or obese range as calculated by Body Mass Index. In Years 1 and 2 of this grant (Sept. 2018 – Aug. 2020), 4,655 children were screened and received oral health nutritional counseling. Of these, 1,362 were found to be in the overweight and obese range and received

two additional counseling sessions. A caries rate of 23.5 % was found in the eligible cohort. The goals of this program are to increase oral health literacy, provide information on proper nutrition and the benefits of physical activity, and improve the dental and overall health for children and their families. Funds for this grant are provided by a 4-year HRSA Support of State's Oral Health Workforce Activities grant, awarded to the Division of Community Health Services commencing September 2018 and ending August 2022. Program deliverables are overseen by the Oral Health Services Unit.

The Oral Health Services Unit collaborated with the Division of Family Health Services, Doula Pilot Project Liaison, and the Department of Human Services, Division of Medical and Health Assistance Services, NJ Family Care to create an oral health training for Doula staff. The goals for the webinar were:

1. Provide workforce with basic oral health knowledge to share with families and pregnant people.
2. Increase oral health literacy of staff working with families and pregnant people.
3. Provide workforce with information on dental services and resources available in New Jersey and through NJ FamilyCare to share with families and pregnant people thereby increasing access to care and utilization of their dental services, especially for those enrolled in NJ FamilyCare.
4. Provide a basis for ongoing discussion to assess the needs of community workforce in assisting their families and pregnant people to increase oral health literacy and improve oral health outcomes.

There were 47 attendees at the June, 2020 presentation. This webinar is now available on the NJ Learning Management Network.

Annual Report - NPM #14:

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

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 from smoking in pregnancy are significant. The excess costs for prenatal care and complicated births among pregnant women who smoke exceed $4 billion a year. (See NJ Pregnancy smoking rates in table A below) It has been estimated that a 1% drop-in rates of smoking among pregnant women could result in a 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% a year over seven years. Secondhand smoke also has significant health effects on an infant. Pregnant women exposed to second hand smoke have a 20% increased risk of having an infant born with low birth weight, and secondhand smoke exposure also increases the risk for infections in the infant, and even death from SUID (Refer to the Perinatal Risk Assessment [NJ Medicaid recipients] below). 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. (See NJ exposure in table B below) The cost to care for childhood illnesses resulting from exposure to second and third hand smoke is estimated at $8 billion a year. In addition to the effects during the perinatal period, health consequences for older children and adults (whether from directly smoking or from a second and third hand exposure) are well documented in the literature and include respiratory infections and disease, cancer, and death. In 2018, the New Jersey State Health Assessment Data shows that 51% of nonsmoking high school youth are exposed to secondhand smoke.

Perinatal Risk Assessment Data

*Majority of assessments completed by Medicaid recipients and not representative of state overall

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%

Initiated in 2001 with funding from the NJDOH-Comprehensive Tobacco Control Program, Mom's Quit

Connection (MQC) is NJ's maternal child health smoking cessation and education program. There have been changes in the services provided and their capacity to be a statewide program through the years based on availability of funds. MQC utilizes a proactive behavior modification model, offering face-to-face individual cessation counseling, telephone counseling and texting support to assist clients in developing a customized quit plan. Through these direct services, both for consumers and professionals, MQCF focuses its efforts to reach the women and family members who need the help to quit, educate them of the dangers of tobacco use and offer judgement free, evidenced-based treatment methods by Nationally Certified Tobacco Treatment Practitioners and NJ Certified Tobacco Treatment Specialists.

The program was expanded during FY 2015 and Mom's Quit Connection (MQC) was able to develop a multi-pronged and comprehensive statewide approach to perinatal smoking cessation activities. The new activities include:

- Promoting Mom's Quit Connection (MQC) to further expand its reach to pregnant and parenting mothers in NJ.
- Increasing capacity of Mom's Quit Connection with respect to direct services for pregnant and parenting mothers statewide.
- Preventing relapse after delivery.

Twenty target municipalities (TMs) were identified on which to focus MQC outreach and intervention, thus maximizing efforts to areas with the greatest need. The TM's were chosen based on the high numbers of pregnant women who used tobacco during pregnancy, and the high rate of preterm delivery among Black, Non-Hispanic women in these municipalities. Seven of the twenty municipalities were located in five counties outside of the southern region; the remainder were within the seven southern counties. In January 2018, the MQC database software program was redesigned and upgraded to a web-based system using the Salesforce platform in order to support more detailed reporting and integration of planned mobile technology.

Given the declining rate of maternal smoking and the stagnant and in some cases increasing numbers of postpartum women who were returning to smoking after delivery, MQC chose to rebrand to MQC for Families. According to the 2017 PRAMS Brief published by the NJDOH, living with other smokers represented the most prevalent indicator for postpartum relapse. Expanding the program to MQC for Families has enhanced its cessation population parameters to include parents and care givers of children under 8 years old along with the pregnant woman 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. 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.

From July 1, 2020 thru June 30, 2021, there were 469 referrals to the program, 26% from the Central region, 27% from the Northern region and 46% from the Southern region. 417 of these referrals came from the automated Perinatal Risk Assessment (PRA) system: referrals were faxed from providers; and, 24 were self-referrals from the MQC website and Facebook page online registration option. All 469 referred clients were sent self-help cessation information and texted the option of enrolling in MQC's cession counseling program. 35 clients received a Level 1 cessation counseling session, and 27 clients went on to enroll in intensive cessation counseling. There were a total of 178 counseling sessions with clients enrolled in case management and 218 providers received client status reports on newly enrolled and existing clients. Of the enrolled pregnant clients, 95% quit or significantly reduced their consumption and 50% quit completely (the national average maternal quit rate is 24%). Among[CBN1] non-pregnant clients enrolled in cessation counseling, 89% quit or significantly reduced consumption, of which 50% completely quit. Throughout this year, 467 MQCF referred clients and their family members/caregivers were referred to the NJ Quitline.

Due to COVID 19, all work between July 1, 2020 and June 30, 2021 by MQCF was completed through the Zoom or Teams platforms. MQCF provides statewide training to clinicians, medical professionals, social service agencies and educators on the Ask, Advise and Refer: Brief tobacco Intervention Model (AAR), in an effort to improve assessing for tobacco use and referring pregnant women, mothers, fathers and caregivers who use tobacco to MQCF. AAR, CDC Best Practice intervention, teaches the trainees how to successfully talk to their clients/patients about smoking, how to advise them to quit and where to make a referral that will facilitate the quit. Brief tobacco dependence treatment is effective as stated in the Treating Tobacco Use and Dependence: Clinical Practice Guidelines. From July 2020 through June 2021, 597 professionals received AAR training through the Zoom and Teams platforms. Professional outreach and networking is vital for reaching new providers, offering MQCF Program Orientations and enhancing their services with professional and consumer education, tobacco resources and a system for direct referral for cessation counseling. From July 2020 thru June 2021, an additional 617 professionals received orientation and information sessions about MQCF and NJ Quitline. MQCF participates in conferences to increase professional awareness of the services that are available. 1710 professionals received information through conference tabling, toolkits, resource requests and networking opportunities. Approximately 93 pregnant women and families received information about the dangers of maternal smoking and MQCF and NJ Quitline services through formal education sessions via the Zoom platform. Virtual community outreach and partner events reached an additional 461 mothers and families. MQCF staff now follow up (332 letters and emails sent this year) with every new prenatal provider trained on the use of the PRA, about scheduling a MQCF program orientation session and to promote ASK ADVISE REFER training. A vast amount of tobacco resource information has been made available online by MQCF for anyone interested, removing any barriers to access.
This past year, funding from the FHI Prematurity Prevention Initiative (PPI) was utilized to continue MQCF services to target municipalities

with the highest rates of black infant mortality, and specifically, Atlantic City and Newark. These efforts resulted in a 6% increase in referrals to MQCF from the Northern region overall, and Essex County moving from the number eleven spot in client referrals last program year to the number one spot this year. According to the MQCF data by target municipalities those communities with highest rates of Black Infant Mortality and adult smoking were approximately 35% of all referrals. These results demonstrate that collaboration and targeted efforts were impactful in reaching mothers most at risk for maternal and infant mortality.

Collaboration with the PPI initiative also facilitated the launch of the Quit for Kids (QFK) texting support Program in May 2020. QFK is offered to stand alone, as texting support to quit or to coexist with the individual MQCF cessation services. To target the difficulties of quitting smoking, texts are personalized for each participant and geared toward their particular triggers, cravings and problems. If the participant would like to talk to an MQCF quit coach they are able to connect through QFK. During the startup year, 16 clients opted to talk to a quit coach. PRA clients with a current or past history of smoking are automatically enrolled to QFK, with an opt-out option. Clients working with MQCF can be enrolled through the client database. The texting program uses the GOMO platform to provide smoking cessation and child development messages to pregnant and post-partum women, as well as dads and family members of children up to eight years old. The goal of the texting program is to engage a broader range of clients, including a demographic naturally drawn to online services, and clients who may not initially be comfortable with one on one counseling. Enrolling with an MQCF cessation specialist is encouraged, but not required. This type of customized perinatal texting programs is relatively new; therefore, extensive analytics and evaluation have been built into the program to help determine its effectiveness in engaging clients and helping them to quit. From May 2020 to June 2021, 590 clients have enrolled in QFK.

MQCF program information remains on the NJ Quitline website and in the downloadable NJ Provider Cessation Toolkit. MQCF is also assisting with cessation content for the PPI website, and “pay attention cards”. MQCF program information is included in the PPI “COVID19 - GO KITS” project, providing supplies and resources for mothers at risk for preterm labor to be better informed and prepared for self-monitoring at home. Go-kits include critical resources such as blood pressure monitor, digital thermometer, face mask and information on achieving a healthy pregnancy and birth. Since the inception of the Go-kit project in March 2020, 1,735 kits have been distributed to New Jersey pregnant and postpartum women. Within the last 6 months 540 kits have been received. To date, 21% of Go-kits were given postpartum women, while 79% were distributed to prenatal women. Tobacco-Free Ride NJ-Clean Air for Kids in Cars (TFR) is a joint project between the FHI-FAS MQCF team and the SNJPC tobacco control program. TFR is designed to educate drivers about the risk of second and third hand smoke and vapor exposure to younger passengers. Those who pledge to keep their cars smoke free for children under 18 receive an incentive that includes a mobile bag, keychain flashlight, tire gage, mini first aid kit, car magnet, and educational materials. The first Tobacco-Free Ride campaign ran from January 17, 2020 through December 31, 2020, and 414 pledges were received from New Jersey drivers in the 2020 pledge year. On January 1, 2021, TFR was relaunched with a focus on keeping cars tobacco free for children eight and younger. There have been 401 unique pledges signed to date.

Tables NPM 14A & B:

1. Percent of women who smoke during pregnancy (last 3 months)

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
14 A. Percent of women who smoke during pregnancy	6.4	6.5	5.7	5.5	5.6	4.8	4.4	4.4	3.5	3.1

Notes - Data is from the NJ PRAMS Survey

B) Percent of children who live in households where someone smokes

Annual Objective and Performance Data	**2003**	**2007**	**2011-2012**	**2016**	**2017**
14B. Percent of children who live in households where someone smokes	28.7	19.7	20.3	n/a	n/a

Data Source: National Survey of Children's Health (NSCH)

[CBN1]Susan, we looked for current rate and don’t have the time for that research.

Cross-Cutting/Systems Building - Application Year

Plan for the Application Year NPM # 13:

A) Percent of women who had a dental visit during pregnancy and
B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

During fiscal year 2018-2019, the Division of Community Health Services established the Oral Health Services (OHS) Unit. Dental Hygienist, Yvonne Mikalopas, was onboarded in March 2019, and Dental Director, Dr. Darwin K. Hayes, in July 2019 to oversee and manage oral health programs and projects for the state. Meetings with key stakeholders and focus groups which took place during 2019-2020, guided by consulting group Health Resources in Action (HRiA), resulted in an oral health key findings report. During 2021 – 2022 this report and additional meetings will culminate in the first ever New Jersey State Oral Health Plan. This plan will guide state oral health programming and create an oral health presence within Healthy New Jersey 2030 (HNJ2030), the state 10-year health improvement plan. Yvonne Mikalopas serves on the HNJ2030 Coordinating Committee, Access to Quality Care Committee, and Integrated Health subcommittee.

The OHS will continue to oversee the deliverables and activities of The Children's Oral Health Program (COHP), now in its 40th year, throughout 2021-2022. The COHP was incredibly successful in continuing to conduct outreach to schools and provide oral health education programming despite the school shutdowns and other challenges caused by the pandemic. Virtual live and virtual recorded programming was used to accommodate schools and community groups and the Home Visitation staff training was updated and revitalized. Dental kits were still provided for school children and over 1200 oral health care kits for families were distributed to HeadStart agencies. The Fluoride Varnish pilot program will continue to expand to new schools and in-person education programs are anticipated to increase throughout the school year. The 2022 NJ Dial a Smile Dental Directory is being updated and will be published online before the end of 2021 on the DOH website.

The award of the 4-year HRSA Workforce grant in 2017 allows for the continuation in 2021-2022 of two oral health initiatives to address the public health crises of opioid addiction and childhood obesity. In partnership with Rowan University School of Osteopathic Medicine, The Opioid Education for Oral Health Workforce and Dental Students Program educates dentists and dental students on best practices for prescribing opioid medications, pain management in the dental setting, and treatment guidelines. This free program, launched online in May 2020, includes continuing education credits conferred by Rutgers University School of Dental Medicine, school of Continuing Education. The modules have been incorporated into the curriculum for 3rd and 4th year dental students, beginning in February 2021. Opioid education is now a requirement per NJ Board of Dentistry regulations for dentists and dental hygienists beginning in the current license renewal period which ends October 31, 2021. Dr. Hayes serves on the NJ Board of Dentistry since February 2020.

Proper nutrition is vital to both oral health and overall health. According to Healthy New Jersey 2020, there has been a dramatic increase in NJ adults, teens and children who are overweight or obese.
The Oral Health Nutrition and Obesity Control Program educates parents of children with body-mass index (BMI) in the overweight or obese range on proper nutrition for good oral health, and provides strategies to reduce dental caries, dental disease, and obesity in children age 6 to 11 who are uninsured, on Medicaid or Medicaid-eligible. This creates a transferable model for use by dental practitioners to screen for BMI and provide nutritional counseling as best practice in the dental setting. In year one of the grant, 3 FQHCs piloted the program. In grant year 2021-2022, thirteen organizations will provide the activities under the grant, including 4 non-traditional partners who are private practitioner dental practices and/or non-profits providing dental services for high numbers of Medicaid patients in underserved areas of the state. Additionally, a healthy food delivery program will be piloted in conjunction with this grant, which reinforces the importance of healthy food choices for patients and their families receiving the oral health nutritional counseling and education.

Additional goals of the OHS unit during 2021 – 2022 include a third-grade oral health Basic Screening Survey (BSS) through partnership with the NJ Department of Education (DOE). BSS is considered to be a national standard for establishing key oral health base-line data. Consultation with the Association of State and Territorial Dental Directors (ASTDD) has determined that a sample-size of 3.000 third-grade students in 73 schools will provide representational base-line data for the state. In collaboration with dental providers and the DOE Office of Early Childhood Education, HeadStart and Early HeadStart enrollees will receive dental screenings and application of Fluoride Varnish, and families will establish local dental homes for regular dental care. These activities are supported by an ongoing Preventive Health Services Block grant award to the Community Health Services Division with a final grant year period of October 1, 2021 – September 30, 2022.

Expanding on the success of the 2020 Doula Oral Health Education project and the 2021 Home Vistation Oral Health Education project, the Oral Health Services unit will on October 19, 2021, participate in a collaborative Department of Early Childhood Education Oral Health Summit, the goal of which is to increase oral health care access and awareness of services for pregnant women and HeadStart families who are enrolled in Early Head Start and Head Start programs in the state. Head Start agencies and Home Visitation staff serving the Head Start population will receive information about resources available through the NJ Department of Health, Department of Human Services, and Managed Care Organizations. Dr. Hayes will make opening remarks and Yvonne Mikalopas will present introductory

information as a basis for future oral health trainings for HeadStart staff.

In November 2021, Yvonne Mikalopas will present, “Oral Health for Student Well Being,” at the annual NJ Education Association Conference in Atlantic City, approved for presentation by the NJEA through proposal application process.

Dr. Hayes will continue to serve on the NJ Board of Dentistry during 2021-2022. Dr. Hayes has been integral at advising the Board throughout the COVID pandemic crisis on the status of dental services provided by Federally Qualified Health Centers and providing guidance regarding the administration of COVID vaccinations by dentists and dental hygienists.

Plan for the Application Year NPM # 14:

National Performance Measure 14:

Plans for the upcoming year to address NPM #14 include:

Promoting Mom’s Quit Connection for Families (MQCF) to expand reach to pregnant and parenting mothers in NJ.

- Continue the development of a tobacco training curriculum specifically for Healthy Women, Healthy Families community health and central intake workers to provide tobacco education in the field.
- Utilize focus group success to pilot an onsite smoking cessation group for prenatal/postpartum Healthy Start clients in Camden, NJ.
- Redesign and enhance momsquit.com website to engage wider range of clients and promote the Quit for Kids texting support program.

Increasing Capacity for Direct Service in NJ.

- Continue to expand MQCF’s existing services to enable face-to-face and telephone counseling in the Northern and Central regions of the state, through increased presence of MQCF staff in prenatal and pediatric health care settings.
- Promote onsite trainings and webinars to maternal and child health 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 first trimester through 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.
- Develop and implement a “Tobacco-free Ride NJ” Clean Air in Cars campaign to reduce second and third hand smoke exposure among children riding in vehicles.

III.F. Public Input

III.G. Technical Assistance

IV. Title V-Medicaid IAA/MOU

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New Jersey

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 0	
A. Preventive and Primary Care for Children		(%)
B. Children with Special Health Care Needs		(%)
C. Title V Administrative Costs		(%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 0	
A. Your State's FY 1989 Maintenance of Effort Amount $ 9,419,570		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 0	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 0	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
No Other Federal Programs were provided by the State on Form 2 Line 9.	

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,500,000			
A. Preventive and Primary Care for Children	$ 3,515,890	(30.6%)		(%)
B. Children with Special Health Care Needs	$ 4,344,241	(37.8%)		(%)
C. Title V Administrative Costs	$ 948,907	(8.3%)		(%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 8,809,038		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 158,057,356			
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0			
5. OTHER FUNDS (Item 18e of SF-424)	$ 0			
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0			
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 158,057,356		$ 0	
A. Your State's FY 1989 Maintenance of Effort Amount $ 9,419,570				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 169,557,356		$ 0	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 65,719,932		$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 235,277,288		$ 0	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 1,700,000	
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,426,000	
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 210,000	
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 187,500	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 10,969,325	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000	
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 37,058,450	
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 11,437,966	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Ryan White	$ 2,185,691	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts:

- The value in Line 1, Federal Allocation, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
- The value in Line 3, State MCH Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: New Jersey

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women		
2. Infants < 1 year		
3. Children 1 through 21 Years		
4. CSHCN		
5. All Others		
Federal Total of Individuals Served		

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women		
2. Infants < 1 year		
3. Children 1 through 21 Years		
4. CSHCN		
5. All Others		
Non-Federal Total of Individuals Served		
Federal State MCH Block Grant Partnership Total		

Form Notes for Form 3a:

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: New Jersey

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services		
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One		
B. Preventive and Primary Care Services for Children		
C. Services for CSHCN		
2. Enabling Services		
3. Public Health Services and Systems		
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Line 4 Expended Total		
Federal Total		

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services		
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One		
B. Preventive and Primary Care Services for Children		
C. Services for CSHCN		
2. Enabling Services		
3. Public Health Services and Systems		
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Line 4 Expended Total		
Non-Federal Total		

Form Notes for Form 3b:

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: New Jersey

Total Births by Occurrence: 0 **Data Source Year:**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions				

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: New Jersey

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	19,094	68.8	0.0	5.1	25.9	0.2
2. Infants < 1 Year of Age	19,838	68.8	0.0	5.1	25.9	0.2
3. Children 1 through 21 Years of Age	168,518	29.0	0.0	65.0	6.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^						
4. Others	33,918	0.0	0.0	0.0	0.0	100.0
Total	241,368					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	99,585	Yes	99,585	100.0	99,585	19,094
2. Infants < 1 Year of Age	96,906	Yes	96,906	100.0	96,906	19,838
3. Children 1 through 21 Years of Age	2,263,586	Yes	2,263,586	100.0	2,263,586	168,518
3a. Children with Special Health Care Needs 0 through 21 years of age^	401,718	Yes	401,718		0	
4. Others	6,519,145	Yes	6,519,145	100.0	6,519,145	33,918

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Source: Estimated number of pregnant women served by the Healthy Women, Healthy Families initiative during calendar year 2020 (pregnant women with CHS or PRA submitted to Central Intake from 1/1/2020 to 12/31/2020). Primary Source of Coverage from the completed PRA or CHS in the SPECT database. Under Primary Source of Coverage, the percent for "Unknown" was changed from .3% to .2% so that columns B to F would add to 100%.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Source: Number of infants delivered to women served by the Healthy Women, Healthy Families initiative during calendar year 2020 (a completed PRA or CHS in the SPECT database). Primary Source of Coverage from the completed PRA or CHS in the SPECT database.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Estimated number of children 1- 21 served by NJ DOH MCH programs in 2020 from MCHS. Largest unduplicated count is from the lead screening program.	
4.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Others include adolescents and young adults (15-24) served by Family Planning in CY 2020. Source NJ Family Planning 2020 Annual Report.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: Total of pregnant women served is estimated from the number of NJ resident mothers delivering in CY 2019 from the birth certificate data (plurality=1) as reported by NJ DOH SHAD. Used reference data for 2020 report because latest birth certificate data available on NJ SHAD is 2019.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Total of Infants <1 year of Age served is estimated from the number of NJ resident mothers delivering in CY 2019 from the birth certificate data (plurality=1) as reported by NJ DOH SHAD. Used reference data for 2020 report because latest birth certificate data available on NJ SHAD is 2019.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Used reference data.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: NJ DOH SCHEIS estimate of the children with special health care needs served in 2019. Used reference data for 2020 report.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Used reference data. Others (22+) - Data source = US Census Bureau Population Estimates, 2019. Includes both men and women age 22 and older.	

Data Alerts:

1.	Please complete all required fields.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: New Jersey

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	99,305	44,044	13,043	27,395	80	10,910	57	1,329	2,447
Title V Served	99,305	44,044	13,043	27,395	80	10,910	57	1,329	2,447
Eligible for Title XIX	29,790	7,775	6,552	12,763	23	1,324	16	545	792
2. Total Infants in State	99,305	44,044	13,043	27,395	80	10,910	57	1,329	2,447
Title V Served	99,305	44,044	13,043	27,395	80	10,910	57	1,329	2,447
Eligible for Title XIX	29,790	7,775	6,552	12,763	23	1,324	16	545	792

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Source: 2019 New Jersey Birth Certificate Database. Retrieved on June 24, 2021 from New Jersey Department of Health, New Jersey State Health Assessment Data website: https://www-doh.state.nj.us/doh-shad/.	
2.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Source: 2019 New Jersey Birth Certificate Database - Count of Mothers with Positive Medicaid Status. Retrieved on June 24, 2021 from New Jersey Department of Health, New Jersey State Health Assessment Data website: https://www-doh.state.nj.us/doh-shad/.	
3.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Source: 2019 New Jersey Birth Certificate Database. Retrieved on June 24, 2021 from New Jersey Department of Health, New Jersey State Health Assessment Data website: https://www-doh.state.nj.us/doh-shad/.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: New Jersey

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 328-3838	(800) 328-3838
2. State MCH Toll-Free "Hotline" Name	Family Health Line	Family Health Line
3. Name of Contact Person for State MCH "Hotline"	Susan Lattimore	Pamela Taylor
4. Contact Person's Telephone Number	(609) 984-0755	(609) 984-0755
5. Number of Calls Received on the State MCH "Hotline"		4,235

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	211	
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	nj.gov/health/fhs	nj.gov/health/fhs
4. Number of Hits to the State Title V Program Website		12,854
5. State Title V Social Media Websites	twitter, facebook	Followers on NJDOH Twitter and Facebook
6. Number of Hits to the State Title V Program Social Media Websites		124,066

Form Notes for Form 7:

In 2019, the Family Health Line (FHL) call center was moved and they began implementing a different method of calculating calls. Their level of services increased, resulting in longer call times, and transferring callers internally to discuss programs and services. A decision was made to discontinue counting calls to the FHL that were transferred to other service lines. This resulted in a reduction in call county by approximately 1000 calls per quarter.

Form 8
State MCH and CSHCN Directors Contact Information

State: New Jersey

1. Title V Maternal and Child Health (MCH) Director	
Name	Dr. Marilyn Gorney-Daley
Title	MCH Director
Address 1	55 North Willow Street
Address 2	
City/State/Zip	Trenton / NJ / 08608
Telephone	(609) 913-5471
Extension	
Email	marilyn.gorney-daley@doh.nj.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Dr. Sandra Howell
Title	SCHEIS Director
Address 1	55 North Willow Street
Address 2	
City/State/Zip	Trenton / NJ / 08608
Telephone	(609) 913-5471
Extension	
Email	sandra.howell@doh.nj.gov

3. State Family or Youth Leader (Optional)	
Name	Diana MTK Autin
Title	Executive Co-Director - Statewide Parent Advocacy Network
Address 1	35 Halsey Street
Address 2	
City/State/Zip	Newark / NJ / 07102
Telephone	(973) 642-8100
Extension	
Email	diana.autin@spanadvocacy.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: New Jersey

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increasing equity in healthy births.	Continued
2.	Reducing Black Maternal and Infant Mortality.	Continued
3.	Improving Nutrition & Physical Activity.	Continued
4.	Promoting Youth Development Programs.	Continued
5.	Improving Access to Quality Care for CYSHCN	Continued
6.	Reducing Teen Pregnancy	Continued
7.	Improving & Integrating Information Systems	Continued
8.	Smoking Prevention	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increasing equity in healthy births.	Continued
2.	Reducing Black Maternal and Infant Mortality.	Continued
3.	Improving Nutrition & Physical Activity.	Continued
4.	Promoting Youth Development Programs.	Continued
5.	Improving Access to Quality Care for CYSHCN	Continued
6.	Reducing Teen Pregnancy	Continued
7.	Improving & Integrating Information Systems	Continued
8.	Smoking Prevention	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: New Jersey

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	76.1 %	0.1 %	74,788	98,339
2018	76.5 %	0.1 %	76,188	99,582
2017	76.3 %	0.1 %	76,128	99,736
2016	76.5 %	0.1 %	77,067	100,728

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	81.4	2.9	795	97,638
2017	74.4	2.8	728	97,907
2016	73.2	2.7	733	100,153
2015	71.1	3.1	536	75,406
2014	73.5	2.7	737	100,305
2013	71.4	2.7	710	99,434
2012	67.8	2.6	687	101,351
2011	66.9	2.6	686	102,496
2010	74.9	2.7	776	103,655
2009	77.3	2.7	825	106,726
2008	74.1	2.6	802	108,253

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	20.3	2.0	103	507,832
2014_2018	23.8	2.2	122	511,552

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	7.9 %	0.1 %	7,812	99,173
2018	7.9 %	0.1 %	8,001	101,205
2017	7.9 %	0.1 %	8,040	101,215
2016	8.1 %	0.1 %	8,272	102,622
2015	8.1 %	0.1 %	8,345	103,095
2014	8.1 %	0.1 %	8,315	103,262
2013	8.3 %	0.1 %	8,469	102,516
2012	8.2 %	0.1 %	8,534	104,160
2011	8.5 %	0.1 %	9,005	105,802
2010	8.2 %	0.1 %	8,814	106,844
2009	8.3 %	0.1 %	9,137	110,257

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	9.6 %	0.1 %	9,510	99,447
2018	9.5 %	0.1 %	9,618	101,200
2017	9.5 %	0.1 %	9,613	101,230
2016	9.9 %	0.1 %	10,126	102,607
2015	9.8 %	0.1 %	10,064	103,092
2014	9.6 %	0.1 %	9,885	103,279
2013	9.7 %	0.1 %	9,940	102,527
2012	9.7 %	0.1 %	10,113	104,181
2011	9.9 %	0.1 %	10,478	105,844
2010	9.7 %	0.1 %	10,362	106,874
2009	10.0 %	0.1 %	11,048	110,291

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	25.8 %	0.1 %	25,619	99,447
2018	25.3 %	0.1 %	25,635	101,200
2017	25.1 %	0.1 %	25,434	101,230
2016	25.0 %	0.1 %	25,668	102,607
2015	24.4 %	0.1 %	25,133	103,092
2014	23.8 %	0.1 %	24,549	103,279
2013	23.9 %	0.1 %	24,456	102,527
2012	24.4 %	0.1 %	25,381	104,181
2011	24.5 %	0.1 %	25,960	105,844
2010	25.7 %	0.1 %	27,472	106,874
2009	27.6 %	0.1 %	30,482	110,291

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	2.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	3.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.9	0.2	497	101,515
2017	5.2	0.2	529	101,527
2016	5.1	0.2	520	102,922
2015	5.0	0.2	513	103,372
2014	5.0	0.2	514	103,561
2013	5.7	0.2	585	102,903
2012	5.4	0.2	561	104,511
2011	5.3	0.2	564	106,153
2010	5.6	0.2	601	107,231
2009	5.8	0.2	639	110,642

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	3.8	0.2	385	101,223
2017	4.5	0.2	451	101,250
2016	4.0	0.2	414	102,647
2015	4.7	0.2	483	103,127
2014	4.4	0.2	454	103,305
2013	4.5	0.2	463	102,575
2012	4.4	0.2	463	104,230
2011	5.1	0.2	538	105,883
2010	4.8	0.2	513	106,922
2009	5.2	0.2	576	110,331

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.6	0.2	265	101,223
2017	3.2	0.2	319	101,250
2016	2.9	0.2	295	102,647
2015	3.2	0.2	331	103,127
2014	3.0	0.2	310	103,305
2013	3.2	0.2	327	102,575
2012	3.2	0.2	335	104,230
2011	3.5	0.2	367	105,883
2010	3.5	0.2	371	106,922
2009	3.7	0.2	407	110,331

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	1.2	0.1	120	101,223
2017	1.3	0.1	132	101,250
2016	1.2	0.1	119	102,647
2015	1.5	0.1	152	103,127
2014	1.4	0.1	144	103,305
2013	1.3	0.1	136	102,575
2012	1.2	0.1	128	104,230
2011	1.6	0.1	171	105,883
2010	1.3	0.1	142	106,922
2009	1.5	0.1	169	110,331

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	142.3	11.9	144	101,223
2017	169.9	13.0	172	101,250
2016	148.1	12.0	152	102,647
2015	165.8	12.7	171	103,127
2014	156.8	12.3	162	103,305
2013	179.4	13.2	184	102,575
2012	168.9	12.7	176	104,230
2011	211.6	14.2	224	105,883
2010	199.2	13.7	213	106,922
2009	213.9	13.9	236	110,331

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	51.4	7.1	52	101,223
2017	69.1	8.3	70	101,250
2016	57.5	7.5	59	102,647
2015	69.8	8.2	72	103,127
2014	61.0	7.7	63	103,305
2013	53.6	7.2	55	102,575
2012	29.7	5.3	31	104,230
2011	64.2	7.8	68	105,883
2010	48.6	6.8	52	106,922
2009	80.7	8.6	89	110,331

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	10.1 %	1.0 %	9,109	89,761
2018	9.7 %	0.9 %	8,992	92,499
2017	10.7 %	1.0 %	9,925	93,143
2016	8.9 %	0.9 %	8,290	93,565
2015	10.5 %	1.0 %	9,896	94,736
2014	10.5 %	1.0 %	10,119	96,484
2013	10.7 %	1.2 %	6,847	63,854
2012	10.5 %	1.1 %	10,199	96,852
2011	7.6 %	0.8 %	7,369	97,123
2010	7.4 %	0.8 %	7,235	97,809
2009	7.7 %	0.8 %	7,683	100,088
2008	7.2 %	0.7 %	7,303	102,138
2007	8.0 %	0.8 %	8,409	105,447

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.2	0.3	604	97,566
2017	6.9	0.3	677	98,407
2016	6.5	0.3	664	101,490
2015	6.3	0.3	485	76,667
2014	6.0	0.2	616	102,104
2013	5.4	0.2	547	101,289
2012	5.2	0.2	531	103,017
2011	4.8	0.2	504	104,429
2010	4.3	0.2	458	105,573
2009	3.6	0.2	388	108,684
2008	2.9	0.2	316	110,101

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	11.4 %	1.4 %	214,498	1,875,460
2017_2018	11.4 %	1.6 %	210,487	1,852,318
2016_2017	13.0 %	1.6 %	240,834	1,855,980
2016	13.0 %	1.7 %	243,501	1,869,386

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	11.5	1.1	109	947,489
2018	13.8	1.2	131	951,826
2017	10.2	1.0	98	961,497
2016	13.4	1.2	129	964,131
2015	13.4	1.2	130	972,271
2014	13.2	1.2	129	979,224
2013	13.0	1.2	128	985,651
2012	13.7	1.2	135	985,609
2011	14.9	1.2	148	991,697
2010	11.6	1.1	116	1,000,784
2009	11.9	1.1	119	1,000,485

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	22.0	1.4	243	1,104,539
2018	19.3	1.3	216	1,116,429
2017	21.5	1.4	244	1,132,492
2016	21.9	1.4	249	1,135,578
2015	21.5	1.4	245	1,141,408
2014	23.4	1.4	269	1,150,665
2013	21.2	1.4	245	1,157,468
2012	23.5	1.4	274	1,167,897
2011	22.8	1.4	268	1,174,188
2010	23.5	1.4	278	1,185,434
2009	23.4	1.4	279	1,190,456

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	5.5	0.6	92	1,677,632
2016_2018	5.1	0.6	86	1,695,579
2015_2017	5.5	0.6	94	1,711,079
2014_2016	6.0	0.6	103	1,720,833
2013_2015	5.6	0.6	97	1,731,938
2012_2014	5.6	0.6	98	1,748,011
2011_2013	5.6	0.6	98	1,762,774
2010_2012	6.1	0.6	108	1,778,991
2009_2011	6.8	0.6	121	1,791,565
2008_2010	7.3	0.6	132	1,803,971
2007_2009	9.2	0.7	166	1,808,004

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	5.4	0.6	91	1,677,632
2016_2018	5.2	0.6	88	1,695,579
2015_2017	5.2	0.6	89	1,711,079
2014_2016	5.0	0.5	86	1,720,833
2013_2015	5.2	0.6	90	1,731,938
2012_2014	5.0	0.5	87	1,748,011
2011_2013	4.9	0.5	86	1,762,774
2010_2012	5.2	0.5	92	1,778,991
2009_2011	5.2	0.5	94	1,791,565
2008_2010	4.3	0.5	78	1,803,971
2007_2009	3.8	0.5	68	1,808,004

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	17.0 %	1.4 %	333,065	1,959,620
2017_2018	16.1 %	1.5 %	318,461	1,975,369
2016_2017	16.9 %	1.4 %	335,399	1,984,620
2016	17.6 %	1.6 %	350,186	1,991,095

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	13.3 %	3.3 %	44,257	333,065
2017_2018	13.0 %	2.8 %	41,290	318,461
2016_2017	13.1 %	2.5 %	43,696	334,610
2016	15.4 %	3.4 %	53,777	348,608

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.0 %	0.7 %	52,153	1,732,728
2017_2018	3.2 %	0.7 %	53,583	1,695,512
2016_2017	3.8 %	0.8 %	63,962	1,675,182
2016	3.0 %	0.8 %	51,125	1,690,459

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	6.8 %	1.1 %	115,814	1,710,013
2017_2018	6.1 %	1.0 %	102,953	1,677,636
2016_2017	6.9 %	1.0 %	115,072	1,675,136
2016	6.7 %	1.2 %	113,028	1,699,618

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	62.2 %	5.5 %	93,938	150,959
2017_2018	47.6 %	6.6 %	84,310	177,146
2016_2017	48.0 %	6.5 %	82,294	171,448
2016	63.1 %	7.1 %	93,943	148,814

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	93.2 %	1.1 %	1,816,045	1,949,180
2017_2018	95.1 %	0.9 %	1,864,112	1,960,503
2016_2017	93.4 %	0.9 %	1,848,679	1,978,263
2016	91.4 %	1.4 %	1,818,162	1,989,732

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	14.9 %	0.2 %	6,934	46,668
2016	15.0 %	0.2 %	8,098	53,917
2014	15.3 %	0.2 %	8,706	56,815
2012	16.8 %	0.2 %	10,101	59,964
2010	18.9 %	0.2 %	11,136	59,000
2008	19.6 %	0.2 %	9,518	48,518

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.9 %	1.0 %	43,284	362,776
2013	8.7 %	1.0 %	33,210	379,797
2011	11.0 %	0.9 %	43,593	395,014
2009	10.2 %	0.9 %	40,304	395,166
2005	11.3 %	1.4 %	42,584	377,203

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	14.0 %	2.2 %	124,304	888,926
2017_2018	15.0 %	2.4 %	124,782	833,921
2016_2017	14.8 %	2.1 %	121,951	824,735
2016	14.8 %	2.2 %	129,139	870,033

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.2 %	0.3 %	82,098	1,932,681
2018	3.6 %	0.2 %	69,597	1,949,789
2017	3.5 %	0.2 %	69,726	1,976,538
2016	3.2 %	0.2 %	62,486	1,982,347
2015	3.8 %	0.3 %	75,961	1,997,134
2014	4.5 %	0.3 %	89,447	2,011,305
2013	5.7 %	0.3 %	114,520	2,019,748
2012	5.2 %	0.2 %	105,002	2,026,059
2011	5.2 %	0.3 %	106,520	2,040,881
2010	6.0 %	0.3 %	122,925	2,061,715
2009	6.2 %	0.3 %	125,910	2,044,860

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	70.2 %	4.1 %	74,000	106,000
2015	71.8 %	3.4 %	76,000	105,000
2014	64.4 %	3.5 %	68,000	106,000
2013	68.0 %	4.1 %	73,000	108,000
2012	64.3 %	3.7 %	71,000	110,000
2011	67.6 %	4.1 %	75,000	111,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	72.3 %	1.6 %	1,323,877	1,831,089
2018_2019	72.8 %	1.5 %	1,358,881	1,867,877
2017_2018	69.1 %	1.9 %	1,290,697	1,868,112
2016_2017	67.7 %	1.6 %	1,271,444	1,877,501
2015_2016	69.5 %	1.5 %	1,313,109	1,888,278
2014_2015	64.3 %	1.8 %	1,227,458	1,908,361
2013_2014	66.8 %	1.7 %	1,288,473	1,928,502
2012_2013	66.4 %	2.0 %	1,267,268	1,909,729
2011_2012	61.5 %	2.3 %	1,188,545	1,933,599
2010_2011	60.0 %	2.1 %	1,141,067	1,901,779
2009_2010	50.1 %	2.4 %	988,975	1,974,001

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	67.1 %	3.3 %	378,199	563,651
2018	65.4 %	3.3 %	373,691	571,261
2017	65.8 %	2.9 %	377,861	574,278
2016	58.5 %	3.0 %	337,079	576,618
2015	59.7 %	3.1 %	346,709	580,517

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	89.0 %	2.3 %	501,729	563,651
2018	88.4 %	2.2 %	505,206	571,261
2017	90.0 %	2.0 %	516,850	574,278
2016	89.9 %	1.9 %	518,630	576,618
2015	87.2 %	2.2 %	506,110	580,517
2014	90.1 %	2.2 %	525,677	583,635
2013	85.5 %	2.7 %	503,999	589,290
2012	90.9 %	2.1 %	538,700	592,555
2011	78.9 %	2.5 %	472,946	599,364
2010	68.9 %	3.1 %	406,490	589,753
2009	61.1 %	2.9 %	361,505	591,504

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	90.6 %	2.2 %	510,837	563,651
2018	91.9 %	1.8 %	525,257	571,261
2017	93.3 %	1.6 %	535,995	574,278
2016	91.7 %	1.6 %	528,657	576,618
2015	95.7 %	1.2 %	555,634	580,517
2014	94.9 %	1.6 %	553,785	583,635
2013	91.8 %	2.1 %	541,065	589,290
2012	91.6 %	2.0 %	542,627	592,555
2011	85.9 %	2.1 %	514,807	599,364
2010	81.7 %	2.7 %	481,886	589,753
2009	71.4 %	2.8 %	422,276	591,504

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.0	0.2	2,697	269,310
2018	10.3	0.2	2,814	271,905
2017	10.3	0.2	2,837	276,014
2016	11.0	0.2	3,060	277,139
2015	12.1	0.2	3,374	278,556
2014	13.1	0.2	3,678	279,807
2013	14.8	0.2	4,188	282,863
2012	16.7	0.2	4,772	286,132
2011	18.6	0.3	5,358	288,611
2010	20.0	0.3	5,793	289,102
2009	22.0	0.3	6,408	290,724

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.4 %	1.0 %	9,112	87,728
2018	11.2 %	1.0 %	10,067	90,244
2017	13.2 %	1.0 %	12,009	91,199
2016	10.6 %	0.9 %	9,641	91,345
2015	9.5 %	0.9 %	8,982	94,573
2014	8.9 %	0.8 %	8,435	94,814
2013	9.4 %	1.0 %	5,984	63,371
2012	9.9 %	1.0 %	9,431	95,258

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.0 %	0.5 %	38,753	1,954,055
2017_2018	2.3 %	0.6 %	44,758	1,966,085
2016_2017	2.2 %	0.6 %	43,332	1,973,069
2016	2.1 %	0.7 %	40,767	1,976,422

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: New Jersey

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					77
Annual Indicator				77.9	77.9
Numerator				1,186,086	1,186,086
Denominator				1,522,317	1,522,317
Data Source				BRFSS	BRFSS
Data Source Year				2018	2018

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	78.0	78.0	79.0	79.0	80.0	80.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	83	83	86	86	87
Annual Indicator	82.0	83.9	82.8	88.8	88.7
Numerator	80,278	85,949	78,449	88,793	82,802
Denominator	97,849	102,457	94,703	100,033	93,345
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	83	83	86	86	87
Annual Indicator	85.8	85.8	85.8	89.8	89.4
Numerator	1,132	1,132	1,132	1,053	79,628
Denominator	1,319	1,319	1,319	1,173	89,080
Data Source	New Jersey PRAMS	New Jersey PRAMS	New Jersey PRAMS	NJ PRAMS	NJ PRAMS
Data Source Year	2016	2016	2016	2018	2019
Provisional or Final ?	Final	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	87.0	88.0	88.0	89.0	90.0	90.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
NJ PRAMS weighted numerator and denominator are entered.

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	20	21	25	25	26
Annual Indicator	23.1	24.8	24.4	22.8	27.7
Numerator	21,220	24,771	22,262	22,315	24,921
Denominator	92,052	100,086	91,389	97,759	90,129
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	26.0	26.0	27.0	27.0	27.0	28.0

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	69	70	70	76	76
Annual Indicator	69.5	70.5	75.0	73.4	73.0
Numerator	43,610	66,406	68,365	66,608	64,315
Denominator	62,769	94,153	91,207	90,735	88,060
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2017	2018	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	69	70	70	76	76
Annual Indicator	69.4	75	75		
Numerator	64,111	68,365	68,365		
Denominator	92,428	91,207	91,207		
Data Source	NJ PRAMS	NJ PRAMS	NJ PRAMS		
Data Source Year	2016	2017	2017		
Provisional or Final ?	Final	Final	Provisional		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	77.0	77.0	78.0	78.0	78.0	78.0

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		88	88
Annual Indicator	25.8	28.6	29.7
Numerator	22,403	24,865	24,716
Denominator	86,724	86,846	83,326
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			88	88
Annual Indicator	89.9	89.9		
Numerator	77,962	77,962		
Denominator	86,721	86,721		
Data Source	NJ PRAMS	NJ PRAMS		
Data Source Year	2016	2017		
Provisional or Final ?	Provisional	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	89.0	89.0	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This is from the 2016 NJ PRAMS weighted data

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		42	42
Annual Indicator	43.1	45.8	47.5
Numerator	37,032	40,078	39,288
Denominator	85,971	87,507	82,694
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			42	42
Annual Indicator	41.3	41.3		
Numerator	37,644	37,644		
Denominator	91,170	91,170		
Data Source	NJ PRAMS	NJ PRAMS		
Data Source Year	2017	2017		
Provisional or Final ?	Final	Provisional		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	43.0	43.0	44.0	44.0	44.0	44.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This is from the 2016 NJ PRAMS weighted data

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			33	34	35
Annual Indicator		32.9	36.3	36.1	32.2
Numerator		65,432	77,344	68,548	50,931
Denominator		198,930	213,230	189,731	157,934
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	36.0	37.0	38.0	39.0	39.0	39.0

Field Level Notes for Form 10 NPMs:

None

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2019	**2020**
Annual Objective		
Annual Indicator	26.6	21.5
Numerator	104,200	82,289
Denominator	391,821	383,470
Data Source	YRBSS	YRBSS
Data Source Year	2013	2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Perpetration		
	2019	**2020**
Annual Objective		
Annual Indicator	13.1	11.6
Numerator	89,695	78,725
Denominator	684,057	680,984
Data Source	NSCHP	NSCHP
Data Source Year	2018	2018_2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Victimization		
	2019	**2020**
Annual Objective		
Annual Indicator	29.9	27.7
Numerator	204,274	188,436
Denominator	684,057	681,427
Data Source	NSCHV	NSCHV
Data Source Year	2018	2018_2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	29.0	28.0	27.0	26.0	25.0	25.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			43	44	45
Annual Indicator		42.0	35.2	35.6	40.6
Numerator		146,471	117,862	113,515	135,084
Denominator		348,608	334,610	318,461	333,065
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	46.0	47.0	48.0	49.0	49.0	49.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			44	44	45
Annual Indicator		18.8	13.8	17.9	19.1
Numerator		28,694	18,598	22,805	26,530
Denominator		152,712	135,014	127,305	139,223
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	45.0	46.0	46.0	46.0	46.0	46.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			83	83	84
Annual Indicator		82.1	82.0	83.2	84.9
Numerator		1,534,885	1,510,657	1,530,393	1,594,112
Denominator		1,868,922	1,842,384	1,839,454	1,877,182
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	84.0	85.0	85.0	85.0	86.0	86.0

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data				
Data Source: National Vital Statistics System (NVSS)				
	2017	**2018**	**2019**	**2020**
Annual Objective			3.8	3.7
Annual Indicator	3.9	3.7	3.2	2.8
Numerator	3,952	3,690	3,235	2,740
Denominator	102,002	100,785	100,785	98,840
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2016	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			3.8	3.7
Annual Indicator	4.4	4.4		
Numerator	4,208	4,208		
Denominator	95,288	95,288		
Data Source	NJ PRAMS	NJ PRAMS		
Data Source Year	2016	2016		
Provisional or Final ?	Provisional	Provisional		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	3.6	3.5	3.4	3.4	3.3	3.3

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This is from the 2016 NJ PRAMS weighted data

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: New Jersey

2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2017	**2018**	**2019**	**2020**
Annual Objective			25	26
Annual Indicator	24.7	26.1	28.6	23.4
Numerator	145,670	169,894	195,766	150,823
Denominator	589,709	651,892	684,924	644,939
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2016	2016_2017	2017_2018	2018_2019

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			85	85	86
Annual Indicator		84.4	86.5	86.5	88.7
Numerator		626,832	589,243	589,243	635,009
Denominator		742,521	681,414	681,414	716,126
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: New Jersey

SPM 1 - The percentage of Black non-Hispanic preterm births in NJ

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		13	13	13	12.8
Annual Indicator	13.6	13.1	13.1	13.5	13.8
Numerator	1,855	1,774	1,774	1,835	1,803
Denominator	13,657	13,537	13,537	13,643	13,043
Data Source	New Jersey Birth Certificate Database, Office of V	New Jersey Birth Certificate Database, Office of V	New Jersey Birth Certificate Database, Office of V	NJ Birth Certificate Database	NJ Birth Certificate Database
Data Source Year	2016	2017	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	12.8	12.6	12.6	12.5	12.5	12.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Accessed on NJ SHAD website - https://www-doh.state.nj.us/doh-shad/.	

SPM 2 - The percentage of children (≤6 years of age) with elevated blood lead levels (≥10 ug/dL).

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		0.5	0.5	0.5	0.5
Annual Indicator	0.5	0.5	0.5	0.4	0.5
Numerator	889	882	882	757	660
Denominator	174,114	172,217	172,217	174,734	144,753
Data Source	Childhood Lead Information database, MCHS, FHS	Childhood Lead Information database, MCHS, FHS	Childhood Lead Information database	Childhood Lead Information Database	Childhood Lead Information Database
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.4	0.4	0.4	0.4	0.4	0.4

Field Level Notes for Form 10 SPMs:

None

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.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		85.8	85.8	86	86.5
Annual Indicator	89	76.7	76.7	82.1	
Numerator	1,833	1,366	1,366	1,334	
Denominator	2,059	1,782	1,782	1,625	
Data Source	Early Hearing Detection and Intervention Program	Early Hearing Detection and Intervention Program	Early Hearing Detection and Intervention Program	Early Hearing Detection and Intervention Program	
Data Source Year	2016	2017	2018	2019	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	87.0	87.5	88.0	88.5	89.0	

Field Level Notes for Form 10 SPMs:

None

SPM 4 - 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 who are receiving services.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		90.4	92	92.2	92.4
Annual Indicator	90.1	91.8	91.8	94.6	
Numerator	13,634	14,011	14,011	13,326	
Denominator	15,135	15,261	15,261	14,093	
Data Source	NJ Case Management Referral System	NJ Case Management Referral System	NJ Case Management Referral System	NJ Case Management Referral System	
Data Source Year	2016	2017	2018	2019	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	92.6	92.8	93.0	93.0	93.2	

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Age of Autism Diagnosis

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5.3	5.3	5.2	5.1
Annual Indicator	5	5.4	5.4	4.9	
Numerator					
Denominator					
Data Source	NJ Birth Defects and Autism Reporting System	NJ Birth Defects and Autism Reporting System	NJ Birth Defects and Autism Reporting System	NJ Birth Defects and Autism Reporting System	
Data Source Year	2016	2017	2018	2019	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	5.0	5.0	4.9	4.9	4.8	

Field Level Notes for Form 10 SPMs:

None

SPM 6 - Increase the percentage of students completing the TOP program, Reducing the Risk, and Teen PEP per year.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	57.9	84
Numerator	1,129	2,025
Denominator	1,950	2,411
Data Source	Child and Adolescent Health program	Child and Adolescent Health program
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	75.0	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: New Jersey

ESM 1.1 - Increase first trimester prenatal care rate

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		74	75	75	76
Annual Indicator	72.3	74.7	74.7	73.2	74.6
Numerator	73,862	75,582	75,582	74,081	74,047
Denominator	102,200	101,159	101,159	101,171	99,305
Data Source	Birth Certificate data	Birth Certificate data	Birth Certificate data	Birth Certificate Data - NJ SHAD website	Birth Certificate Data - NJ SHAD website
Data Source Year	2016	2017	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	76.0	77.0	77.5	78.0	78.0	78.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Increase the Percentage of Births in Baby Friendly Hospitals

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		16	20	20	22
Annual Indicator	18.1	19	19	29.1	27.6
Numerator	19,071	18,089	18,089	28,224	26,253
Denominator	105,385	95,065	95,065	96,908	95,275
Data Source	NJ Birth Certificate Data	NJ Birth Certificate Data	NJ Birth Certificate Data	NJ Birth Certificate Database	NJ Birth Certificate Database
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.0	24.0	24.0	25.0	26.0	27.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - Promote the complete Infant Safe Sleep Environment (no co-sleeping, on back, and no soft bedding)

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		30	22	23	23
Annual Indicator	21.7	22.1	22.1	22.1	42.8
Numerator	20,743	18,024	18,024	18,024	39,479
Denominator	95,391	81,480	81,480	81,480	92,262
Data Source	NJ PRAMS	NJ PRAMS	NJ PRAMS	NJ PRAMS	NJ PRAMS
Data Source Year	2016	2017	2017	2017	2019
Provisional or Final ?	Final	Final	Provisional	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.0	24.0	24.5	24.5	25.0	25.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
2017 NJ PRAMS data is not yet available. Therefore columns are populated with 2016 data twice.

ESM 6.1 - Promote parent-completed early childhood developmental screening using an online ASQ screening tool.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		200	300	600	2,000
Annual Indicator	200	200	200	241	914
Numerator					
Denominator					
Data Source	DCF ECCS Impact Program	DCF ECCS Impact Program	DCF ECCS Impact Program	DCF ECCS Impact Program	DCF ECCS Impact Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3,000.0	4,000.0	5,000.0	5,000.0	5,000.0	5,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Piloting of ASQ Enterprise software (Brookes Publishing) through the NJ Project LAUNCH in 2018 will add a parent/family portal for easy access to developmental screening and links screening to Central Intake Hubs.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Total for ECCS Impact / Central Intake ASQ online screens for calendar year 2019. Source: Office of Early Childhood Services, NJ-DCF – Family & Community Partnerships.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Total for ECCS Impact / Central Intake ASQ online screens for calendar year 2020. Source: Office of Early Childhood Services, NJ-DCF – Family & Community Partnerships.	

ESM 9.1 - Reduce the percentage of high school students who are electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media).

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	13.8	
Numerator		
Denominator		
Data Source	CDC High School YRBS	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.0	12.0	11.0	10.0	9.0	

Field Level Notes for Form 10 ESMs:

None

ESM 9.2 - Reduce the percentage of high school students who are bullied on school property.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	16.4	
Numerator		
Denominator		
Data Source	CDC High School YRBS	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	16.0	15.0	14.0	13.0	12.0	

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Percent of CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units (SCHS CMUs) with a primary care physician and/or Shared Plan of Care (SPoC).

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		35	36	37	38
Annual Indicator	29.6	35.8	35.8	35.5	
Numerator	6,276	7,653	7,653	8,779	
Denominator	21,220	21,354	21,354	24,714	
Data Source	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	
Data Source Year	2016	2017	2018	2019	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	39.0	40.0	41.0	42.0	43.0	

Field Level Notes for Form 10 ESMs:

None

ESM 12.1 - Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		28	31	34	37
Annual Indicator	41.3	43	43	48.1	
Numerator	2,073	2,208	2,208	2,663	
Denominator	5,017	5,137	5,137	5,534	
Data Source	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	SCHEIS-Case Management Referral System	
Data Source Year	2016	2017	2018	2019	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	43.0	46.0	47.0	48.0	

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.1 - Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416)

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		50	51	53	54
Annual Indicator	49.5	50.9	52.3	50.5	41.5
Numerator	404,579	407,596	419,284	429,996	345,790
Denominator	816,685	801,375	801,940	852,219	833,312
Data Source	CMS-416 form from DHS	CMS-416 form from DHS	CMS-416 form from DHS	CMS-416 form from DHS	CMS-416 form from DHS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	55.0	56.0	57.0	58.0	59.0	59.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Source: Form CMS-416: Annual EPSDT Participation Report provided by the NJ Department of Human Services.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2019 data is for EPSDT participants ages 0-20. Source: Form CMS-416: Annual EPSDT Participation Report provided by the NJ Department of Human Services.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 data is for EPSDT participants ages 0-20. Numerator = Total Eligibles Receiving Any Dental Services Denominator = Total Individuals Eligible for EPSDT Source: Form CMS-416: Annual EPSDT Participation Report provided by the NJ Department of Human Services.	

ESM 14.1.1 - Increase referrals of pregnant women to Mom's Quit Connection.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			5	575
Annual Indicator			575	618
Numerator				
Denominator				
Data Source			Number of PRA referrals to MQC	Number of PRA and self/site referrals to MQC
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	580.0	585.0	590.0	595.0	600.0	605.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Number of PRA and self/site referrals to Mom's Quit Connection for calendar year 2020.

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 8.1.1 - Number of schools participating in an activity (training, professional development, policy development, technical assistance) to improve physical activity among children (6-17).

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			140	145
Annual Indicator			6	
Numerator				
Denominator				
Data Source			Needs data source (DOE)	
Data Source Year			2019	
Provisional or Final ?			Provisional	

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: ESM.8.1.1 was discontinued.	

2016-2020: ESM 10.1 - Number of pediatric patients served in practices participating in the Medical Home Technical Assistance Program in the last year.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		128,500	128,500	129,000	130,000
Annual Indicator	128,500	128,500	128,500	128,500	
Numerator					
Denominator					
Data Source	Medical Home Technical Assistance Program	Medical Home Technical Assistance Program	Medical Home Technical Assistance Program	Medical Home	
Data Source Year	2016	2017	2018	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: New Jersey

SPM 1 - The percentage of Black non-Hispanic preterm births in NJ
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Reduce the percentage rate of Black non-Hispanic preterm births in NJ
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants born before 37 completed weeks of gestation based on obstetrical estimate recorded on birth certificate. **Denominator:** Number of live births
Data Sources and Data Issues:	Official Birth Certificate file not completed for up to 2 years after close of calendar birth year.
Significance:	Preterm birth is the greatest contributor to infant death, with most preterm-related deaths occurring among babies who were born very preterm (before 32 weeks). Preterm birth is also a leading cause of long-term neurological disabilities in children. Important growth and development occur throughout pregnancy—especially in the final months and weeks. Premature birth is a concern because babies born too soon miss out on this valuable time to grow and develop. Premature birth is the biggest contributor for infant death, with most preterm-related deaths occurring among babies who were born very preterm (before 32 weeks). Babies who survive may spend weeks or months hospitalized in a neonatal intensive care unit (NICU) and may face lifelong problems such as: intellectual disabilities, cerebral palsy, breathing and respiratory problems, visual problems including retinopathy of prematurity, hearing loss, feeding and digestive problems.

SPM 2 - The percentage of children (≤6 years of age) with elevated blood lead levels (≥10 ug/dL).
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Reduce the percentage of children (≤6 years of age) with elevated blood lead levels (≥10 ug/dL).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children (≤6 years of age) with elevated blood lead levels (≥10 ug/dL) **Denominator:** Number of children (≤6 years of age)
Data Sources and Data Issues:	Childhood Lead Poisoning Information Database, MCHS, FHS.
Significance:	SPM #2 was selected to address the issue of childhood lead poisoning which is not specifically addressed by the NPMs or NOMs. Long-term exposure to lead can cause serious health problems, particularly in young kids. Lead is toxic to everyone, but unborn babies and young children are at greatest risk for health problems from lead poisoning — their smaller, growing bodies make them more susceptible to absorbing and retaining lead. Lead exposure can cause permanent damage to the brain and nervous system, resulting in learning, behavioral, and hearing problems, as well as slowed growth and anemia. Children with elevated blood lead levels are at increased risk for behavioral problems, developmental delays, and learning disorders. Recent evidence suggests that children suffer adverse health effects from BLLs substantially lower than 10 µg/dL. Moreover, there is no level of exposure of lead that has been found to be safe for children. Consequently it is important not only to eliminate the prevalence of children with elevated BLLs (i.e. ≥ 10 µg/dL), but to also reduce the central measure of BLLs in the target population. The level 5 µg/dL is a reference level used by the Centers for Disease Control and Prevention (CDC) that indicates a need for emphasis on primary prevention activities. Primary care providers should take appropriate action -- household education and retesting -- for children above the reference level.

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.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Improve the number and percent of infants that receive a timely diagnosis of hearing loss and timely enrollment in early intervention services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** NJ births discharged from the hospital that reside in NJ and did not pass initial inpatient hearing screen and pass outpatient rescreening or completed outpatient diagnostic testing. **Denominator:** NJ births discharged from the hospital that reside in NJ and did not pass initial inpatient hearing screen.
Data Sources and Data Issues:	Birth Certificate records from the NJ VIP system, follow-up reports from the Early Hearing Detection and Intervention (EHDI) data system.
Significance:	Undetected hearing loss impedes speech, language, and cognitive development. Delays can be minimized or avoided through early detection and intervention. While 99% of infants born in New Jersey receive a hearing screening test before discharge from the hospital, a significant number of those that did not pass that initial screen fail to receive outpatient follow-up audiologic evaluations. These children are at risk for undiagnosed hearing loss and the resulting language and communication delays. Improving outpatient follow-up rates will reduce the incidence of undiagnosed hearing loss in young children.

SPM 4 - 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 who are receiving services.
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage 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 who are receiving services.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number 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 who are receiving services.</td></tr>
<tr><td>Denominator:</td><td>Number 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.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Case Management Referral System (CMRS)</td></tr>
<tr><td>Significance:</td><td>SPM #4 was chosen to improve the timeliness and effectiveness of using the Birth Defects and Autism Reporting System (BDARS), which has been an invaluable tool for surveillance, needs assessment, service planning, research, and to link families to services.</td></tr>
</table>

SPM 5 - Age of Autism Diagnosis
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Decrease the age that children are diagnosed with Autism. By receiving a timely diagnosis of autism, children can be enrolled in early intervention services as soon as possible. Early recognition and services is linked to improved outcomes.
Definition:	**Unit Type:** Ratio **Unit Number:** 1 **Numerator:** Total age in years at initial diagnosis for all children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder. **Denominator:** Number of children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.
Data Sources and Data Issues:	Autism Registry data provides both the date of diagnosis and the child's date of birth. Date of Birth is verified with Birth Certificate records from the NJ VIP system.
Significance:	A recent study from the University of California, Davis, estimated that the cost for autism in 2015 was $268 billion and this includes, medical, nonmedical, and productivity losses related to the disorder. The authors estimate that without early intervention and preventative activities, the cost would increase to $461 billion by 2025. Early diagnosis and treatment can also have a profound effect on the long-term function of the child. Dr. Rebecca Landa of the Kennedy Krieger Institute believes delays in communication, social skills and motor skills can be recognized as early as 14 months. If a diagnosis can be made earlier, when the child's brain is more malleable and still developing circuitry, treatment can begin with increased positive outcomes.

SPM 6 - Increase the percentage of students completing the TOP program, Reducing the Risk, and Teen PEP per year.
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To reduce the percent of adolescents who are bullied or who bully others
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of students completing (or percent completing) the TOP program, Reducing the Risk and Teen PEP in a year **Denominator:** Total number of students enrolled in the TOP, Reducing the Risk and Teen PEP programs in a year.
Data Sources and Data Issues:	NJ Child and Adolescent Health Program Youth Risk Behavior Surveillance System (YRBSS) National Survey of Children's Health (NSCH)
Significance:	Bullying, particularly among school-age children, is a major public health problem. Estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, be more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation; and suicide attempts. Bullying victims who also perpetrate bullying (i.e., bully-victims) may exhibit the poorest functioning, in comparison with either victims or bullies. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation. www.stopbullying.gov

Form 10
State Outcome Measure (SOM) Detail Sheets

State: New Jersey

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: New Jersey

ESM 1.1 - Increase first trimester prenatal care rate
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the use of early prenatal care which will promote access to womens' preventive health services and the health of New Jersey mothers, infants, and families.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Birth certificates documenting first trimester (<13 weeks gestation) initiation of prenatal care **Denominator:** Birth certificates
Data Sources and Data Issues:	Birth Certificate records from the NJ VIP system
Significance:	Early and adequate prenatal care is an important component for 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. NPM #1 (Percent of women with a past year preventive medical visit) is thought to be strongly influenced by health insurance status in the same way early prenatal care (ESM #1.1) is influenced by health insurance status. If intervention strategies can be directed and monitored at increasing health insurance status then ESM #1.1 and eventually NPM #1 will be increased. The advantage of tracking ESM #1.1 is that it is available for all live births from birth certificates along with health insurance inforamtion and can be analyzed at small geographic levels.

ESM 4.1 - Increase the Percentage of Births in Baby Friendly Hospitals
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the delivery of babies in Baby Friendly hospitals which will increase breastfeeding rates statewide.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Births in Baby Friendly hospitals **Denominator:** Total New Jersey Births
Data Sources and Data Issues:	New Jersey VIP Birth Certificate System
Significance:	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. Breastfeeding is a cost-effective preventive intervention with far-reaching benefits for mothers and babies and significant cost savings for health providers and employers. Breastfeeding provides superior nutrition, prevents disease and enhances infant development. Increasing Baby Friendly hospitals is an evidence-based strategy to increase breastfeeding. Breastfeeding data at the individual infant level could be combined with hospital level including mPINC data and Baby Friendly status to provide more information on the policies and practices that promote breastfeeding.

ESM 5.1 - Promote the complete Infant Safe Sleep Environment (no co-sleeping, on back, and no soft bedding) NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the use of the Infant Safe Sleep Environment (on co-sleeping, on back, no soft bedding)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Mothers reporting Infant Safe Sleep Environment (no co-sleeping, on back, and no soft bedding) on the NJ PRAMS survey **Denominator:** Mothers completing the NJ PRAMS survey
Data Sources and Data Issues:	NJ PRAMS Survey
Significance:	Tracking infant safe sleep practices using PRAMS data will inform the NJ DOH whether educational efforts to train health professionals and awareness campaigns targeting caregivers is having an impact on infant safe sleep practices. More information other than the percent of infants placed to sleep on their backs (NPM #5) is needed to ensure adherence to the complete Infant Safe Sleep message. Reporting NJ PRAMS data on co-sleeping and soft bedding in addition to on back would provide a more complete message on Infant Safe Sleep education.

ESM 6.1 - Promote parent-completed early childhood developmental screening using an online ASQ screening tool.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of parent-completed early childhood developmental screens using an online ASQ screening tool.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>The number of parent-completed early childhood developmental screens using an online ASQ screening tool for children 0 - 5 years old.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Developmental Screening data using the online ASQ Tool from the ECCS Impact Grant with NJ DCF.</td></tr>
<tr><td>Significance:</td><td>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. Promoting parent-completed early childhood developmental screening using an online ASQ screening tool (ESM6.1) through the ECCS Impact Program will raise community awareness of available parent-completed developmental screening tools and will lead to an increase in NPM #6 (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool).</td></tr>
</table>

ESM 9.1 - Reduce the percentage of high school students who are electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media).
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Reduce the percentage of high school students who are electronically bullied
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Students reporting electronic bullying (counting being bullied through texting, Instagram, Facebook, or other social media). **Denominator:** Students completing the survey.
Data Sources and Data Issues:	CDC High School YRBS
Significance:	Cyber-bullying can lead to the same psychological effects as bullying on school grounds. Low self-esteem, loneliness, poor academic performance, and increased potential to engage in risky behaviors such as drug use, alcohol use and early/unprotected sex can impact both the bullied and the bully. Although most school policies include cyber-bullying policies, it is significantly harder to track and can have a more exponential impact due to the nature of social media. Social and Emotional Learning (SEL) combined with social media awareness can dramatically reduce bullying because it teaches the skills, attitudes and behaviors that teens who bully are typically deficient in and can lead them to bully in the first place. SEL creates an anti-bullying environment that can be extended to online activities by teaching adolescents how to better manage their emotions both on and offline while promoting a safe and caring learning environment where all adolescents are supported and respected.

ESM 9.2 - Reduce the percentage of high school students who are bullied on school property.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Reduce the percentage of high school students bullied on school property.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Students reporting being bullied on school property. **Denominator:** Students completing the survey.
Data Sources and Data Issues:	CDC High School YRBS
Significance:	Bullying can lead to significant psychological effects as low self-esteem, loneliness, poor academic performance, and increased potential to engage in risky behaviors such as drug use, alcohol use and early/unprotected sex. These issues may persist into adulthood. It should be recognized that these mental impacts do not stop at the bullied, they also extended to the bullies. Social and Emotional Learning (SEL) can dramatically reduce bullying because it teaches the skills, attitudes and behaviors that teens who bully are typically deficient in and can lead them to bully in the first place. People are not born with the ability to manage their emotions and get along with others, these skills must be cultivated in caring and nurturing environments. SEL creates an anti-bullying environment by teaching adolescents how to better manage their emotions while promoting a safe and caring learning environment where all adolescents are supported and respected.

ESM 11.1 - Percent of CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units (SCHS CMUs) with a primary care physician and/or Shared Plan of Care (SPoC).
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Having a PCP is a 1st step in building a medical home for CYSHCN. ESM 11.1 provides a baseline for programmatic needs to increase % of CYSHCN with a PCP and identify next steps of medical home for CYSHCN. SPoC was added to ESM 11.1 for MCHBG 2019.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of CYSHCN ages 0-18 years served by SCHS CMUs with a primary care physician and/or SPoC</td></tr>
<tr><td>Denominator:</td><td>Number of CYSHCN ages 0-18 years served by SCHS CMUs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data source is a statewide electronic documentation system used by all 21 county SCHS CMUs. The Case Management Referral System (CMRS) is used to track and monitor services provided to CYSHCN and their families. Included in CMRS is the ability to create and modify an Individual Service Plan (ISP), track services, and create a record of each contact with the child and child's family. The primary limitation of the data is that it is limited to CYSHCN served by SCHS CMUs (i.e., excludes children without special health care needs and CYSHCN not served by SCHS CMUs).</td></tr>
<tr><td>Significance:</td><td>The first principle of the Joint Principles of the Patient Centered Medical Home is that a CYSHCN has a personal physician who is “trained to provide first contact, continuous and comprehensive care.” ESM #11.1 is the ‘first step’ in establishing and building a medical home. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.</td></tr>
</table>

ESM 12.1 - Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>ESM 12.1 monitors over 20 services, within 7 categories: PCP; transition-specific services; employment; health insurance; Supplemental Security Income; Shared Plan of Care; and any service tied to ‘transition to adulthood’ as an exceptional event.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of CYSHCN ages 12-17 years served by SCHS CMUs with at least one transition to adulthood service</td></tr>
<tr><td>Denominator:</td><td>Number of CYSHCN ages 12-17 years served by SCHS CMUs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data source is a statewide electronic documentation system used by all 21 county SCHS CMUs. The Case Management Referral System (CMRS) is used to track and monitor services provided to CYSHCN and their families. Included in CMRS is the ability to create and modify an Individual Service Plan (ISP), track services, and create a record of each contact with the child and child's family. The primary limitation of the data is that it is limited to CYSHCN served by SCHS CMUs (i.e., excludes children without special health care needs and CYSHCN not served by SCHS CMUs).</td></tr>
<tr><td>Significance:</td><td>The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and 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 to be employed. Successful transition to all aspects of adulthood is a critical life course measure for CYSHCN.</td></tr>
</table>

ESM 13.2.1 - Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416)
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the use of preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416)</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children (<19) enrolled in Medicaid or CHIP reported receiving any dental or oral health services</td></tr>
<tr><td>Denominator:</td><td>Number for children (<19) enrolled in Medicaid or CHIP</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Annual Center for Medicaid and Medicare Services (CMS) 416 Report</td></tr>
<tr><td>Significance:</td><td>Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Monitoring ESM #13.1 (Preventive and any dental services for children enrolled in Medicaid or CHIP) will allow the tracking of progress on NPM #13 for the large number of low-income children enrolled statewide in Medicaid or CHIP.</td></tr>
</table>

ESM 14.1.1 - Increase referrals of pregnant women to Mom's Quit Connection.
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Reduce household smoking (NPM# 4) by increasing referrals of pregnant women to Mom's Quit Connection.
Definition:	**Unit Type:** Rate **Unit Number:** 1,000 **Numerator:** The number pregnant women referred to Mom's Quit Connection during the calendar year. **Denominator:** The number of women delivering a newborn during the calendar year.
Data Sources and Data Issues:	Mom's Quit Connection data
Significance:	Maternal smoking is one of the most significant and preventable risk factors of adverse birth outcomes.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 8.1.1 - Number of schools participating in an activity (training, professional development, policy development, technical assistance) to improve physical activity among children (6-17).
2016-2020: NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of schools participating in an activity (training, professional development, policy development, technical assistance) to improve physical activity among children (6-17).
Definition:	<table><tr><td>**Unit Type:**</td><td>Rate</td></tr><tr><td>**Unit Number:**</td><td>1,000</td></tr><tr><td>**Numerator:**</td><td>The number of schools participating in an activity (training, professional development, policy development, technical assistance) to improve physical activity among children (6-17) during the calendar year.</td></tr><tr><td>**Denominator:**</td><td>The number of schools during the calendar year.</td></tr></table>
Data Sources and Data Issues:	Child and Adolescent Health Program
Significance:	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

2016-2020: ESM 10.1 - Number of pediatric patients served in practices participating in the Medical Home Technical Assistance Program in the last year.
2016-2020: NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Promote access to a medical home by increasing the number of pediatric patients served in practices participating in the Medical Home Technical Assistance Program in the last year.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>500,000</td></tr>
<tr><td>Numerator:</td><td>Number of pediatric patients served in practices participating in the Medical Home Technical Assistance Program in the last year.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The Medical Home Technical Assistance Program</td></tr>
<tr><td>Significance:</td><td>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 patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to improve patients’ and providers’ experience of care and the quality of care for all children.</td></tr>
</table>

Form 11
Other State Data

State: New Jersey

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: New Jersey

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	0		• PRAMS
2) Vital Records Death	Yes	Yes	Annually	24	Yes	
3) Medicaid	No	No				
4) WIC	Yes	Yes	Quarterly	0	No	
5) Newborn Bloodspot Screening						
6) Newborn Hearing Screening						
7) Hospital Discharge	Yes	Yes				
8) PRAMS or PRAMS-like	Yes	Yes	Annually	18	Yes	• WIC

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**4) WIC**
	Field Note: PRAMS monthly sample is matched to WIC data to obtain the most current contact information for the mothers.
Data Source Name:	**8) PRAMS or PRAMS-like**
	Field Note: PRAMS monthly sample data is matched to WIC data to obtain the most current contact information for the mothers.