

Commissioner's Prenatal Care Task Force

JULY 2008



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PRENATAL CARE TASK FORCE

**REPORT AND RECOMMENDATIONS TO
COMMISSIONER HEATHER HOWARD**

**NEW JERSEY DEPARTMENT OF HEALTH AND
SENIOR SERVICES**

JULY 2008

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Executive Summary

Prenatal care, which refers to the medical care recommended for women before and during pregnancy, helps ensure the health of the new mom and her baby and also reduces negative outcomes such as maternal death rates, miscarriages, birth defects, low birth weight and other preventable infant problems. Access to prenatal care is extremely important; yet many factors delay the initiation of early prenatal care, including unintended pregnancies, lack of awareness of a pregnancy and lack of insurance. Mothers most likely to benefit from early prenatal care because of higher risk of poor birth outcomes - such as teens, minorities, unmarried mothers and mothers with less education - remain less likely to receive early prenatal care. Even mothers with chronic prepregnancy conditions such as diabetes and hypertension known to benefit from early pregnancy management have not experienced increases in first trimester prenatal care. Many states have tried to respond to the needs of women by implementing programmatic and systemic responses such as Medicaid family planning waivers to help women avoid unintended pregnancies, and improve infant and maternal health outcomes. Preconception care is needed for screening and interventions for women of reproductive age and to provide health promotion to reduce a woman's risk factors, especially where pregnancies have not been planned.

Unfortunately, a recent study which ranked New Jersey 40th in women receiving first trimester prenatal care, showed the critical needs that must be addressed to ensure the health of women and children in this state. As a result, Commissioner Heather Howard, New Jersey Department of Health and Senior Services, convened the Prenatal Care Task Force in February 2008. The Task Force's charge was: to make recommendations to improve access to early prenatal care; to increase the number of women seeking and receiving care; and to review data related to prenatal care access, including racial and ethnic disparities. The Task Force was also charged with reviewing adequacy of the provider network and identification of any regional or geographic barriers to care; reviewing best practices and identifying successful programs to increase prenatal care; reviewing current support for improved pregnancy outcome activities; and making recommendations to improve first trimester prenatal care rates in New Jersey.

The Task Force, which was comprised of leaders and experts in the field of Maternal and Child Health, prepared this document with recommendations for consideration and possible implementation. Three subcommittees were formed: Education Subcommittee; Capacity Subcommittee; Quality Outcomes Subcommittee. Subcommittee meetings were convened between scheduled meetings of the Task Force and all three subcommittees formulated goals and recommendations, which focused primarily around: 1) Education; 2) Access to Reproductive Health Care Services and Practitioners; 3) Systems and 4) Evaluation. The recommendations stress many important goals such as increasing public awareness of preconception health; ensuring the availability of ongoing early prenatal care services for women in areas affected by hospital closures and or reduction in obstetric services and promoting equity in birth outcomes.

It is the hope of the Task Force that this report will be instrumental in helping New Jersey move to the forefront of caring for women, children and their families.



Overview

Improving access to early prenatal care is essential to promoting the health of New Jersey mothers, infants, and families. Early prenatal care is an important component for a healthy pregnancy because it offers the best opportunity for risk assessment, health education, and the management of pregnancy-related complications and conditions. (1, 2) According to the Guidelines for Perinatal Care (sixth edition) published in 2007, by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, "the content and timing of prenatal care should be varied according to the needs and risk status of the woman and her fetus." While prenatal care is not a guarantee for a healthy pregnancy outcome, it is well documented that early and appropriate prenatal care increases the likelihood that clinical concerns will be addressed. Therefore, prenatal care is integral in helping to prevent poor birth outcomes such as preterm labor and birth, low birth weight and infant mortality. (3) In addition to improving maternal health and birth outcomes, early and adequate prenatal care promotes preventive care for young children. (2, 4)

The quality of prenatal care is sometimes judged in the context of the infant mortality rate. However, recent knowledge indicates a more pervasive effect, in that healthy pregnancies are important for the life-long health of offspring. It is understood that small babies (undernourished or premature) are more likely to become adults with hypertension, obesity, diabetes, and osteoporosis. (5)

Efforts to improve access to early prenatal care must take a multi-pronged approach in order to reduce barriers to care. Ensuring that pregnant women have health insurance during their first trimester of pregnancy would improve receipt of early prenatal care; coverage later in pregnancy is not sufficient to assure early entry into prenatal care. Despite major expansions of health care access during the 1990s, one in five women giving birth in New Jersey in 2006 still failed to receive first trimester prenatal care. Mothers most likely to benefit from early prenatal care because of their higher risk of poor birth outcomes remain even less likely to receive it. (6)

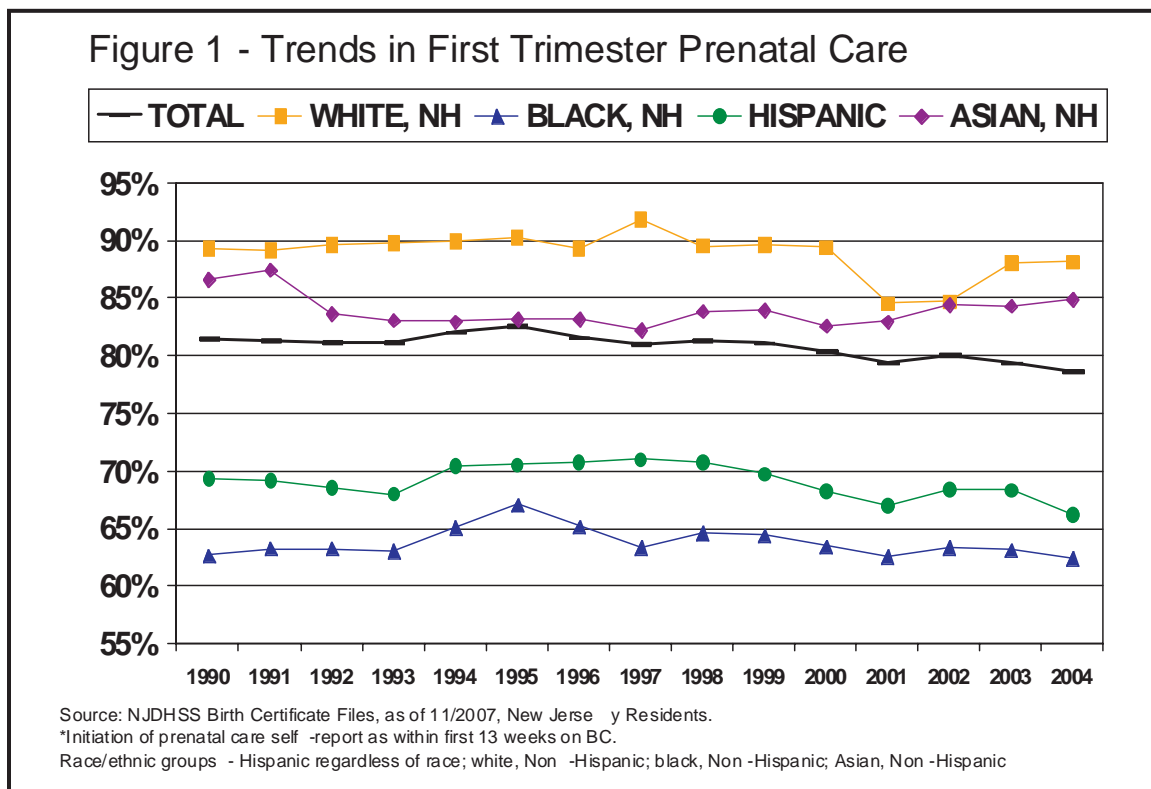
Efforts to improve access to early prenatal care must also focus on women before they become pregnant through the promotion of preconception care and family planning services. Essential to the health and well-being of all women is adequate preconception and interpregnancy care. (7) Nationally, about 60% of all pregnancies are unintended, mistimed or unwanted. (8) In New Jersey, this figure is about 32%. To address this reality, there is a need for reproductive education, with an emphasis on timely and adequate prenatal care, to ensure and optimize the health of women and children in New Jersey.

The National Women's Law Center recently published their 2007 edition of *Making the Grade on Women's Health*; New Jersey ranked 40th in women receiving first trimester prenatal care. (9) Recognizing that this statistic reflects a critical need that must be addressed to ensure the health of women and children in this state, the Department of Health and Senior Services (DHSS) Commissioner Heather Howard convened the Prenatal Care Task Force in February 2008. The Task Force's charge was to make recommendations to improve access to first trimester prenatal care in New Jersey and ultimately to increase the number of women seeking and receiving care within the first trimester of their pregnancy. The Task Force, comprised of leaders and experts in the field of Maternal and Child Health, have prepared this document with recommendations for consideration.

Trends in First Trimester Prenatal Care and Birth Outcomes

The overall trend in first trimester prenatal care for New Jersey mothers has decreased slightly over the past decade (Figure 1). The rate of first trimester prenatal care for New Jersey mothers for 2004 was 78.6% which falls short of the national Healthy People 2010 goal of 90%. Recent publications such as "Making the Grade on Women's Health" rank New Jersey below the national average in mothers receiving first trimester prenatal care. (9) Significant progress has been made in improving access to prenatal care in New Jersey during the 1980's and 1990's when expansions in eligibility for maternity care coverage under Medicaid were implemented. However during the last decade, rates of first trimester prenatal care have declined slightly while significant racial/ethnic disparities persist.

The data presented in this report were obtained from two sources. Trends in first trimester prenatal care and birth outcomes using 1990 to 2004 birth and infant death certificate data were summarized by the Maternal Child Health Epidemiology Program of the DHSS. Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) Survey for 2002 - 2006, were used to examine prenatal care utilization by sociodemographic factors and health insurance coverage groups. New Jersey PRAMS is a survey of about one in every forty New Jersey mothers, completed two to six months after delivery. (10 / 11)

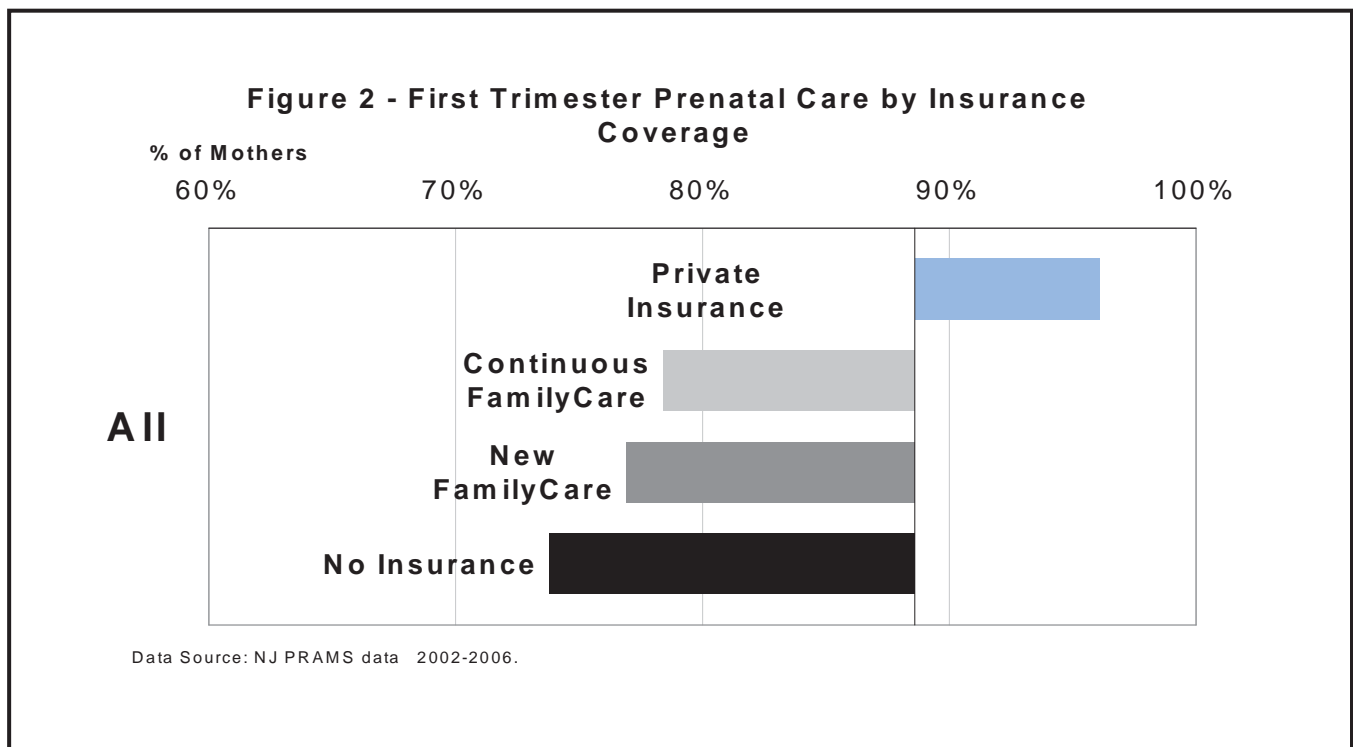


Teens, minorities, unmarried mothers and mothers with less education remain less likely to receive early prenatal care even though these mothers are most likely to benefit from early prenatal care because of higher risk of poor birth outcomes (6, Appendix 1). Increases in the rates of low birth weight and prematurity, births to foreign born mothers, births via assisted reproductive technologies and births to older mothers have not been associated with increased rates of early care (Appendices 2-4). Even mothers with chronic prepregnancy conditions such as diabetes and hypertension known to benefit from early pregnancy management have not experienced increases in first trimester prenatal care. (12)

The Crucial Role of Health Insurance Coverage

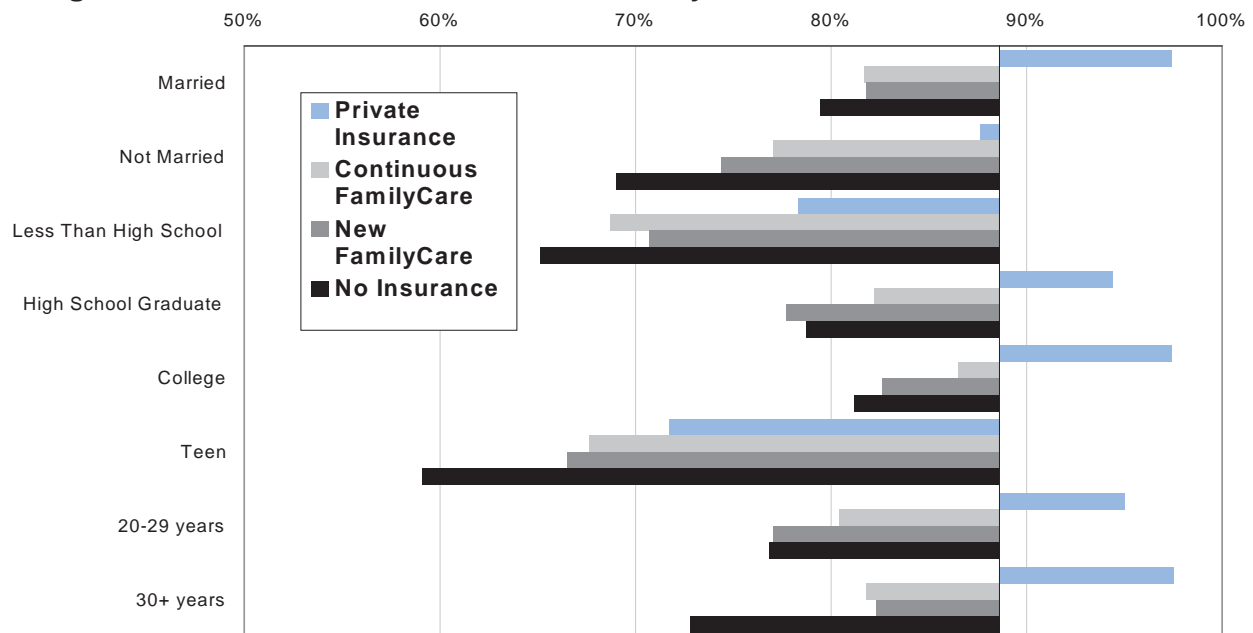
Access to health insurance coverage early in pregnancy is crucial for early prenatal care. Using New Jersey PRAMS survey data, rates of first trimester prenatal care by type of insurance coverage during pregnancy were compared. (Figure 2)

Mothers with Private Insurance, the largest group at an estimated 69,000 mothers per year, had the highest rate of first trimester prenatal care at nearly 96%. The statewide average of first trimester prenatal care, based on PRAMS responses for 2002 to 2006, was 89% (indicated by the vertical line on Figure 2). Mothers with continuous FamilyCare coverage, meaning they had FamilyCare coverage both before and during the pregnancy, had a first trimester prenatal care rate of 78%. New FamilyCare mothers, which include those who enrolled in FamilyCare during their pregnancy, had a first trimester prenatal care rate of 76%. Almost 6,500 (6%) mothers who either had no insurance or no prenatal care were represented in the No Insurance group. Mothers with No Insurance during prenatal care had the lowest rate of first trimester prenatal care at 73%. Before pregnancy 21% of mothers, including 54% of FamilyCare mothers, had no health insurance and most likely lacked ongoing preventive health care before pregnancy. In this regard, New Jersey's Federal Qualified Health Centers (FQHCs) play a major role in extending prenatal care to pregnant women enrolled in both FamilyCare and also to uninsured women by providing services on a sliding fee scale that are subsidized by charity care funds from the State. (Appendix 6)

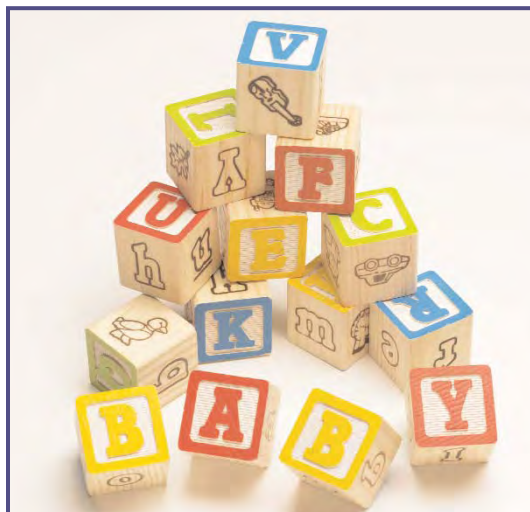


Maternal demographics such as age, education and marital status affected first trimester prenatal care rates, but health insurance status during pregnancy had the stronger effect on first trimester prenatal care rates (Figure 3). Mothers who were privately insured were most likely to enter first trimester prenatal care for all age, education or marital status groups. Teens, although a small group of approximately 6,600, represented 6% of all births, and had the lowest rates of first trimester prenatal care regardless of insurance coverage. Chances of first trimester prenatal care increased when the mothers were married, had at least a high school education and were at least 20-29 years old.

Figure 3 - First Trimester Prenatal Care By Maternal Characteristics

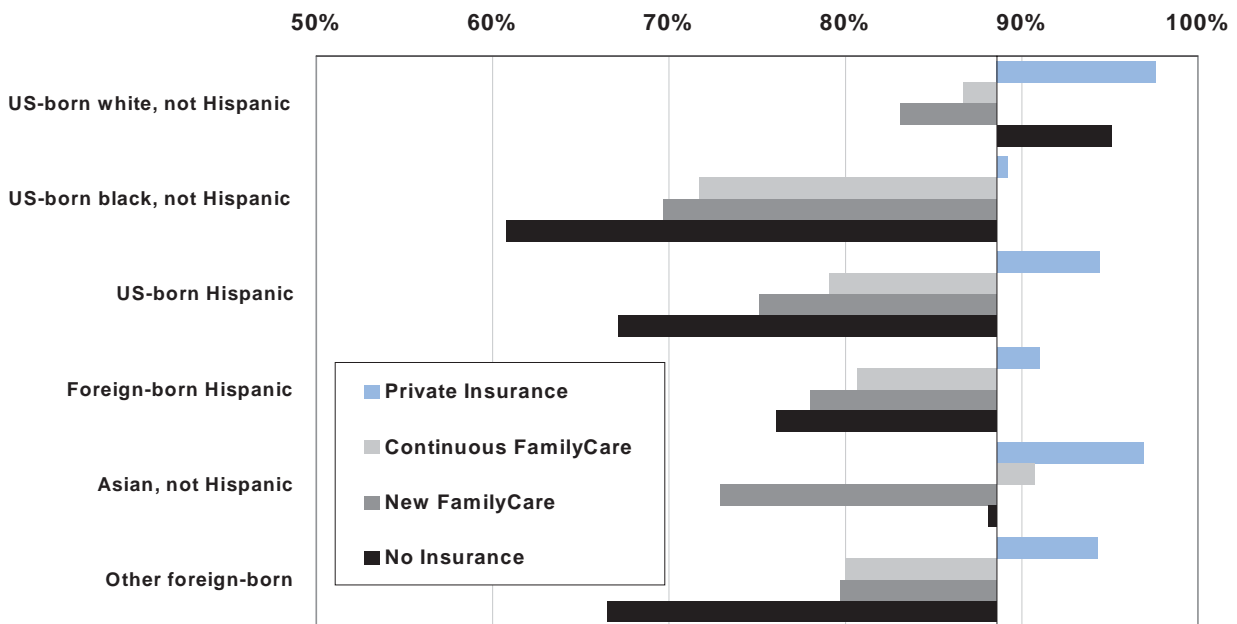


Data Source: NJ PRAMS data 2002-2006.



Across all racial and ethnic groups and regardless of birth place, privately insured mothers had first trimester prenatal care rates that exceeded the statewide average of 89% (Figure 4). US-born black non-Hispanic mothers had the lowest rates of first trimester prenatal care and those rates were lower than the rates for all foreign-born mothers as well as US born Hispanic mothers.

Figure 4 - First Trimester Prenatal Care By Race/Ethnicity



Data Source: NJ PRAMS data 2002-2006.



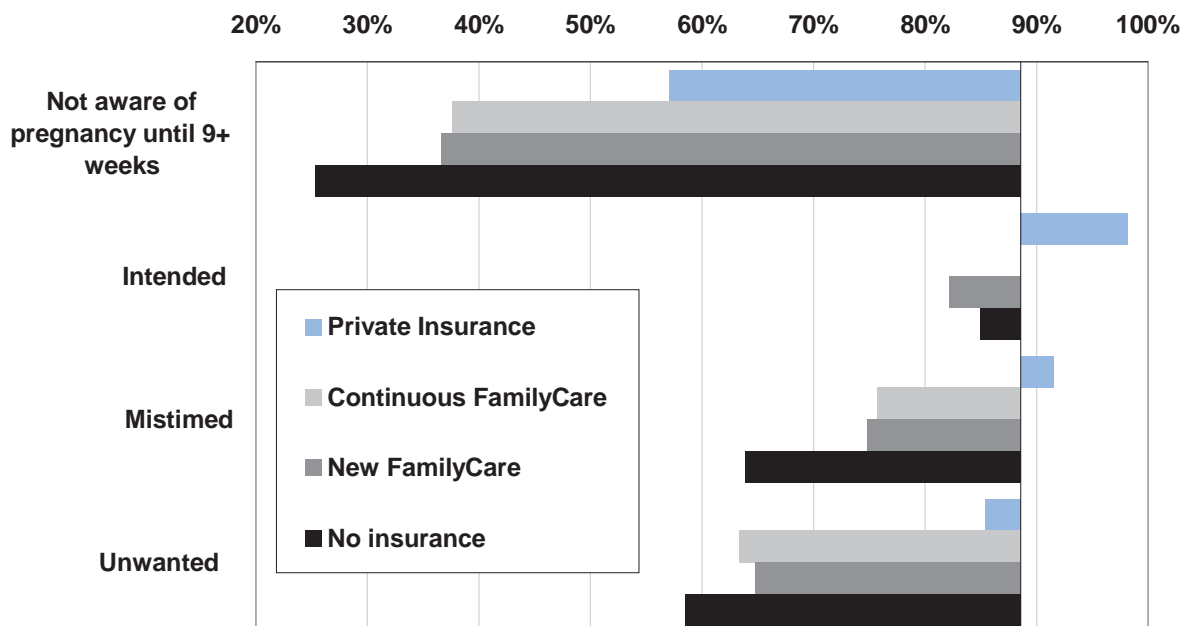
The Role of Pregnancy Intention and Early Pregnancy Awareness

An unintended pregnancy or a lack of awareness of a pregnancy can delay the initiation of early prenatal care. An estimated one out of every three recent births in New Jersey was either a mistimed (26%) or unwanted (8%) pregnancy. Many of these unintended births occurred to mothers between the ages of 25-34, who were college educated, married, and who had private insurance coverage. (12)

Mothers who intended to be pregnant were more likely to enter first trimester prenatal care, but the lack of insurance prior to pregnancy was a barrier for mothers with new FamilyCare (83%) (Figure 5). Mothers with mistimed or unwanted pregnancies are much less likely to receive first trimester prenatal care, while women with Private Insurance and unintended pregnancies receive first trimester prenatal care close to the statewide average of 89%.

Mothers who were not aware of their pregnancy for nine (9) or more weeks had the lowest first trimester prenatal care initiation rates. This was true for the privately insured as their first trimester prenatal care initiation rate also fell below 60%, while mothers with FamilyCare had first trimester prenatal care rates in the 30% range.

Figure 5. First Trimester Prenatal Care by Pregnancy Intention and Awareness



Data Source: NJ PRAMS data 2002-2006.

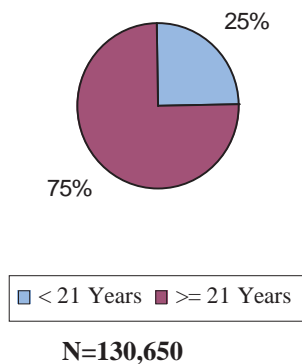
Family Planning and Importance of Preconception Health

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. (13) 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. (14, 15) Policies to promote family planning are a priority not only because they reduce unintended pregnancies, but also because they can improve the initiation of early prenatal care.

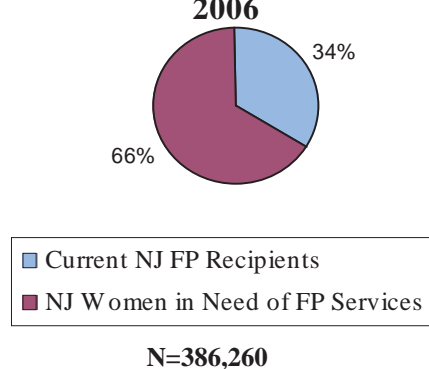
Currently New Jersey serves about 130,000 women of childbearing age at family planning centers with 72% of the recipients 21 years or older. However, these women comprise only about one-third of the estimated women in need of publicly supported reproductive health care. (16)

Figure 6. Family Planning

**New Jersey
Family Planning Recipients
2007**



**Guttmacher Institute
Estimate of New Jersey
Women in Need of
Family Planning
2006**



Data Sources: Dana Schwartz, FHS, DHSS; Guttmacher Institute

Many states have implemented Medicaid family planning waivers to help promote reproductive health, help women avoid unintended pregnancies, and improve infant and maternal health outcomes. Family planning waivers, which allow states to provide family planning services to individuals who are not otherwise eligible for coverage under Medicaid or the State Children's Health Insurance Program (SCHIP), have been successful in reducing the social and economic costs associated with unintended pregnancies. (17)

Geographic Variation in Prenatal Care

First trimester prenatal care varies by geographic location, reflecting expected differences in socio-demographic composition, access to prenatal care providers, environmental factors, and other community factors. Rates of first trimester prenatal care and related birth data by geographic regions are presented in Appendix 3. Summary tables from a municipal need assessment developed to identify targets for maternal child health programs is presented in Appendix 4 and includes statistics on other maternal child health indicators.

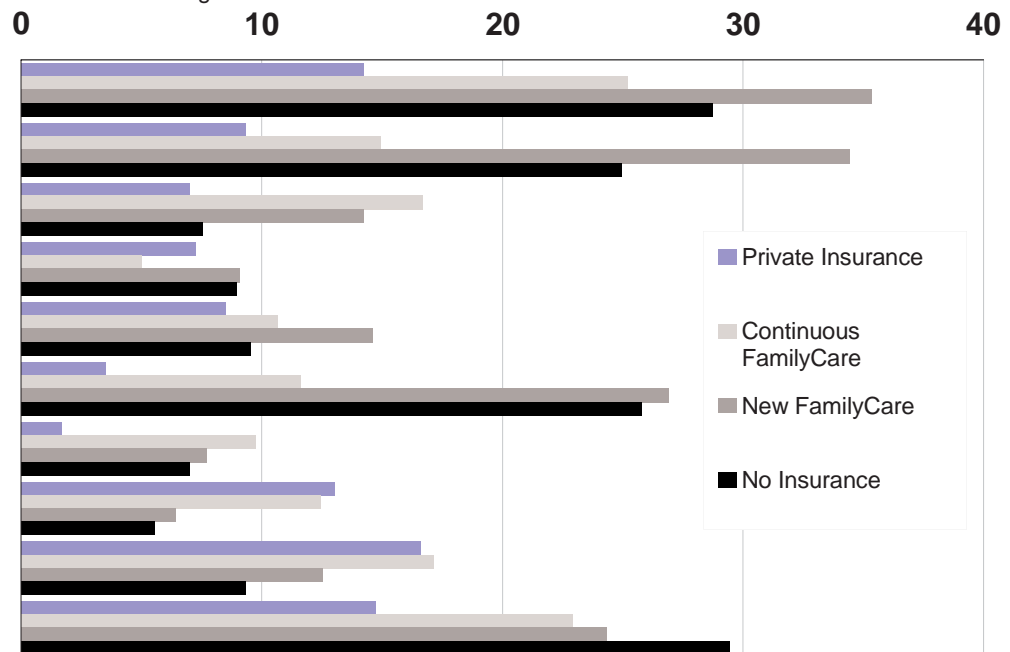
Focusing on first trimester prenatal care rates for mothers with FamilyCare by municipality demonstrates sizable variation among similar mothers which could be used to identify best practices in providing early prenatal care (Appendix 3a and 3d).

Barriers to Early Prenatal Care

Efforts to improve first trimester prenatal care must address barriers to early prenatal care. (14, 18) According to New Jersey PRAMS data, the leading barriers for mothers receiving late prenatal care were not being able to get an appointment, not having insurance or money to pay for care and not having a Medicaid card. Mothers with FamilyCare reported more barriers related to insurance coverage and scheduling appointments in addition to non-insurance barriers. Mothers with Private Insurance reported a similar pattern of barriers, but at a lower frequency.

Figure 7 - Prenatal Care Barriers

% of mother with late Prenatal Care citing each barrier



Commissioner's Prenatal Care Task Force



In order to improve New Jersey's rate of first trimester prenatal care, a Task Force of stakeholders was convened. The Task Force, appointed by the Commissioner included representatives from the following organizations. The list of Task Force Members is included as Appendix 7.

American College of Obstetricians and Gynecologists (ACOG);
New Jersey Obstetric and Gynecologic Society (NJOGS);
New Jersey Academy of Family Physicians;
Association of Women's Health, Obstetric and

Neonatal Nursing (AWHONN);
American College of Nurse Midwives;
March of Dimes, New Jersey Chapter;
New Jersey Family Planning Association;
New Jersey Hospital Association;
New Jersey Primary Care Association;
Maternal and Child Health Consortia (Central New Jersey Maternal and Child Health Consortium, Gateway Northwest Maternal and Child Health Network, Hudson Perinatal Consortium, Northern New Jersey Maternal Child Health Consortium, Regional Perinatal Consortium of Monmouth and Ocean Counties, Southern New Jersey Perinatal Cooperative);
Departments of State Government including Human Services, Division of Medical Assistance and Health Services, Children and Families and Office of the Child Advocate.

The Task Force met from February - June 2008. Background material and data trends along with other references were provided to the Task Force at the first meeting.

Charge of the Task Force

- ❖ Review current data on first trimester prenatal care access, racial and ethnic disparities in prenatal care access, contributing factors to women not accessing first trimester care, adequacy of the provider network and identification of any regional or geographic barriers to care;
- ❖ Review best practices and identify successful programs to increase prenatal care;
- ❖ Review current support for improved pregnancy outcome activities; and
- ❖ Make recommendations to improve first trimester prenatal care rates in New Jersey.

Subcommittees

Three subcommittees were formed with the following Task Force members volunteering to serve on the subcommittees:

Education Subcommittee

Chair: Alyce Thomas.

Members: Kay O'Keefe, Laurie Navin, Melinda W. Green, Phyllis Kinsler, Linda Holmes, Meghan Davey, Ingrid Morton, and Joan Salay Janusz.

Preconception care is a set of interventions that identify and modify biomedical, behavioral, and social risks to a woman's health and future pregnancies. It includes both prevention and management, emphasizing health issues that require action before conception or very early in pregnancy for maximal impact. The primary target population for preconception care is women of reproductive age. Effective strategies should also include men, significant others, community groups, and health and social service professionals. The goals and recommendations of the education subcommittee are based on the Centers for Disease Control and Prevention's Morbidity and Mortality Weekly Report, "Recommendations to Improve Preconception Health and Health Care - United States" (19)

Capacity Subcommittee

Chair: Shirley White-Walker.

Members: Ilise Zimmerman, Mariann Moore, Marijane Lundt, Andrea Hoberman, Katherine Grant Davis, Francine Sinofsky, Firoozhe Vali, Velve Dawson, Judy Donlen, Maria McGowan, Michele Torchia, Kay Morrow, Linda Jones-Hicks, Chuck Denk, Margaret Gray, Sandra Schwarz, and Robyn D'Oria.

This subcommittee focused on access to care issues related to hospital/facility closures or service reduction, Medicaid presumptive enrollment and health care provider issues including escalating malpractice premiums, number of available providers, geographic accessibility and high risk perinatal consultation.

Quality/Outcomes Subcommittee

Chair: Dan Notterman.

Members: Judith Richardson, Shirley White-Walker, Laurie Navin, Robyn D'Oria, Margaret Springer, Lakota Kruse, and Sandra Schwarz.

This subcommittee focused on issues of standardizing measures of quality, availability of data, and promoting quality improvement. Different measures of quality assessment were reviewed and it was felt by the subcommittee that the Healthcare Effectiveness Data and Information Set (HEDIS) measures, infant mortality rates, and the Perinatal Risk Index for New Jersey should be reviewed for usefulness and accuracy in addressing the State's ability to meet women's prenatal care needs. The Population Perinatal Risk Index, developed by DHSS, measures perinatal risk factors on a municipality specific basis. HEDIS measures are a widely used set of performance measures in the managed care industry, developed by the National Committee for Quality Assurance (NCQA) and used by purchasers of healthcare coverage, including state Medicaid agencies and employers.

Subcommittee meetings were convened between scheduled meetings of the Task Force. All three subcommittees formulated recommendations for consideration by the Prenatal Care Task Force. After review of all of the goals, recommendations and action steps formulated by the three subcommittees, it was determined that these recommendations focused primarily around: 1) Education; 2) Access to Reproductive Health Care Services and Practitioners; 3) Systems Improvement and 4) Evaluation. Thus, the recommendations will be presented in that format.

*Goals, Recommendations and Action Steps Identified by the Prenatal Task Force's
Education, Capacity, and Quality and Data Subcommittees*

Preconception and Prenatal Education

**GOAL I. Increase public awareness of the importance of preconception health.
(Education)**

***Recommendation:** Increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various variables, such as age; literacy level, including health literacy; and cultural/linguistic contexts.*

Action Steps:

- * Provide information on the importance of preconception health to educators.
- * Increase health provider (including primary and specialty area providers) awareness regarding the importance of addressing preconception health among all women of childbearing age. Integrate preconception health messages into existing health promotion campaigns.
- * Use research terms that the public understands and develop messages for promoting preconception health.
- * Utilize social marketing campaigns to develop messages for promoting preconception health knowledge, attitudes and behaviors among women of childbearing age and their partners.
- * Engage media partners to assist in depicting positive role models for lifestyles that promote reproductive health.

GOAL II. Improve community, consumer and healthcare professional knowledge of risks and behaviors that impact preconception health. (Education)

***Recommendation:** Each woman, man and couple should be encouraged to have a reproductive life-plan.*

Action Steps:

- * Identify and disseminate reproductive life planning tools for females and males respecting variations in age, literacy and cultural and linguistic context.
- * Integrate standardized, culturally and age-appropriate preconception education in all New Jersey schools.
- * Establish at least one, no cost prepregnancy risk assessment and education site in each county for women of childbearing age and their partners.
- * Identify research leading to the development, dissemination and evaluation of individual health education materials for females and males regarding preconception risk factors known to affect pregnancy.

- * Educate women and couples regarding the value and availability of prepregnancy planning visits.
- * Integrate preconception and interception health education into all Work First New Jersey activities for women of childbearing age.
- * Integrate preconception health education and counseling as a core service at each of the six Maternal and Child Health Consortia (MCHC).

**GOAL III. Increase awareness among health professionals and the public of first trimester prenatal care as a measure of the quality of maternal health care.
(Quality and Outcomes)**

***Recommendation:** Raise awareness of factors impacting first trimester prenatal care as a standard measure of the quality of healthcare services using the DHSS Population Perinatal Risk Index and HEDIS measures.*

Action Steps:

- * Publicize available documents that report first trimester prenatal care as a standard HEDIS measure of the quality of healthcare services, including the New Jersey HMO Performance Report, produced by the New Jersey Department of Banking and Insurance and available at their web site at: www.state.NewJersey.us/dobi/lifehealthactuarial/comprehensiverpt07.pdf.
- * Publicize documents that report the Population Perinatal Risk Index.
- * Collaborate with New Jersey Medicaid to report New Jersey HMO Performance for Managed Medicaid and Medicaid clients with respect to first trimester prenatal care.
- * Collaborate with the New Jersey Department of Banking and Insurance to develop Internet-based approaches to make first trimester prenatal care performance measures (by region and by insurance provider, including commercial, Medicaid, Managed Medicaid, and other) widely accessible. Collaborate with New Jersey Department of Banking and Insurance and New Jersey Medicaid to develop a report format that identifies, at a minimum, the rate of first trimester entry into prenatal care for women and/or other HEDIS perinatal indicators.
- * Publicize available documents that report disparities in first trimester prenatal care such as Healthy People 2020 and the New Jersey Center for Health Statistics.

Access to Reproductive Health Care Services and Practitioners

GOAL IV. Assure that all females of childbearing age in New Jersey receive preconception care services that will enable them to enter a planned pregnancy in optimal health. (Education)

***Recommendation:** As a component of primary care visits and school-related health contacts, provide risk assessment, education and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes.*

Action Steps:

- * Target statewide continuing education on preconception health to all professionals (especially in the health and educational sectors) who have contact with women of childbearing age.
- * Identify and implement curricula on preconception care for use in clinical education at the graduate, post-graduate and continuing education levels.
- * Standardize and promote a brief risk assessment tool to be used by all health care professionals who have contact with women of childbearing age.
- * Standardize and promote a brief preconception education checklist to be used by all health care professionals who have contact with women of childbearing age.
- * Identify, evaluate and disseminate practical screening tools for primary care settings, with emphasis on the ten areas for preconception risk assessment (e.g., reproductive history, genetic and environmental risk factors).
- * Disseminate existing evidence-based interventions that address risk factors that can be used in primary care settings.
- * Identify, evaluate and disseminate evidence-based modules for integrating components of preconception care to facilitate delivery of and demand for prevention and intervention services.
- * Develop and support public health practice collaborative groups to promote shared learning and dissemination of approaches for increasing preconception health.
- * Apply quality improvement techniques (e.g., conduct rapid improvement cycles, establish benchmarks and brief provider training, use practice self-audits, and participate in quality improvement collaborative groups) to improve provider knowledge, attitudes and practices and to reduce missed opportunities for screening and health promotion in grant funded projects or wherever possible.
- * Create a fee code for preconception care to encourage provider participation and provide reasonable reimbursement.

Recommendation: Offer as a component of reproductive health care, one prepregnancy visit for women of childbearing age and their partner planning a pregnancy.

Action Steps:

- * Expand Medicaid coverage to include preconception and interconception care visits.
- * Provide fiscal incentives to all providers who offer preconception health care visits.
- * Establish at least one (no-cost) stand-alone prepregnancy risk assessment and education site in each county for women of childbearing age and their partners.

Recommendation: Improve access to prenatal care by focusing on women before they become pregnant by promoting the use of preconceptual care and family planning services.

Action Steps:

- * Support the application and implementation of a Medicaid Family Planning Waiver to promote reproductive health, help women avoid unintended pregnancies and improve infant and maternal health.
- * Expand the range of family planning services under the favorable 90% federal match of the Medicaid Family Planning Waivers to include screenings and preventive services to promote the quality of both preconception and prenatal care.

GOAL V. Reduce risks indicated by a previous adverse pregnancy outcome through interventions during the interconception period, which can prevent or minimize future health problems. (Education)

Recommendation: Increase the proportion of women who receive interventions as a follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact).

Action Steps:

- * Monitor the percent of women who complete postpartum visits.
- * Enhance the content of postpartum visits to include interconception health and modify third party payor rules regarding any additional diagnostic testing.
- * Utilize existing public health programs, including those offered by local health departments to provide or link postpartum women to health related interventions.
- * Consolidate and disseminate existing professional guidelines to develop a recommended screening and health promotion package.
- * Establish at least one (no-cost) stand-alone prepregnancy risk assessment and education site in each county for women of childbearing age and their partners.
- * Establish Memorandums of Agreement between preconception risk screening sites and Regional Perinatal Centers in the State.

Recommendation: Use the interconception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth).

Action Steps:

- * Recommend a modification to third party payer rules that permits payment for one prepregnancy visit.
- * Educate women and couples on the value and availability of prepregnancy visits.
- * Fund home visitation services in each county (which include preconception and interconception focus) for all first time mothers and women with adverse birth outcomes.
- * Integrate formalized interconception health counseling into Special Child Health Services case management programs and Early Intervention Program services in each county.

Recommendation: *Integrate components of preconception health into existing local public health and related programs, including emphasis on interconception interventions for women with previous adverse outcomes.*

Action Steps:

- * Monitor the percent of women who complete postpartum visits and expand postpartum visits to include interconception health.
- * Utilize existing public health programs to provide or link post postpartum women to health related interventions.
- * Promote universal home visitation services in New Jersey (which includes preconception and interconception focus) to all first time mothers and women with previous adverse birth outcomes.
- * Integrate preconception and interconception healthcare counseling at all New Jersey Special Supplemental Nutrition Program for Women, Infants and Children (WIC) sites.
- * Engage women of childbearing age service sites (beauty parlors, nail salons, tanning salons, etc.) and places of worship to promote prepregnancy services in their community.
- * Establish at least one (no - cost) stand-alone prepregnancy risk assessment and education site in each county for women of childbearing age and their partners (partner with Family Success Centers when possible).
- * Integrate interconception health counseling into Special Child Health Services case management programs and Early Intervention Program services in each county.

GOAL VI. Increase the number of available obstetric providers to care for underserved populations. (Capacity)

Recommendation: *Increase the number of obstetric providers and maternal fetal medicine/perinatology specialists to provide timely and adequate prenatal and obstetric services throughout the State.*

Action Steps:

- * Examine the issue of medical malpractice insurance and tort reform as it relates to the provision of obstetric (OB) services.
- * Explore current state of OB malpractice coverage in New Jersey including but not limited to availability, cost, opportunities for subsidy, etc.
- * Identify appropriate incentives for care including but not limited to performance improvement/outcome initiatives to attract OB providers in areas of need.
- * Provide incentives to OB providers to ensure that prenatal and postpartum services are delivered to uninsured Medicaid patients within two weeks of patient contact.

- * Increase medical malpractice subsidies.
- * Include non-physician providers in medical malpractice subsidies.
- * Increase the visibility of the loan redemption program via earlier marketing to midwives, advanced practice nurses and OB residents.
- * Increase funding and award amounts for the loan redemption program.
- * Identify those issues specific to the uninsured that prohibit them from receiving early and comprehensive prenatal and OB services.

GOAL VII. Ensure availability of ongoing early prenatal care services to women in areas affected by hospital closures and or reduction in obstetric services. (Capacity)

***Recommendation:** Implement a mechanism to track annually available OB providers and facilities throughout specific geographic regions to identify shortages and service needs.*

Action Steps:

- * The MCH consortia should gather data and report to DHSS any issues or concerns regarding the availability of providers and/or facilities.
- * The DHSS should recognize obstetrics as an essential health service and assure prenatal and OB health services within a region when a hospital closes or services are reduced.

GOAL VIII: Promote quality improvement programs to improve first trimester prenatal care rates and infant mortality rates. (Quality and Outcomes)

***Recommendation:** Identify and target high-risk communities for improvement using the Population Perinatal Risk Index for New Jersey, Infant Mortality Rates (IMR) and other appropriate measures. (Appendix 4)*

Action Steps:

- * Identify the communities of greatest need using needs assessment tools and the Population Perinatal Risk Index for New Jersey Municipalities.
- * Re-evaluate priority areas for infant mortality reduction funding and then redirect infant mortality reduction funds to the regions identified.
- * Identify other funding sources and/or revenue activities that could supplement infant mortality reduction funds such as a license plate focused on healthy mothers and healthy babies.

***Recommendation:** Provide incentives for strategies that enhance rates of first trimester prenatal care and other perinatal indicators.*

Action Steps:

- * Develop performance incentive initiatives to improve first trimester prenatal care enrollment and address other perinatal indicators in the identified high risk communities.
- * Initiate meetings with Medicaid Managed Care Organizations and Centers for Medicaid and Medicare Services to develop a performance incentive initiative.

Recommendation: *Develop a scorecard for perinatal health care that encompasses a broad range of quantitative and qualitative measures. At a minimum, this should incorporate nationally recognized quality measures such as Guidelines for Perinatal Care by the American College of Obstetricians and Gynecologists and American Academy of Pediatrics and the Population Perinatal Risk Index for New Jersey Municipalities as defined by DHSS.*

Action Steps:

- * Identify a subset of qualitative and quantitative measures that are representative of overall quality, accessible to the DHSS, and for which national benchmarks exist.
- * These measures should bear an important relationship to maternal and fetal outcomes.
- * Collaborate with other Departments to access non-Electronic Birth Certificate indicators for this report card.
- * Update and establish a web based electronic birth certificate to ensure accurate and timely access to perinatal data.

Recommendation: *Share best practices among providers and their organizations in promoting early prenatal care.*

Action Steps:

- * Identify provider sites with documented best practices in the provision of early prenatal care among women of childbearing age and pregnant women.
- * Develop a process and incentive to share the identified best practices.



Systems Improvement

GOAL IX. Promote equity in pregnancy outcomes. (Education)

Recommendation: Ensure cultural competence/sensitivity in the delivery of healthcare to women of childbearing age.

Action Steps:

- * Guidelines need to be defined and distributed that identify criteria and opportunities for cultural sensitivity training.
- * Ensure access to translation services at all points of entry into prenatal care, as appropriate.
- * Define renewal licensing requirements in regard to proof of cultural competency training.

Recommendation: Promote consistency and equity in the quality of care provided to all women of childbearing age and their partners to improve preconception health and birth outcomes.

Action Steps:

- * Encourage the identification and support of model programs and projects, including integrated service delivery and community health promotion projects.
- * Identify and promote the use of effective prenatal education and health literacy tools which are culturally appropriate and designed to engage and educate vulnerable populations.
- * Identify and disseminate statewide best practices in model programs, including Healthy Start, which promote cultural and linguistic competency in provider and staff attitudes.
- * Identify and standardize self-assessment tools to identify socio-cultural barriers within the health delivery systems and promote cultural competency interventions, including organizational barriers, cultural, linguistic barriers, and clinical encounters which impact access to prenatal care.

Recommendation: Increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and preconception and interconception care.

Action Steps:

- * Increase health coverage among women who have low incomes and are of childbearing age by using federal options and waivers under public and private health insurance systems and the SCHIP.
- * Increase access to health care services through policies and reimbursement levels for public and private health insurance systems to include a full and diverse range of clinicians who care for women.

GOAL X: Promote women's health issues by improving the coordination efforts of State governmental agencies. (Capacity)

Recommendation: Promote women's health issues by improving the coordination efforts of State government agencies with other public/private and non-profit agencies focused on the needs of women.

Action Steps:

- * Convene an interagency committee with representatives from relevant State agencies, and Governor/Commissioner appointed councils, task forces, or committees to determine how each respective group is or will address the promotion of preconception health and early entry into prenatal care.
- * Integrate the recommendations of this report into the activities of these State agencies and existing State-level Commissions, Task Forces, Councils or Committees.

Recommendation: *Establish an early confidential warning system that identifies hospitals, FQHCs and Family Planning agencies in financial distress thereby placing obstetric services in jeopardy.*

- * Any distressed hospital, health center or agency at risk of closing or reducing prenatal and obstetric services should submit a strategic plan to the DHSS, not less than 90 days before any closure or reduction.
 - ❖ Essential elements of the Strategic Plan should include:
 - Access to prenatal records;
 - Make available a centralized regional location for accessing all prenatal records 24/7;
 - Identify the location(s) where high risk services, prenatal care, intrapartum care, postpartum follow up care will be provided and identify transportation options to the new location(s); and
 - Plan for communication to the community in a culturally and linguistically appropriate manner with options for reconnection appropriate services.
 - ❖ Once the Strategic Plan is implemented, quarterly reports should be developed by the facilities affected by the closure and submitted to DHSS, Office of Licensure, for a minimum of two years.
- * Convene a Strategic Planning Review Committee with representation from the DHSS including Reproductive and Perinatal Health, Office of Primary Care, and Health Facilities Licensure, the Department of Human Services, Division of Medical Assistance, the MCH Consortia, and community stakeholders to discuss issues and concerns within the affected community.

Recommendation: *When notified of a hospital or agency closure/service reduction impacting on prenatal or obstetric care, the DHSS should:*

- * Promote the implementation of a "Prenatal Care Card" for patients to have their prenatal information available at all times.
- * Identify other funding sources to support services.
- * Expedite the review of licensing applications when facilities require modifications to their physical plant and/or revision of licensure scope to accept newly displaced patients due to closure or service reduction.
- * Dedicate a percentage of the Hospital Stabilization funding to support OB services at distressed hospitals when access to obstetric services may be adversely impacted by the financial condition of the hospital.
- * Include criteria for use of the Hospital Stabilization Fund to assist facilities assuming additional obstetric patients and need for services as a result of hospital/service closure in their region.

Goal XI: The Presumptive Eligibility (PE) process will be uniform, cohesive, streamlined and support a timely system for the provision of prenatal services to all women accessing care. (Capacity)

***Recommendation:** The Presumptive Eligibility (PE) system should be revised to expedite enrollment of women into managed care in accordance with current federal law.*

Action Steps:

- * Explore the feasibility of full Medicaid eligibility determination to be done at prenatal care sites including hospitals and FQHCs.
- * Encourage Medicaid to develop a process to ensure that County Boards of Social Service out stationed workers perform uniformly statewide.
- * Establish productivity standards for the PE process.
- * Require PE enrollment personnel to have the recommended hardware and software to process a full Medicaid application on site.
- * Allow hospitals, health centers, HMOs and other appropriate parties to process a PE application without referral to a County Board of Social Services.
- * Complete a comprehensive review of the PE/ Medicaid eligibility determination process to identify additional recommendations for improvement.

Evaluation

GOAL XII: Promote quality improvement programs to improve first trimester prenatal care rates and infant mortality rates; increase awareness among health professionals and the public regarding disparities in maternal health care as well as fetal and infant mortality rates. (Quality and Outcomes)

***Recommendation:** Identify and target high-risk communities for improvement using the Population Perinatal Risk Index for New Jersey Municipalities, Infant Mortality Rates (IMR) and other appropriate measures (Appendix 4).*

Action Steps:

- * Identify the communities of greatest need using the tools identified in this recommendation.
- * Re-evaluate priority areas for infant mortality reduction funding and then redirect infant mortality reduction funds to the regions identified.
- * Identify other funding sources and/or revenue that could supplement infant mortality reduction funds such as a license plate focused on healthy mothers and babies.

GOAL XIII. Assure a system of data collection and evaluation for all preconception care strategies. (Education)

Recommendation: Promote the use of evidence based interventions and evaluation methods to improve preconception care.

Action Steps:

- * Identify and evaluate existing model programs and projects.
- * Use analytical tools to determine the proportion of risk attributable to the health of women before pregnancy.

Recommendation: Maximize public health surveillance and related research mechanisms to monitor preconception health.

Action Steps:

- * Use a public health surveillance system to track the delivery of preconception health services.
- * Use public health surveillance strategies to monitor a selected group of currently collected preconception health indicators.
- * Propose the addition of new Pregnancy Risks Assessment and Monitoring System (PRAMS) questions to monitor individual experiences related to preconception health service use and care.
- * Develop and support public health practice collaborative groups to promote shared learning and dissemination of approaches for increasing preconception health.
- * Examine factors related to individual use of preconception health services.
- * Integrate preconception healthcare questions into the Electronic Birth Certificate program.

GOAL XIV. Evaluate all data which is collected to assure a thorough, comprehensive and equitable development and implementation of all preconception care strategies. (Education)

Recommendation: Include information on existing disparities in all preconception and prenatal education outreach activities.

Action Steps:

- * Compile data on existing disparities.
- * Publicize the need to reduce the disparities in birth outcomes.
- * Educate providers on ways to reduce disparities (i.e., cultural competence).
- * Insure that timelines to meet all goals and objectives and action steps are monitored and finalized.

Summary

Members of the Task Force on Prenatal Care thank Commissioner Heather Howard for the opportunity to provide her with recommendations to ensure adequate and timely prenatal care. Key among the recommendations are preconception education, improved access to reproductive health care services, systems coordination and improvements and utilization of quality evaluation methodologies. It is the Task Force's desire to continue this dialogue to ensure the recommendations set forth are prioritized and implemented. As noted in the recommendations, other relevant State agencies should be invited to participate in this discussion.

Efforts to improve the initiation of prenatal care in the first trimester must be varied and need to address barriers as well as women's knowledge regarding early, comprehensive prenatal care to ensure a positive pregnancy outcome. Mothers most likely to benefit from early prenatal care because of their higher risk of poor birth outcomes, including teens, minorities, unmarried, less education, and those uninsured prior to pregnancy, remain less likely to receive first trimester prenatal care. Expanding health insurance coverage early in pregnancy, increasing early awareness of pregnancies, reducing unintended pregnancies, and reducing delivery system barriers are all necessary to promote early prenatal care. Efforts to improve access to early prenatal care must also focus on women before they become pregnant and promote the use of preconception care and family planning services. Early prenatal care offers the opportunity to undertake a comprehensive needs assessment that is important not only to the current pregnancy, but also to the future health of the mother, the infant, and the family.



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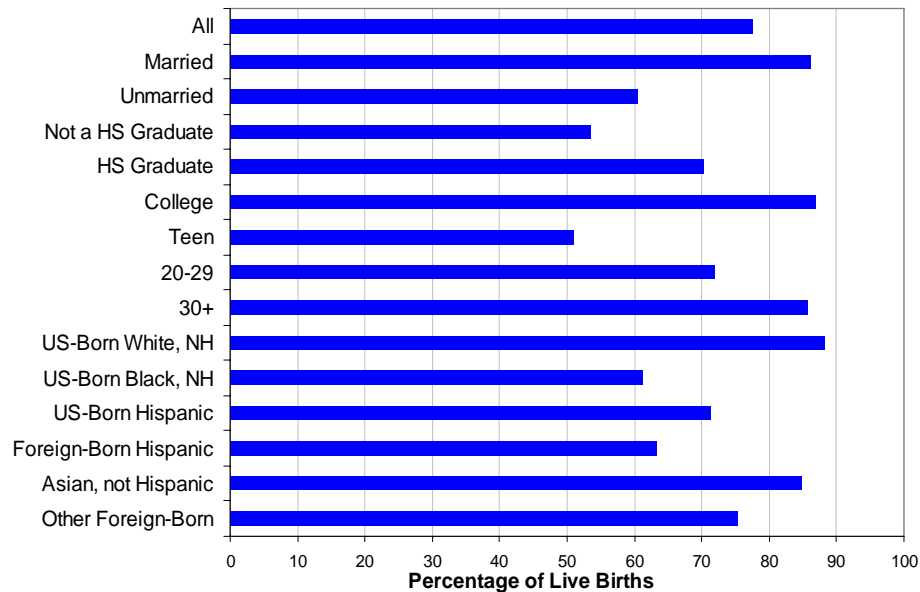
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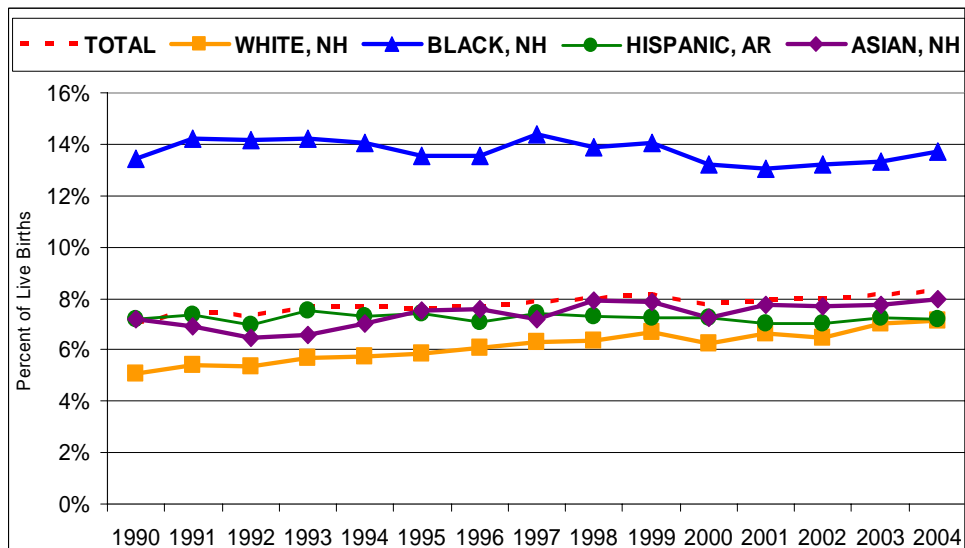
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Appendix 1. Maternal Characteristics of First Trimester Prenatal Care



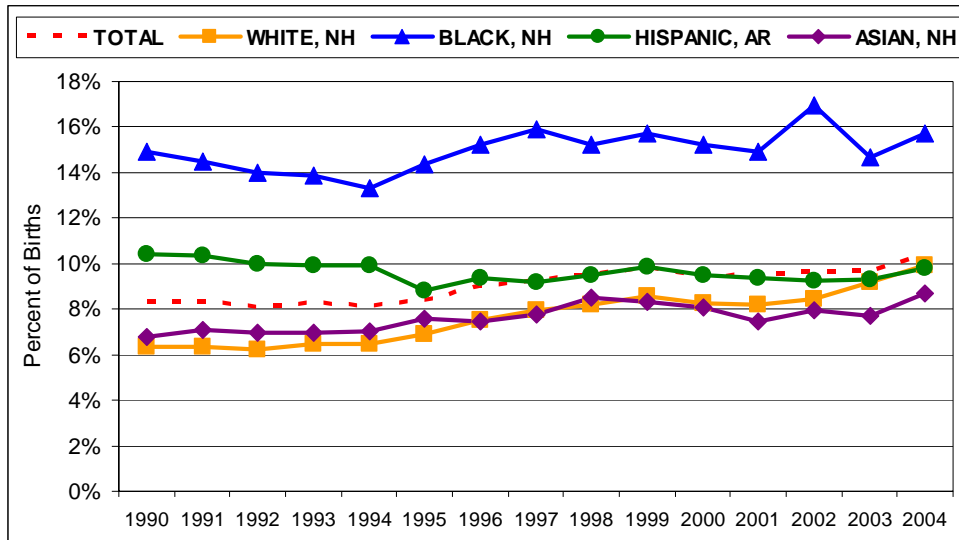
Data source- New Jersey's Electronic Birth Certificate for 2006 as of 6/2008

Appendix 2a. Low Birthweight By Race/Ethnicity



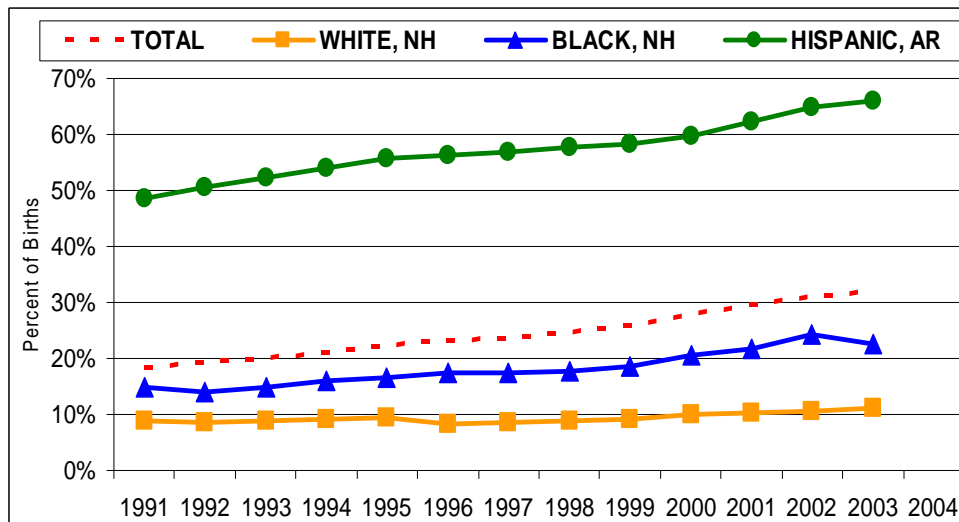
Source: NJDHSS Electronic Birth Certificate Files, as of 6/2008, New Jersey Residents.
 Low Birthweight = Birthweight <2500 grams. Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic; Asian, Non-Hispanic.

Appendix 2b. Preterm Birth By Race/Ethnicity



Source: NJDHSS Electronic Birth Certificate Files, as of 6/2008, New Jersey Residents.
 Preterm Birth = Births less than 37 weeks gestation. Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic; Asian, Non-Hispanic

Appendix 2c. Trends in Births To Foreign-Born Mothers By Race/Ethnicity



Source: NJDHSS Electronic Birth Certificate Files, as of 6/2008, New Jersey Residents.
 Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic; Asian, Non-Hispanic

Appendix 3a. Prenatal Care and Related Population Characteristics by Geographic Region, 2006

	Total Births		FamilyCare/ Uninsured*		1st Trimester PNC, All		Late PNC, FamilyCare/ Uninsured		Late PNC, Insured		Low Birth Weight (<2500g)		PNC by Private Doctor**	
	All	Clinic Service**	Count	%	Count	%	Count	%	Count	%	%	%	%	%
1-Hackensack Hospital Referral Region	Passaic City	1,465	571	44.9%	658	63.5%	275	41.8%	259	32.1%	7.3%	39.0%	43.1%	
	Paterson City	2,875	1,358	66.4%	1,908	64.4%	820	43.0%	204	21.1%	10.7%	47.2%	41.6%	
	Region remainder	12,168	1,783	21.8%	2,650	83.1%	918	34.6%	1,140	12.0%	7.4%	14.7%	81.4%	
	BERGEN CO. remainder	9,044	1,340	20.2%	1,828	83.1%	652	35.7%	877	12.2%	7.4%	14.8%	81.1%	
	PASSAIC CO. remainder	3,124	443	26.3%	822	83.1%	266	32.4%	263	11.4%	7.3%	14.2%	82.1%	
	Region	8,444	962	39.3%	3,322	88.7%	587	17.7%	370	7.2%	7.1%	11.4%	86.4%	
2-Morristown Hospital Referral Region	MORRIS CO. remainder	5,605	700	41.3%	2,317	88.4%	435	18.8%	216	6.6%	7.0%	12.5%	86.0%	
	SUSSEX CO. remainder	1,603	160	34.6%	554	89.3%	91	16.4%	81	7.7%	7.1%	10.0%	88.7%	
	WARREN CO. remainder	1,236	102	36.5%	451	89.2%	61	13.5%	73	9.3%	7.7%	8.3%	84.7%	
	Region	1,038	378	38.1%	395	53.7%	237	60.0%	244	37.9%	14.6%	36.4%	55.6%	
3-Newark Hospital Referral Region	East Orange City	948	422	42.6%	404	57.0%	216	53.5%	192	35.3%	12.4%	44.5%	49.5%	
	Irvington Township	3,365	714	52.7%	1,773	71.4%	668	37.7%	296	18.6%	10.3%	21.2%	47.2%	
	Jersey City	4,913	2,760	42.6%	2,093	53.1%	1,185	56.6%	1,119	39.7%	12.6%	56.2%	36.5%	
	Newark City	1,101	292	64.1%	706	71.8%	224	31.7%	86	21.8%	7.0%	26.5%	34.3%	
	Region remainder	8,326	1,480	31.0%	2,584	79.2%	889	34.4%	845	14.7%	8.1%	17.8%	71.4%	
	ESSEX CO. remainder	4,572	678	24.0%	1,098	81.0%	397	36.2%	472	13.6%	9.0%	14.8%	82.6%	
	HUDSON CO. remainder	3,754	802	39.6%	1,486	77.0%	492	33.1%	373	16.4%	7.0%	21.4%	57.8%	
	Region	2,228	1,073	34.3%	765	60.4%	346	45.2%	536	36.6%	8.2%	48.2%	43.1%	
4-New Brunswick Hospital Referral Region	Elizabeth City	1,106	530	74.1%	820	73.7%	250	30.5%	41	14.3%	10.1%	47.9%	24.2%	
	New Brunswick City	858	333	56.8%	487	52.3%	273	56.1%	136	36.7%	9.1%	38.8%	61.1%	
	Perth Amboy City	973	101	55.0%	535	63.1%	248	46.4%	111	25.3%	7.3%	10.4%	32.1%	
	Plainfield City	17,763	1,740	21.2%	3,762	86.9%	1,005	26.7%	1,324	9.5%	8.2%	9.8%	85.0%	
	Region remainder	1,226	12	16.2%	199	89.4%	51	25.6%	79	7.7%	6.4%	1.0%	96.3%	
	HUNTERDON CO. remainder	8,437	797	19.5%	1,646	87.5%	467	28.4%	591	8.7%	8.7%	9.4%	86.9%	
	MIDDLESEX CO. remainder	3,909	419	26.4%	1,033	89.3%	223	21.6%	194	6.7%	8.7%	10.7%	80.3%	
5-Trenton Hospital Referral Region	SOMERSET CO. remainder	4,191	512	21.1%	884	82.7%	264	29.9%	460	13.9%	7.4%	12.2%	82.6%	
	UNION CO. remainder	1,621	105	71.4%	1,158	64.0%	432	37.3%	152	32.8%	11.8%	6.5%	32.1%	
	Trenton City	2,938	212	35.7%	1,050	86.5%	250	23.8%	146	7.7%	9.0%	7.2%	83.5%	
	MERCER CO. remainder													

* Insurance status from Birth Certificate

** PNC source from Birth Certificate

Appendix 3a. Prenatal Care and Related Population Characteristics by Geographic Region, 2006

	Total Births		FamilyCare/ Uninsured*		1st Trimester PNC, All		Late PNC, FamilyCare/ Uninsured		Late PNC, Insured		Low Birth Weight (<2500g)		PNC by Private Doctor**	
	All	Clinic Service**	Count	%	Count	%	Count	%	Count	%	%	%	%	%
6-Toms River Hospital Referral Region	1,378	533	1,019	73.9%	64.6%	394	38.7%	94	26.2%	8.8%	38.7%	44.2%		
	2,931	218	2,175	74.2%	67.1%	786	36.1%	178	23.5%	3.8%	7.4%	78.3%		
	10,337	1,063	4,353	42.1%	85.4%	987	22.7%	518	8.7%	7.7%	10.3%	82.0%		
	5,789	558	2,100	36.3%	85.9%	529	25.2%	287	7.8%	8.2%	9.6%	82.0%		
	4,548	505	2,253	49.5%	84.9%	458	20.3%	231	10.1%	7.0%	11.1%	81.9%		
7-Camden Hospital Referral Region	1,714	832	1,326	77.4%	58.3%	570	43.0%	145	37.4%	10.3%	48.5%	11.7%		
	13,052	2,327	3,448	26.4%	80.3%	1,100	31.9%	1,468	15.3%	8.6%	17.8%	77.7%		
	4,856	812	1,293	26.6%	79.9%	393	30.4%	582	16.3%	8.9%	16.7%	80.3%		
	5,079	958	1,522	30.0%	79.6%	505	33.2%	529	14.9%	8.9%	18.9%	74.5%		
	3,117	557	633	20.3%	82.1%	202	31.9%	357	14.4%	7.9%	17.9%	78.8%		
8-Atlantic City Hospital Referral Region	803	100	354	44.1%	57.7%	179	50.6%	161	35.9%	11.3%	12.5%	31.5%		
	851	464	530	62.3%	56.1%	283	53.4%	91	28.3%	11.0%	54.5%	40.3%		
	1,337	482	505	37.8%	67.7%	228	45.1%	204	24.5%	11.0%	36.1%	60.2%		
	4,477	865	1,230	27.5%	73.3%	514	41.8%	680	20.9%	7.5%	19.3%	67.0%		
	2,765	537	745	26.9%	73.2%	328	44.0%	414	20.5%	7.8%	19.4%	65.3%		
	898	262	281	31.3%	76.3%	89	31.7%	124	20.1%	6.1%	29.2%	64.4%		
	182	38	48	26.4%	77.5%	19	39.6%	22	16.4%	6.6%	20.9%	78.6%		
	632	28	156	24.7%	68.7%	78	50.0%	120	25.2%	8.1%	4.4%	74.8%		

* Insurance status from Birth Certificate

** PNC source from Birth Certificate

Appendix 3b. Available OB Clinicians* by Geographic Region 2004-07

		Attending Physicians with >10 Deliveries	Attendings that Deliver >25% FamilyCare/Uninsured		
			Number	Proportion of All Attendings	per 100 FamilyCare/ Uninsured
1-Hackensack Hospital Referral Region	Passaic City	283	152	54%	4.3
	Paterson City	331	184	56%	2.4
	BERGEN CO. remainder	567	284	50%	3.1
	PASSAIC CO. remainder	496	249	50%	6.5
2-Morristown Hospital Referral Region	MORRIS CO. remainder	637	320	50%	3.6
	SUSSEX CO. remainder	371	199	46%	9
	WARREN CO. remainder	371	188	51%	9.5
3-Newark Hospital Referral Region	East Orange City	325	196	60%	11.4
	Irvington Township	325	198	61%	10.5
	Newark City	490	287	59%	3.3
	Jersey City	491	253	52%	3.5
	Union City	217	121	56%	4.5
	ESSEX CO. remainder	630	341	54%	7.6
	HUDSON CO. remainder	619	321	52%	5.6
4-New Brunswick Hospital Referral Region	Elizabeth City	452	265	59%	8.6
	New Brunswick City	159	71	45%	2.2
	Perth Amboy City	241	129	54%	7.1
	Plainfield City	281	141	50%	7.1
	HUNTERDON CO. remainder	345	158	46%	12.5
	MIDDLESEX CO. remainder	794	408	51%	6.8
	SOMERSET CO. remainder	584	269	46%	6.8
5-Trenton Hospital Referral Region	UNION CO. remainder	674	364	54%	10.5
	Trenton City	211	128	61%	3
	MERCER CO. remainder	448	195	44%	5.3
6-Toms River Hospital Referral Region	Asbury/Neptune/LongBranch	200	132	66%	3.6
	Lakewood Township	234	168	72%	2.1
	MONMOUTH CO. remainder	618	307	50%	4
	OCEAN CO. remainder	579	287	50%	3.2
7-Camden Hospital Referral Region	Camden City	189	127	67%	2.5
	BURLINGTON CO. remainder	568	294	52%	6.2
	CAMDEN CO. remainder	360	198	55%	3.2
	GLOUCESTER CO. remainder	282	157	56%	6.5
8-Atlantic City Hospital Referral Region	Atlantic City	102	60	59%	4.2
	Bridgeton/Fairfld/Deerfld/Lawrence	101	60	59%	2.7
	Vineland/Milville	183	102	56%	4.7
	ATLANTIC CO. remainder	276	147	53%	5.1
	CAPE MAY CO. remainder	140	80	57%	7.2
	CUMBERLAND CO. remainder	77	48	62%	12.5
	SALEM CO. remainder	143	80	56%	11.2

* From Birth Certificate listing of "attending physician." Includes Certified Nurse Midwives.

Appendix 3c. Timely Prenatal Care Under FamilyCare: Provider Availability

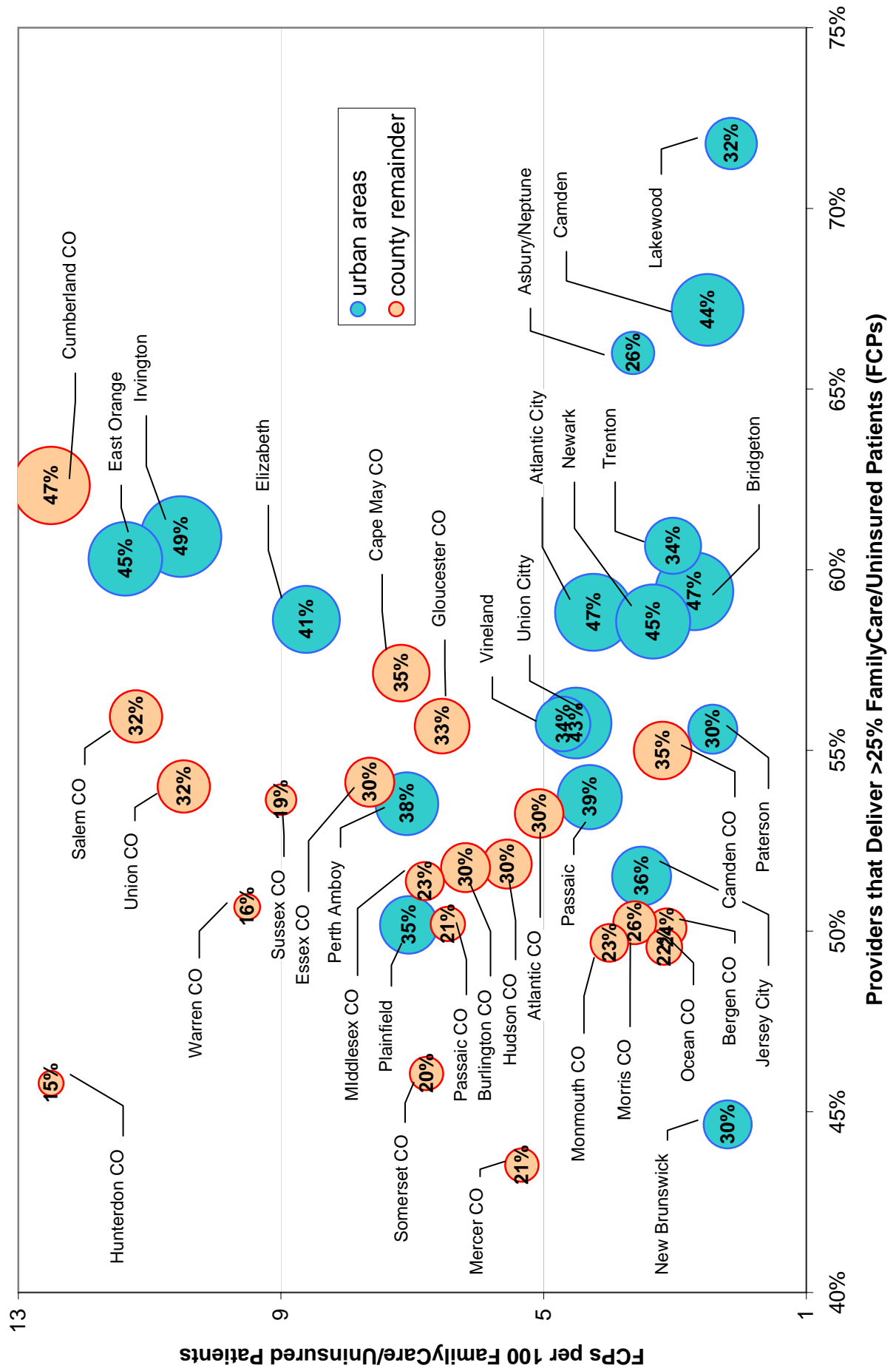
The availability of OB providers to the FamilyCare and uninsured populations is an important determinant of health care access. We defined “FamilyCare Providers” (FCPs) as those “attending physicians” listed in the EBC whose deliveries between 2004-2007 were at least 25% FamilyCare or uninsured. We operationalized each community’s level of provider availability in two ways:

- [1] the proportion of all providers that were FamilyCare Providers as defined above; and
- [2] the number of FamilyCare Providers per 100 patients delivered under FamilyCare or with no insurance.

In the accompanying graph, these two dimensions are the horizontal and vertical axes. The diameter of the “bubbles” and the numbers inside them give the percentage of FamilyCare/uninsured mothers whose PNC began after the first trimester, or not at all.

By our measures the highest level of availability would occur in the top right quadrant, where there are more providers participating in Medicaid among all providers and relative to patients covered. This is not, however, the region of most timely PNC. In fact, late PNC seems paradoxically to *increase* with the percentage of participating providers, but has no relationship to the ratio of providers to deliveries. The graph shows that all communities in New Jersey have fairly high FamilyCare participation among physicians. In general, most urban areas have lower rates of timely PNC than the less urban parts of each county.

Appendix 3c. FamilyCare & Uninsured: Late PNC (bubble value) by Provider Availability

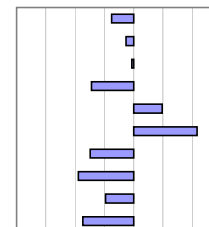


**Appendix 3d. Timely PNC by Hospital
and Regional MCH Consortium, 2006**

Central NJ MCH Consortium

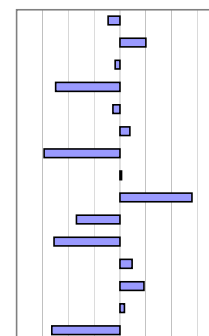
	Births	FC/UI	Late PNC, Private Ins	Late PNC, FC/UI	Late %, All	Late % FC/UI
All	19,242	6,932	1,139	2,252	18%	32%
Hunterdon Medical Center	1,293	115	99	43	11%	37%
Capital Health System - Mercer Campus	2,506	977	275	385	26%	39%
Robert Wood Johnson University Hospital	2,186	1,883	37	481	24%	26%
Muhlenberg Regional Medical Center	1,114	621	149	309	41%	50%
Raritan Bay Medical Center	1,082	669	197	413	56%	62%
Medical Center at Princeton	1,972	239	66	60	6%	25%
Saint Peter's University Hospital	6,055	799	195	169	6%	21%
Somerset Medical Center	1,588	303	102	92	12%	30%
RWJ University Hospital at Hamilton	1,446	1,326	19	300	22%	23%

Bar graph: Late PNC %
among FC/UI vs. 40%
(FC/UI state average).



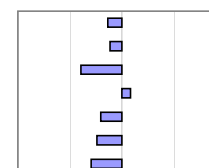
Gateway Northwest MCH Network

	Births	FC/UI	Late PNC, Private Ins	Late PNC, FC/UI	Late %, All	Late % FC/UI
All	25,926	9,145	3,389	3,239	26%	35%
Newark Beth Israel Medical Center	2,821	1,068	694	535	44%	50%
Hackensack University Medical Center	4,983	875	623	334	19%	38%
Hackettstown Community Hospital	757	251	67	38	14%	15%
JFK Medical Center	2,793	190	377	71	16%	37%
Clara Maass Medical Center	1,332	278	235	122	27%	44%
Morristown Memorial Hospital	3,575	2,573	43	273	9%	11%
The Mountainside Hospital	795	140	62	57	15%	41%
University of Medicine & Dentistry of New Jersey - University Ho	2,074	1,566	312	1,065	66%	68%
Newton Memorial Hospital	746	332	34	77	15%	23%
Overlook Hospital	2,502	365	99	53	6%	15%
The General Hospital Center at Passaic	453	297	36	133	37%	45%
Trinitas Hospital (fmr. St. Eliz/Eliz General)	1,833	678	555	335	49%	49%
Saint James Hospital	873	261	236	109	40%	42%
Warren Hospital	389	271	16	37	14%	14%



Hudson Perinatal Cooperative, Inc.

	Births	FC/UI	Late PNC, Private Ins	Late PNC, FC/UI	Late %, All	Late % FC/UI
All	6,539	3,671	445	1,269	26%	35%
Bayonne Medical Center	73	31	6	11	23%	35%
Christ Hospital	1,226	682	78	165	20%	24%
Liberty HealthCare System, Inc. - Jersey City Medical Center	1,881	1,476	82	639	38%	43%
Palisades Medical Center - New York Presbyterian Healthcare S	1,461	950	111	303	28%	32%
Liberty HealthCare System, Inc. - Meadowlands Hospital Medica	696	56	86	17	15%	30%
St. Mary Hospital	1,202	476	82	134	18%	28%



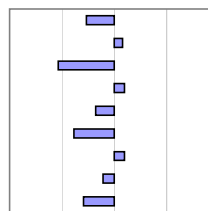
FC/UI = Medicaid/FamilyCare/Uninsured

**Appendix 3d. Timely PNC by Hospital
and Regional MCH Consortium, 2006**

Regional Perinatal Consortium of Monmouth and Ocean Counties, Inc.

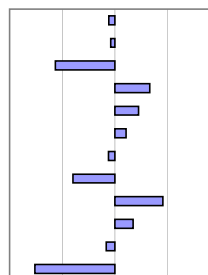
	Births	FC/UI	Late PNC, Private Ins	Late PNC, FC/UI	Late %, All	Late % FC/UI
All	14,089	7,369	779	2,163	21%	29%
Meridian Hospitals Corporation - Medical Center of Ocean Coun	1,019	162	121	70	19%	43%
Community Medical Center	1,736	1,373	40	255	17%	19%
CentraState Healthcare System	1,871	328	154	144	16%	44%
Meridian Hospitals Corporation - Jersey Shore Medical Center D	1,765	893	144	294	25%	33%
Monmouth Medical Center	4,013	3,078	155	756	23%	25%
Kimball Medical Center	1,697	1,257	77	552	37%	44%
Meridian Hospitals Corporation - Riverview Medical Center	1,705	179	69	64	8%	36%
Southern Ocean County Hospital	283	99	19	28	17%	28%

Bar graph: Late PNC %
among FC/UI vs. 40%
(FC/UI state average).



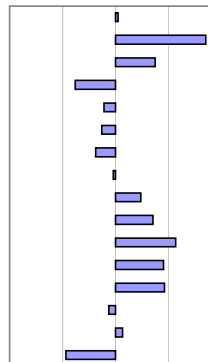
Northern NJ MCH Consortium

	Births	FC/UI	Late PNC, Private Ins	Late PNC, FC/UI	Late %, All	Late % FC/UI
All	23,246	6,068	2,574	2,287	21%	38%
Barnert Hospital	903	523	96	201	33%	38%
Chilton Memorial Hospital	1,135	299	21	52	6%	17%
Columbus Hospital	898	394	206	210	46%	53%
Englewood Hospital and Medical Center	2,137	414	195	203	19%	49%
Holy Name Hospital	1,176	140	115	62	15%	44%
Pascack Valley Hospital	1,077	101	155	38	18%	38%
Saint Barnabas Medical Center	6,586	1,074	882	258	17%	24%
Saint Clare's Hospital/Denville	1,926	326	106	190	15%	58%
St. Joseph's Regional Medical Center	2,894	1,781	268	835	38%	47%
St. Mary's Hospital Passaic	1,373	517	326	190	38%	37%
The Valley Hospital	3,141	499	204	48	8%	10%



Southern NJ Perinatal Cooperative, Inc.

	Births	FC/UI	Late PNC, Private Ins	Late PNC, FC/UI	Late %, All	Late % FC/UI
All	22,089	7,226	2,931	2,962	27%	41%
AtlantiCare Regional MC - City Division	79	58	12	43	70%	74%
Kennedy Memorial Hospitals UMC Stratford	236	80	73	44	50%	55%
Burdette Tomlin Memorial Hospital	505	210	50	52	20%	25%
Virtua Memorial Hospital of Burlington County	2,211	457	337	163	23%	36%
The Cooper Health System	2,200	1,900	67	662	33%	35%
South Jersey - Elmer	340	43	33	14	14%	33%
AtlantiCare Regional MC - Mainland Division	2,357	618	361	242	26%	39%
South Jersey Regional MC - Newcomb	2,182	1,079	298	534	38%	49%
Our Lady of Lourdes Medical Center	1,294	849	159	460	48%	54%
Lourdes MC - Burlington	956	188	209	118	34%	63%
The Memorial Hospital of Salem County, Inc.	406	110	104	64	41%	58%
Shore Memorial Hospital	1,343	405	273	237	38%	59%
Underwood Memorial Hospital	1,201	152	174	57	19%	38%
Kennedy Memorial Hospitals UMC Washington Township	1,355	199	189	85	20%	43%
Virtua West Jersey Hospital - Voorhees	5,424	878	592	187	14%	21%



FC/UI = Medicaid/FamilyCare/Uninsured

Appendix 4. Population Perinatal Risk Index for New Jersey Municipalities

Prepared by
Charles E Denk, PhD
MCH Epidemiology Program, NJDHSS
June 9, 2008

Background

Historically the Department of Health and Senior Services has provided state funding to improve perinatal public health services in communities with the worst birth outcomes. Such efforts require a method for ranking municipalities across an array of indicators.

In 1985, the *New Jersey Infant Mortality Reduction Initiative* was launched to reduce infant mortality by reducing low birth weight and very low birth weight births, increasing the early utilization of prenatal care, and reducing the number of adolescent pregnancies. Services supported under this initiative have included grants for comprehensive prenatal care to high risk mothers at six perinatal centers; a statewide telephone hotline for prenatal and WIC referrals; increased community-based outreach and education services; and an extensive public media education and awareness campaign.

The original needs assessment included 63 municipalities with population over 30,000. These communities were rated on a score that combined fetal and infant mortality, low birthweight, poverty and teen births in a weighted sum. In 2002 the MCH Epidemiology Program conducted an updated needs assessment using a *population risk scoring* methodology.

The new approach capitalizes on three observations: [1] New Jersey communities exhibit a diverse array of demographic profiles; [2] demographic risk factors have strong effects on birth outcomes; and [3] because the adverse outcomes we track tend to have the same risk factors, municipalities tend to be equally “at risk” for all those outcomes. Thus municipalities with similar composition with regard to race, education, etc. will have similar values on such varied measures as perinatal death rates, low birth weight, and teen pregnancy.

The population risk scoring methodology increases the validity and stability of community assessments. Our outcomes of primary interest—infant death, fetal demise, low birth weight—are rare events, subject to considerable random fluctuation even in samples of moderate size. The population risk approach yields more stable estimates of risk for small area analysis, because it is less sensitive to random fluctuations in these rare events.

Methods

For the current update, all births, fetal deaths and infant deaths recorded for New Jersey residents by the Office of Vital Statistics from 1999 to 2003 were included in our analysis. We analyzed 146 municipalities with 1,000 or more births in that five year period. See the appendix for cases and indicators available.

The *population risk scoring* procedure starts with the selection of primary indicators:

- low birth weight
- infant mortality
- perinatal (fetal+neonatal) mortality
- late prenatal care
- births to teens.

We use logistic regression to isolate the population component from these five indicators. The procedure includes four steps:

1. A separate regression equation for each birth outcome estimates the effect of race, Hispanic origin, foreign birthplace of mother, parity, mother's age, marital status and education for all births statewide.
2. Each equation generates expected probabilities for individual birth outcomes.
3. Averaging those probabilities yields the municipality's *expected rate* for each outcome, five *population risk components*.
4. To combine the five risk components, we used principal components factor analysis to obtain a weighted, standardized composite score.

Assessment of Results

Exhibit 1 presents the municipal-level correlations of the primary outcomes (plus preterm birth, for interest) with the population risk components (step 3). The correlations ranged from 0.61 to 0.95. Lower correlations would be expected between the rarer mortality events and other outcomes.

Exhibit 2 presents the correlations among the individual risk model components, illustrating the principle that the risk factors have parallel effects on all outcomes.

A single-factor principal components model fits the community variation very well. As shown in Exhibit 3, each expected rate contributes about equally to the composite that we call the *population risk index*.

Summary of Findings

Scores for the *population risk index* and primary outcome indicators are presented in Table 1. The index is tabulated for all 146 municipalities, sorted from highest to lowest overall risk.

Twenty-four municipalities have scores greater than 1.0, which would be the 83rd percentile of risk in a theoretical normal distribution. These municipalities represent eleven of New Jersey's 21 counties, and include all eleven cities designated as target sites under the Infant Mortality Reduction Initiative. The twenty-four had an average fetal-neonatal death rate of 1.9%, and an average of 9.5% low birthweight infants (born less than 2,500g), 58% and 48% above the statewide averages, respectively.

Exhibit 1: Correlation of Population Risk Components with Outcome Indicators, N = 146

		outcome indicators					
population risk components		fetal+neonatal death	low birthweight	preterm birth	infant mortality	teen birth ratio	late prenatal care
	fetal+neonatal death	0.72	0.89	0.84	0.67	0.81	0.83
	low birthweight	0.73	0.93	0.86	0.69	0.85	0.89
	infant mortality	0.74	0.92	0.86	0.71	0.90	0.89
	late prenatal care	0.65	0.83	0.79	0.66	0.93	0.95
	teen birth ratio	0.61	0.77	0.73	0.66	1.00	0.90
	population risk score	0.72	0.90	0.85	0.70	0.93	0.93

Exhibit 2: Correlation of Population Risk Components, N = 146

	fetal+neonatal death	low birthweight	infant mortality	late prenatal care	teen birth ratio
low birthweight	0.95				
infant mortality	0.97	0.97			
late prenatal care	0.85	0.92	0.91		
teen birth ratio	0.81	0.85	0.89	0.93	
population risk score	0.95	0.98	0.99	0.96	0.93

Exhibit 3: Factor Analysis for Population Risk Assessments

Predicted Risk Item	Scoring Weight
Infant Mortality Rate	.214
Perinatal (fetal + neonatal) Mortality Rate	.206
Rate of Low Birth Weight (<2,500 grams)	.211
Proportion of Late Prenatal Care	.207
Teenage Birth Ratio	.202

Appendix: Data Sources and Measures

Official birth certificate, fetal death certificate and linked birth-infant death files produced by the Center for Health Statistics were analyzed. A total of 542,572 live births, 4,314 fetal deaths and 3,670 infant deaths to New Jersey residents from 1999 to 2003 were included for our analysis.

Definition of Outcome/MCH Indicator Variables

- Infant Mortality Rate: Number of deaths per every 100 infants during their first 12 months of age.
- Neonatal Mortality: Number of deaths per every 100 live births during the first 27 days after birth.
- Post Neonatal Mortality: Number of deaths per every 100 live births between 28-365 days after birth.
- Perinatal Mortality: Fetal deaths (20 or more weeks of gestation) plus infant deaths (0-27 days after birth) per every 100 neonates (20 or more weeks of gestation to 27 days after birth).
- Fetal Mortality Rate: Fetal deaths with 20 or more weeks of gestation per every 100 still births or live births.
- Low Birth Weight: Births with birthweight of less than 2500 grams.
- Teen birth: Births to women aged 15 to 17 years.
- First Trimester Prenatal care: Deliveries with prenatal care that started during the first three months of pregnancy.

**Table 1. Population Perinatal Risk Index and Related Outcome Measures
(Based on births 1999-2003)**

Vital Statistics Geo Code	County	Municipality	Population		Fetal+ Neonatal (0- 27 days)	Low Birth Weight (<2500g)	Preterm Birth (<37 wks Gestation)	Infant Mortality Rate	PNC Not in 1st Trimester	Births to Mothers <20 Years Old
			Total Births	Risk Index Value						
0417	CAMDEN	Camden City	8,595	3.55	2.1%	11.1%	12.9%	1.6%	44.6%	25.6%
0724	ESSEX	East Orange City	5,845	2.78	2.5%	13.5%	14.7%	1.5%	41.6%	14.3%
1306	MONMOUTH	Asbury Park City	1,984	2.61	1.8%	10.8%	13.6%	1.2%	33.9%	17.4%
0736	ESSEX	Irington Township	5,393	2.59	2.8%	12.7%	15.1%	1.3%	41.5%	11.6%
1155	MERCER	Trenton City	8,087	2.54	2.0%	10.3%	12.3%	1.1%	35.9%	18.3%
0756	ESSEX	Newark City	24,200	2.53	2.2%	11.6%	13.9%	1.1%	43.3%	16.0%
0379	BURLINGTON	Willingboro Township	1,755	2.37	1.3%	10.1%	10.6%	0.7%	35.8%	14.9%
0172	ATLANTIC	Pleasantville City	1,441	2.32	2.3%	9.5%	9.7%	1.0%	43.5%	20.8%
0605	CUMBERLAND	Bridgeton City	2,571	2.20	1.7%	9.5%	10.5%	1.2%	38.2%	23.5%
2048	UNION	Plainfield City	4,289	2.13	2.0%	9.5%	10.8%	0.9%	45.7%	14.0%
0108	ATLANTIC	Atlantic City	3,794	2.02	2.0%	10.1%	10.6%	1.2%	49.1%	17.4%
0768	ESSEX	Orange City	3,007	1.87	2.3%	10.4%	12.5%	0.6%	35.2%	10.5%
1242	MIDDLESEX	New Brunswick City	4,952	1.83	1.4%	7.8%	11.1%	0.7%	31.1%	16.6%
2056	UNION	Roselle Borough	1,486	1.54	2.4%	10.5%	11.3%	1.1%	30.5%	11.5%
0930	HUDSON	Jersey City	17,658	1.40	1.8%	9.4%	11.5%	1.0%	28.8%	11.5%
1640	PASSAIC	Paterson City	14,488	1.38	1.2%	8.9%	11.2%	0.7%	36.7%	15.4%
0455	CAMDEN	Pennsauken Township	1,988	1.35	2.0%	8.2%	10.4%	1.3%	31.0%	14.3%
0445	CAMDEN	Lindenwold Borough	1,413	1.23	1.4%	9.2%	10.0%	1.2%	31.9%	11.7%
2024	UNION	Hillside Township	1,374	1.23	2.9%	10.4%	11.3%	1.2%	26.3%	7.7%
0349	BURLINGTON	Mount Holly Township	1,125	1.18	1.0%	6.1%	8.4%	0.4%	27.5%	15.6%
0655	CUMBERLAND	Millville City	2,210	1.17	1.8%	7.1%	7.9%	0.8%	28.6%	16.9%
2012	UNION	Elizabeth City	10,669	1.10	1.6%	8.1%	9.3%	0.6%	38.0%	11.7%
0361	BURLINGTON	Pemberton Township	1,607	1.07	1.1%	6.8%	8.3%	0.4%	28.1%	15.2%
0680	CUMBERLAND	Vineland City	3,759	1.07	1.8%	7.4%	8.8%	1.3%	26.9%	17.3%
1348	MONMOUTH	Long Branch City	2,602	0.99	1.2%	6.9%	9.3%	0.7%	20.1%	12.7%
1364	MONMOUTH	Neptune Township	1,705	0.98	2.1%	7.8%	11.6%	0.8%	17.7%	11.0%
1635	PASSAIC	Passaic City	7,528	0.96	1.2%	6.3%	8.5%	0.8%	37.4%	14.3%
0222	BERGEN	Englewood City	1,630	0.86	1.2%	5.8%	7.0%	0.6%	16.5%	6.0%
1248	MIDDLESEX	Perth Amboy City	4,197	0.83	1.9%	6.8%	8.1%	1.2%	40.3%	15.0%
0824	GLOUCESTER	Glassboro Borough	1,080	0.80	1.7%	8.2%	10.0%	0.8%	27.9%	12.4%
2052	UNION	Rahway City	1,681	0.64	1.7%	6.4%	8.3%	0.9%	23.2%	7.3%
2032	UNION	Linden City	2,336	0.61	2.4%	7.9%	9.8%	1.2%	23.9%	7.2%

**Table 1. Population Perinatal Risk Index and Related Outcome Measures
(Based on births 1999-2003)**

Vital Statistics Geo Code	County	Municipality	Population		Fetal+ Neonatal (0- 27 days)	Low Birth Weight (<2500g)	Preterm Birth (<37 wks Gestation)	Infant Mortality Rate	PNC Not in 1st Trimester	Births to Mothers <20 Years Old
			Total Births	Risk Index Value						
0473	CAMDEN	Winslow Township	2,629	0.52	1.5%	6.7%	8.0%	1.0%	19.4%	8.3%
0950	HUDSON	Union City	5,251	0.45	1.1%	5.5%	7.5%	0.7%	28.9%	10.9%
0234	BERGEN	Hackensack City	3,153	0.42	1.7%	7.5%	9.4%	1.0%	24.8%	6.2%
0960	HUDSON	West New York Town	3,287	0.38	1.2%	5.2%	8.0%	0.6%	26.5%	9.8%
1372	MONMOUTH	Red Bank Borough	1,194	0.37	0.9%	4.7%	6.6%	0.6%	21.2%	9.1%
1418	MORRIS	Dover Town	1,781	0.31	1.2%	4.7%	6.8%	0.7%	19.6%	7.8%
0144	ATLANTIC	Hamilton Township	1,431	0.27	0.8%	5.8%	6.9%	0.8%	23.8%	9.2%
1332	MONMOUTH	Freehold Borough	1,592	0.26	0.9%	5.0%	7.6%	0.4%	22.6%	8.0%
1206	MIDDLESEX	Carteret Borough	1,283	0.25	1.6%	7.5%	8.2%	1.3%	27.9%	7.6%
1816	SOMERSET	Bound Brook Borough	1,011	0.22	1.4%	5.7%	8.3%	0.6%	26.3%	6.3%
1860	SOMERSET	North Plainfield Borough	1,801	0.21	0.9%	6.1%	7.3%	0.3%	28.3%	5.9%
0905	HUDSON	Bayonne City	3,501	0.20	1.1%	6.5%	8.1%	0.6%	14.7%	6.9%
0148	ATLANTIC	Hammonton Town	1,094	0.19	1.3%	5.4%	9.1%	0.8%	23.3%	8.8%
1110	MERCER	Ewing Township	1,386	0.14	1.3%	7.0%	8.7%	0.9%	15.2%	4.8%
0752	ESSEX	Montclair Township	2,172	0.12	1.7%	6.0%	7.7%	0.7%	15.3%	3.6%
1876	SOMERSET	Somerville Borough	1,067	0.10	1.0%	5.5%	8.3%	1.0%	22.2%	6.2%
1272	MIDDLESEX	South River Borough	1,041	0.09	1.2%	6.2%	8.2%	0.4%	15.0%	5.9%
1836	SOMERSET	Franklin Township	4,287	0.05	1.1%	6.6%	9.0%	0.6%	11.4%	3.9%
0230	BERGEN	Garfield City	1,965	0.04	0.9%	5.5%	7.4%	0.5%	26.0%	6.8%
2076	UNION	Union Township	2,946	0.01	2.0%	6.8%	8.7%	0.9%	14.7%	3.7%
0940	HUDSON	North Bergen Township	3,696	0.01	0.9%	5.2%	7.3%	0.5%	21.3%	6.5%
1446	MORRIS	Morristown Town	1,958	-0.05	0.6%	4.7%	7.3%	0.6%	16.8%	5.1%
0925	HUDSON	Hoboken City	1,532	-0.08	0.7%	5.1%	7.7%	0.3%	13.9%	8.0%
0286	BERGEN	Teaneck Township	2,081	-0.10	1.5%	5.5%	7.0%	0.5%	13.7%	3.5%
0935	HUDSON	Kearny Town	2,288	-0.11	1.2%	6.1%	7.4%	0.7%	20.1%	5.6%
0844	GLOUCESTER	Monroe Township	1,753	-0.12	1.5%	6.2%	9.0%	1.0%	20.0%	6.9%
0744	ESSEX	Maplewood Township	1,594	-0.13	0.9%	6.0%	7.5%	0.4%	15.1%	3.0%
0313	BURLINGTON	Burlington Township	1,315	-0.14	1.6%	5.9%	7.4%	0.6%	14.1%	4.3%
1245	MIDDLESEX	North Brunswick Township	2,646	-0.14	1.0%	6.4%	9.1%	0.3%	12.3%	3.0%
0431	CAMDEN	Gloucester Township	2,438	-0.15	1.6%	6.5%	8.0%	0.8%	17.7%	6.6%
0128	ATLANTIC	Egg Harbor Township	2,160	-0.16	0.8%	5.9%	6.8%	0.5%	21.6%	6.6%
0704	ESSEX	Belleville Township	2,322	-0.17	1.2%	6.3%	8.0%	0.3%	17.7%	4.8%

**Table 1. Population Perinatal Risk Index and Related Outcome Measures
(Based on births 1999-2003)**

Vital Statistics Geo Code	County	Municipality	Total Births	Population		Fetal+ Neonatal (0-27 days)	Low Birth Weight (<2500g)	Preterm Birth (<37 wks Gestation)	Infant Mortality Rate	PNC Not in 1st Trimester	Births to Mothers <20 Years Old
				Perinatal Risk Index Value	Risk Index						
0140	ATLANTIC	Galloway Township	1,410	-0.19		1.6%	4.2%	6.6%	0.5%	17.0%	6.1%
1251	MIDDLESEX	Piscataway Township	3,166	-0.20		1.2%	5.9%	7.6%	0.6%	13.4%	3.3%
1610	PASSAIC	Clifton City	4,675	-0.20		0.8%	5.4%	7.7%	0.5%	21.3%	4.9%
1530	OCEAN	Lakewood Township	9,896	-0.20		0.7%	4.0%	4.6%	0.3%	26.6%	5.4%
1322	MONMOUTH	Eatontown Borough	1,019	-0.20		1.1%	5.7%	7.6%	0.7%	13.3%	4.1%
0708	ESSEX	Bloomfield Township	2,855	-0.21		1.4%	6.6%	8.2%	0.9%	15.2%	4.0%
0204	BERGEN	Bergenfield Borough	1,391	-0.21		0.7%	5.9%	8.2%	0.5%	13.2%	3.4%
0209	BERGEN	Cliffside Park Borough	1,170	-0.26		1.0%	5.1%	7.4%	0.6%	18.7%	2.9%
0266	BERGEN	Palisades Park Borough	1,123	-0.26		1.2%	4.2%	5.1%	0.6%	17.0%	2.2%
0245	BERGEN	Lodi Borough	1,534	-0.26		1.1%	6.8%	8.5%	0.7%	17.3%	3.0%
0808	GLOUCESTER	Deptford Township	1,044	-0.27		1.0%	6.3%	9.2%	0.4%	19.8%	5.9%
0341	BURLINGTON	Maple Shade Township	1,085	-0.27		0.6%	5.4%	7.0%	0.5%	18.5%	5.1%
0788	ESSEX	West Orange Township	3,016	-0.27		1.3%	6.2%	8.5%	0.7%	14.4%	2.8%
1356	MONMOUTH	Matawan Borough	1,148	-0.32		0.9%	5.7%	8.1%	0.5%	12.8%	4.4%
1115	MERCER	Hamilton Township	4,486	-0.33		1.4%	5.9%	8.5%	0.6%	15.3%	4.8%
1260	MIDDLESEX	Sayreville Borough	2,858	-0.39		1.2%	6.0%	8.0%	0.6%	13.3%	2.4%
1269	MIDDLESEX	South Plainfield Borough	1,305	-0.42		1.2%	5.0%	6.9%	0.8%	14.5%	2.8%
1510	OCEAN	Berkeley Township	1,171	-0.43		1.4%	5.3%	6.6%	0.5%	11.1%	7.2%
1278	MIDDLESEX	Woodbridge Township	5,990	-0.47		1.0%	6.6%	7.7%	0.5%	14.9%	2.6%
0217	BERGEN	Elmwood Park Borough	1,050	-0.47		0.8%	5.1%	7.3%	0.3%	14.3%	3.1%
1135	MERCER	Lawrence Township	1,664	-0.49		1.1%	5.0%	6.3%	0.5%	11.8%	2.0%
1366	MONMOUTH	Ocean Township	1,543	-0.51		0.8%	6.9%	8.9%	0.3%	10.2%	2.5%
0469	CAMDEN	Voorhees Township	1,269	-0.52		1.7%	6.4%	7.2%	0.8%	15.6%	3.1%
0425	CAMDEN	Cherry Hill Township	2,758	-0.52		1.5%	4.8%	5.8%	0.9%	14.8%	2.5%
1514	OCEAN	Dover Township	4,936	-0.52		0.9%	5.4%	7.6%	0.4%	11.8%	4.7%
1227	MIDDLESEX	Old Bridge Township	2,763	-0.53		1.1%	5.2%	8.2%	0.4%	10.7%	2.7%
1257	MIDDLESEX	Edison Township	6,995	-0.54		0.9%	6.1%	7.7%	0.4%	12.8%	2.1%
1105	MERCER	East Windsor Township	1,649	-0.55		1.6%	5.4%	6.2%	0.3%	9.9%	2.9%
0840	GLOUCESTER	Mantua Township	1,307	-0.56		1.5%	4.9%	7.1%	0.7%	15.2%	4.0%
0227	BERGEN	Fort Lee Borough	1,582	-0.57		0.6%	4.0%	5.4%	0.2%	13.5%	0.9%
0351	BURLINGTON	Mount Laurel Township	2,049	-0.59		1.5%	5.1%	6.1%	0.6%	11.8%	2.7%
0872	GLOUCESTER	Washington Township	1,765	-0.62		1.3%	4.9%	6.6%	0.7%	13.5%	3.6%

**Table 1. Population Perinatal Risk Index and Related Outcome Measures
(Based on births 1999-2003)**

Vital Statistics Geo Code	County	Municipality	Total Births	Population		Fetal+ Neonatal (0-27 days)	Low Birth Weight (<2500g)	Preterm Birth (<37 wks Gestation)	Infant Mortality Rate	PNC Not in 1st Trimester	Births to Mothers <20 Years Old
				Perinatal Risk Index Value	Risk Index						
1562	OCEAN	Stafford Township	1,275	-0.66		1.2%	4.7%	6.4%	0.7%	10.1%	5.2%
1266	MIDDLESEX	South Brunswick Township	2,684	-0.67		0.9%	5.4%	7.1%	0.4%	7.1%	1.6%
1524	OCEAN	Jackson Township	3,014	-0.68		0.7%	4.8%	8.2%	0.3%	9.7%	3.5%
1512	OCEAN	Brick Township	4,378	-0.68		0.8%	5.2%	7.5%	0.4%	9.9%	3.8%
1254	MIDDLESEX	Plainsboro Township	1,480	-0.69		0.5%	5.8%	6.5%	0.3%	7.2%	0.6%
1526	OCEAN	Lacey Township	1,353	-0.69		0.7%	5.1%	7.4%	0.6%	8.6%	4.4%
1458	MORRIS	Parsippany-Troy Hills Township	2,790	-0.70		1.0%	5.1%	6.8%	0.5%	8.1%	1.3%
1215	MIDDLESEX	East Brunswick Township	2,510	-0.71		1.0%	4.9%	7.9%	0.6%	6.4%	1.3%
1988	SUSSEX	Vernon Township	1,113	-0.71		1.1%	4.1%	6.1%	0.7%	8.9%	2.3%
1675	PASSAIC	West Milford Township	1,613	-0.75		1.4%	5.0%	7.4%	0.6%	5.3%	2.4%
1333	MONMOUTH	Freehold Township	1,576	-0.77		0.7%	3.5%	6.9%	0.4%	9.6%	2.2%
1338	MONMOUTH	Howell Township	2,977	-0.77		0.9%	4.4%	7.3%	0.4%	8.3%	2.6%
1454	MORRIS	Mount Olive Township	1,967	-0.78		0.7%	4.6%	6.5%	0.7%	8.5%	1.3%
0764	ESSEX	Nutley Township	1,406	-0.78		0.6%	5.0%	8.8%	0.5%	9.0%	1.4%
1370	MONMOUTH	Hazlet Township	1,111	-0.80		1.4%	4.8%	7.6%	0.9%	8.4%	2.3%
1844	SOMERSET	Hillsborough Township	2,635	-0.80		0.8%	4.5%	7.0%	0.4%	7.8%	1.6%
1620	PASSAIC	Hawthorne Borough	1,121	-0.80		1.2%	4.5%	7.8%	0.5%	10.2%	2.1%
1472	MORRIS	Roxbury Township	1,551	-0.81		1.0%	4.2%	6.3%	0.5%	6.1%	1.8%
2064	UNION	Scotch Plains Township	1,562	-0.82		1.2%	4.9%	6.9%	0.4%	6.6%	1.2%
0225	BERGEN	Fair Lawn Borough	1,400	-0.82		1.0%	4.1%	6.5%	0.5%	9.9%	0.7%
1550	OCEAN	Point Pleasant Borough	1,071	-0.83		1.0%	5.2%	8.0%	0.6%	8.3%	2.6%
0267	BERGEN	Paramus Borough	1,009	-0.83		1.0%	4.5%	6.4%	0.3%	8.7%	1.2%
0327	BURLINGTON	Evesham Township	2,551	-0.83		1.3%	5.1%	5.4%	0.7%	11.8%	1.8%
1670	PASSAIC	Wayne Township	2,770	-0.83		0.8%	4.7%	6.6%	0.5%	7.7%	0.8%
1428	MORRIS	Jefferson Township	1,223	-0.84		1.3%	4.8%	6.3%	0.8%	6.1%	1.3%
1824	SOMERSET	Bridgewater Township	2,977	-0.84		0.8%	3.9%	6.1%	0.3%	7.8%	1.5%
0247	BERGEN	Mahwah Township	1,422	-0.87		1.0%	4.6%	6.6%	0.4%	6.9%	1.4%
1239	MIDDLESEX	Monroe Township	1,002	-0.88		0.9%	3.4%	7.4%	0.8%	4.3%	1.5%
1165	MERCER	West Windsor Township	1,071	-0.88		0.6%	3.0%	4.5%	0.5%	4.5%	1.2%
0343	BURLINGTON	Medford Township	1,092	-0.89		1.1%	3.6%	6.2%	0.8%	10.0%	1.7%
2072	UNION	Summit City	1,684	-0.90		0.8%	3.7%	6.6%	0.7%	4.4%	1.0%
1358	MONMOUTH	Middletown Township	3,428	-0.90		1.1%	3.8%	6.5%	0.4%	6.4%	1.7%

**Table 1. Population Perinatal Risk Index and Related Outcome Measures
(Based on births 1999-2003)**

Vital Statistics Geo Code	County	Municipality	Population		Fetal+ Neonatal (0-27 days) Death Rate	Low Birth Weight (<2500g)	Preterm Birth (<37 wks Gestation)	Infant Mortality Rate	PNC Not in 1st Trimester	Births to Mothers <20 Years Old
			Total Births	Risk Index Value						
1464	MORRIS	Randolph Township	1,724	-0.90	0.7%	4.9%	6.2%	0.5%	4.5%	1.2%
1434	MORRIS	Madison Borough	1,030	-0.91	0.1%	3.1%	5.4%	0.2%	5.0%	1.2%
1350	MONMOUTH	Manalapan Township	1,451	-0.91	1.4%	5.9%	7.6%	0.4%	5.9%	1.1%
1470	MORRIS	Rockaway Township	1,114	-0.91	1.4%	5.2%	6.5%	0.2%	5.0%	1.3%
1442	MORRIS	Montville Township	1,328	-0.91	0.8%	5.6%	6.9%	0.6%	8.0%	1.0%
1354	MONMOUTH	Marlboro Township	1,914	-0.94	0.9%	4.0%	5.1%	0.2%	6.1%	0.5%
1856	SOMERSET	Montgomery Township	1,120	-0.95	0.9%	3.6%	6.4%	0.4%	3.9%	0.6%
1474	MORRIS	Washington Township	1,003	-0.95	0.6%	3.4%	4.0%	0.1%	4.2%	0.8%
1063	HUNTERDON	Raritan Township	1,192	-0.95	0.3%	2.6%	4.0%	0.1%	9.1%	1.4%
1972	SUSSEX	Sparta Township	1,186	-0.96	0.6%	3.7%	6.1%	0.3%	6.8%	1.3%
1392	MONMOUTH	Wall Township	1,174	-0.97	0.5%	4.5%	8.6%	0.3%	5.4%	1.6%
0273	BERGEN	Ridgewood Village	1,534	-0.97	0.7%	3.1%	5.3%	0.1%	6.3%	0.7%
1416	MORRIS	Denville Township	1,085	-1.00	0.9%	4.0%	5.2%	0.3%	4.5%	0.7%
2080	UNION	Westfield Town	2,015	-1.01	1.0%	3.6%	5.3%	0.4%	4.5%	0.8%
2008	UNION	Cranford Township	1,419	-1.01	0.9%	4.2%	6.5%	0.3%	5.0%	0.9%
1808	SOMERSET	Bernards Township	1,739	-1.03	0.8%	3.2%	5.4%	0.3%	4.1%	0.3%
0740	ESSEX	Livingston Township	1,585	-1.07	0.8%	4.4%	5.8%	0.1%	5.5%	0.3%
0748	ESSEX	Millburn Township	1,090	-1.08	0.7%	4.2%	6.7%	0.2%	6.5%	0.1%

Contraceptive Needs and Services, 2001–2002

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www.guttmacher.org/pubs/win/index.html

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Contraceptive Needs and Services, 2001—2002: Definitions and Notes

(www.guttmacher.org/pubs/win/notes2002.pdf)

Detailed Methodology for Calculating 2002 Women in Need

(www.guttmacher.org/pubs/win/winmethods2002.pdf)

Expanded Methodology for the 2001 Census of Publicly Funded Family Planning Clinics

(www.guttmacher.org/pubs/win/clinicmethods2001.pdf)

The Availability and Use of Publicly Funded Family Planning Clinics: U.S. Trends, 1994–2001, *Perspectives on Sexual and Reproductive Health*, 2004, 36(5):206–215.

(www.guttmacher.org/pubs/journals/3620604.pdf)

Table 1. Total number of women aged 13-44 and number of women in need of contraceptive services and supplies, by age, poverty status and race/ethnicity, 2002—New Jersey

STATE AND COUNTY	(1) All women aged 13-44	(2) Total	(3) Women needing contraceptive services and supplies										(4) By race/ethnicity			
			(5) By age					(6) By poverty status (among those 20-44)					(7) Non-Hispanic		(8) Black	
			(3) Total	(4) <18	(5) 18-19	(6) 20-29	(7) 30-44	(8) <100%	(9) 100-132%	(10) 133-184%	(11) 185-249%	(12) 250+%	(13) White	(14) Non-Hispanic		
US Total	66,107,760	34,241,690	2,227,640	2,639,610	14,465,900	14,908,540	4,262,550	1,594,940	2,559,540	3,492,460	17,464,960	21,978,200	4,696,770	5,143,750		
New Jersey	1,925,840	1,088,920	73,490	70,610	386,730	558,090	86,880	31,190	53,320	79,010	694,420	646,930	163,770	183,240		
34001 Atlantic County	58,660	33,150	2,300	2,310	11,780	16,760	3,270	1,420	2,560	3,520	17,760	19,680	5,970	4,970		
34003 Bergen County	190,070	106,800	6,970	6,040	34,560	59,240	5,070	1,870	3,690	5,760	77,420	67,330	6,620	15,990		
34005 Burlington County	96,540	54,010	3,840	3,240	18,280	28,650	2,160	1,050	2,000	3,750	37,970	39,790	8,690	2,800		
34007 Camden County	116,930	65,490	5,060	4,420	23,540	32,480	6,340	2,360	3,660	5,970	37,690	40,790	13,160	8,080		
34009 Cape May County	19,480	10,810	830	730	3,640	5,610	940	410	720	1,100	6,080	9,580	530	520		
34011 Cumberland County	30,910	17,280	1,440	1,260	6,450	8,130	2,460	1,030	1,300	1,820	7,970	9,370	3,390	4,060		
34013 Essex County	188,030	107,080	7,490	7,320	41,380	50,880	14,350	4,180	6,070	9,270	58,400	32,520	48,570	20,070		
34015 Gloucester County	61,830	34,940	2,390	2,670	12,660	17,210	2,270	740	1,350	2,560	22,960	29,650	3,240	1,120		
34017 Hudson County	150,490	88,860	5,200	4,950	36,810	41,900	11,300	3,830	6,780	8,050	48,750	29,170	11,640	37,160		
34019 Hunterdon County	27,140	14,670	1,100	820	3,970	8,770	400	180	290	690	11,190	13,050	540	600		
34021 Mercer County	82,370	47,460	3,040	4,320	17,810	22,300	4,060	1,490	2,550	3,470	28,550	27,990	9,870	5,610		
34023 Middlesex County	181,620	105,230	5,960	7,470	40,200	51,600	7,440	2,650	4,390	6,690	70,630	55,210	10,300	18,010		
34025 Monmouth County	137,010	75,560	5,470	4,820	23,900	41,380	4,250	1,500	2,690	4,270	52,570	58,390	6,520	6,150		
34027 Morris County	103,360	57,430	3,800	3,500	17,410	32,720	2,220	580	1,460	2,090	43,790	44,140	1,740	6,180		
34029 Ocean County	106,510	59,820	4,100	3,760	21,520	30,430	4,180	1,550	2,940	4,660	38,630	51,930	2,140	4,240		
34031 Passaic County	114,690	65,470	4,570	4,520	25,240	31,130	6,990	2,930	4,300	5,710	36,440	28,690	9,390	23,970		
34033 Salem County	14,020	7,800	620	540	2,850	3,780	820	270	480	690	4,370	6,050	1,240	370		
34035 Somerset County	69,290	38,390	2,390	1,840	11,280	22,870	1,460	600	1,270	1,910	28,910	25,210	3,440	4,570		
34037 Sussex County	33,430	18,140	1,420	1,120	5,530	10,080	630	230	530	940	13,280	16,620	220	890		
34039 Union County	119,350	67,200	4,570	4,120	23,740	34,760	5,520	2,070	3,770	5,220	41,920	29,820	16,240	17,180		
34041 Warren County	24,100	13,320	910	840	4,160	7,410	760	260	510	880	9,160	11,950	330	710		

Table 2. Number of women in need of publicly supported contraceptive services and supplies, by race/ethnicity and need status (under age 20 or age 20-44 and under 250% of poverty), 2002—New Jersey

STATE AND COUNTY	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)
	Women needing publicly supported contraceptive services and supplies											
	Non-Hispanic White						Non-Hispanic Black					
	Total	<20	20-44 and <250% pov	Total	<20	20-44 and <250% pov	Total	<20	20-44 and <250% pov	Total	<20	20-44 and <250% pov
US Total	16,776,730	4,867,240	11,909,490	9,285,680	2,884,210	6,401,470	2,974,230	909,850	2,064,380	3,371,110	782,990	2,588,120
New Jersey	394,510	144,100	250,400	179,260	81,900	97,350	83,780	25,590	58,200	101,270	26,230	75,050
34001 Atlantic County	15,390	4,610	10,780	7,520	2,560	4,970	3,520	1,050	2,480	3,360	730	2,630
34003 Bergen County	29,390	13,000	16,390	15,780	8,280	7,500	2,250	890	1,350	6,040	2,070	3,980
34005 Burlington County	16,040	7,090	8,960	10,610	4,950	5,660	3,280	1,330	1,950	1,180	430	740
34007 Camden County	27,810	9,480	18,330	12,810	5,340	7,470	7,870	2,230	5,630	5,610	1,400	4,220
34009 Cape May County	4,740	1,550	3,180	3,970	1,330	2,640	320	100	220	370	90	280
34011 Cumberland County	9,310	2,710	6,610	3,900	1,260	2,640	2,230	640	1,590	2,970	720	2,240
34013 Essex County	48,680	14,810	33,860	8,260	3,980	4,280	26,480	7,250	19,230	11,640	2,870	8,770
34015 Gloucester County	11,970	5,060	6,910	9,330	4,100	5,230	1,700	600	1,100	570	200	370
34017 Hudson County	40,110	10,150	29,960	8,240	2,250	5,990	6,220	1,770	4,450	21,610	5,220	16,390
34019 Hunterdon County	3,480	1,920	1,560	2,900	1,750	1,150	270	30	230	210	80	140
34021 Mercer County	18,920	7,350	11,560	8,520	4,340	4,180	5,650	1,660	3,990	3,230	830	2,410
34023 Middlesex County	34,610	13,430	21,170	15,710	7,150	8,550	3,720	1,520	2,200	9,460	2,660	6,800
34025 Monmouth County	22,990	10,290	12,700	15,020	7,790	7,230	3,550	1,050	2,500	3,180	870	2,320
34027 Morris County	13,640	7,300	6,340	9,240	5,690	3,550	640	280	360	2,550	760	1,790
34029 Ocean County	21,190	7,860	13,330	17,300	6,590	10,710	1,130	380	750	2,200	680	1,520
34031 Passaic County	29,030	9,090	19,940	7,430	3,440	4,000	5,410	1,610	3,810	14,720	3,580	11,140
34033 Salem County	3,430	1,160	2,260	2,270	840	1,430	810	230	580	270	70	200
34035 Somerset County	9,480	4,240	5,250	5,060	2,810	2,250	1,240	450	790	2,240	550	1,700
34037 Sussex County	4,860	2,540	2,330	4,360	2,310	2,050	60	30	30	320	130	190
34039 Union County	25,280	8,690	16,590	7,440	3,610	3,840	7,300	2,430	4,870	9,250	2,190	7,050
34041 Warren County	4,160	1,750	2,410	3,590	1,540	2,050	130	70	70	280	110	180

Table 3. Total number of publicly funded family planning clinics by type of provider, number of female contraceptive clients served, and number of Title X-funded clinics and clients served, 2001—New Jersey

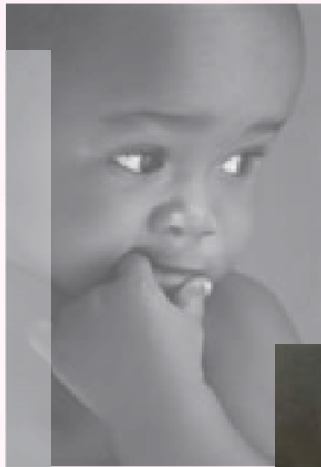
STATE AND COUNTY	(27)										(35)					(37)	
	(28)										(33)					(36)	
	Publicly funded family planning clinics										Female clients					Title X-funded clinics and clients	
	(29)		(30)		(31)		(32)		(33)		(34)		(35)		(36)		(37)
	Hospital		Health department		Planned Parenthood		Community health center		Other		Total		Aged <20		Total clients		Clients aged <20
	Total		Total		Total		Total		Total		Total		Total		Total		Total
US Total	7,683	813	2,874	889	1,730	1,377	12	129,630	1,872,420	4,389	4,650,310	1,333,970	56	103,590	26,240	1,333,970	
New Jersey	94	20	7	33	22	12	129,630	1,872,420	4,389	4,650,310	1,333,970	56	103,590	26,240	1,333,970		
34001 Atlantic County	5	3	0	0	2	0	4,070	1,310	3	1,740	480	3	1,740	480	3	1,740	480
34003 Bergen County	4	2	0	2	0	0	9,960	2,220	0	8,910	1,990	2	8,910	1,990	2	8,910	1,990
34005 Burlington County	6	1	4	1	0	0	2,560	760	0	2,360	710	5	2,360	710	5	2,360	710
34007 Camden County	12	2	0	6	4	0	10,700	2,610	0	4,850	1,630	6	4,850	1,630	6	4,850	1,630
34009 Cape May County	1	0	1	0	0	0	1,460	530	0	1,460	530	1	1,460	530	1	1,460	530
34011 Cumberland County	5	0	0	0	2	3	3,080	1,000	0	2,850	940	3	2,850	940	3	2,850	940
34013 Essex County	11	3	0	4	4	0	20,730	4,670	0	18,150	4,550	6	18,150	4,550	6	18,150	4,550
34015 Gloucester County	1	0	0	0	0	1	2,010	640	0	2,010	640	1	2,010	640	1	2,010	640
34017 Hudson County	6	0	1	0	3	2	13,830	2,150	0	13,240	2,000	5	13,240	2,000	5	13,240	2,000
34019 Hunterdon County	1	0	0	1	0	0	1,140	400	0	1,140	400	1	1,140	400	1	1,140	400
34021 Mercer County	7	2	0	3	2	0	5,990	1,520	0	4,210	1,010	3	4,210	1,010	3	4,210	1,010
34023 Middlesex County	5	1	0	3	1	0	9,690	2,250	0	4,730	1,420	3	4,730	1,420	3	4,730	1,420
34025 Monmouth County	7	1	0	4	0	2	9,980	2,870	0	8,820	2,610	4	8,820	2,610	4	8,820	2,610
34027 Morris County	4	2	0	2	0	0	7,480	1,500	0	7,050	1,400	2	7,050	1,400	2	7,050	1,400
34029 Ocean County	2	0	0	0	0	2	3,870	1,130	0	3,870	1,130	2	3,870	1,130	2	3,870	1,130
34031 Passaic County	5	1	0	2	2	0	7,100	2,180	0	4,640	1,410	2	4,640	1,410	2	4,640	1,410
34033 Salem County	2	0	0	0	1	1	1,410	570	0	280	120	1	280	120	1	280	120
34035 Somerset County	3	0	1	1	0	1	3,620	790	0	3,490	750	2	3,490	750	2	3,490	750
34037 Sussex County	1	0	0	1	0	0	1,730	560	0	1,730	560	1	1,730	560	1	1,730	560
34039 Union County	5	2	0	2	1	0	8,530	2,000	0	7,380	1,750	2	7,380	1,750	2	7,380	1,750
34041 Warren County	1	0	0	1	0	0	700	240	0	700	240	1	700	240	1	700	240

*50–74% of clients are estimated.

†Data unavailable for 75–100% of clients.

Appendix 6.

A Report on New Jersey's Federally Qualified Health Centers (FQHCs) Performance in Prenatal Care August 2007



Selina Haq, Ph.D.
New Jersey Primary Care Association

Introduction:

New Jersey's Federally Qualified Health Centers (FQHCs) deliver many essential primary and preventive care services to the medically underserved populations throughout the state. Prenatal care and well baby care services constitute a major segment of services provided by many of New Jersey's FQHCs. Among New Jersey's nineteen FQHCs, fourteen currently provide pre-natal care services through obstetricians/gynecologists, certified nurse midwives, and nurse practitioners who have admitting privileges at affiliated local hospitals. Majority of patients who receive their prenatal care at the centers also deliver under the care of their providers. In 2005, among 6,581 patients who delivered, 5,969 deliveries were performed by health center providers (91%). In 2004, among the 6,544 patients who delivered, 6,285 deliveries were performed by health center providers (96%).¹ These numbers may be understated because New Jersey primary care centers that did not submit their UDS for 2004 and 2005 were not included in the total number of pre-natal care patients and total number of deliveries being accounted in this report.

Poverty and consequent lack of health insurance is a major reason why many women forego timely and adequate prenatal care, which can impact the well being of both the mother and the newborn. In an issue brief compiled by the Pregnancy Risk Assessment Monitoring System (PRAMS) it was reported that about 65% of women who had a live birth between 2002 and 2005 were covered by private insurance for their prenatal care services. During that same period, 28% of the pregnancies were provided care through New Jersey FamilyCare. In New Jersey, pregnant women who do not have

¹ Source: 2004 and 2005 Uniform Data System (UDS) data, a Bureau of Primary Health Care (BPHC)/Health Resources Services Administration (HRSA) mandated data reporting system for all 330 grant funded health centers.

privately funded health insurance are able to obtain care via the New Jersey FamilyCare program which provides health insurance to near-poverty families.²

While publicly funded health insurance covered many of the uninsured, about 5% of those pregnancies, total of 5,000 births annually, had no insurance coverage for prenatal care during that same period.³ In this regard, New Jersey's FQHCs play a major role in extending prenatal care to pregnant women enrolled in both FamilyCare and also to uninsured women by providing services on a sliding fee scale that are subsidized by charity care funds from the state. According to 2005 data on insurance profile of health center patients, about 7.4% had private insurance, 41.1% had Medicaid/SCHIP coverage, 3.9% Medicare, and an overwhelming 47.6% uninsured.⁴ Given this distribution, it is very likely that majority of health center prenatal care users are either publicly insured or uninsured.

Importance of Prenatal Care:

Prenatal care is important because poor birth outcomes such as infant mortality, pre-term births, and low-birth weights among newborns are preventable to a large extent with proper and early prenatal care.⁵ All three birth outcomes are inextricably related. Birth weight is closely tied to gestational length among other factors. Generally, full term infants (at least 36 weeks of gestation) tend to have normal birth weights (2500 grams or more) than infants born before 35 weeks of gestation. Low birth weight is one of the

² New Jersey Pregnancy Risk Assessment Monitoring System (PRAMS), Division of Family Health Services, New Jersey Department of Health and Senior Services (NJDHSS): *A survey for Healthier babies in New Jersey*. <http://nj.gov/health/fhs/professional/prams.shtml>

³ *ibid.*

⁴ National Association of Community Health Centers, Inc (NACHC). *Health Center Fact Sheet*. 2005.

⁵ Shi, Leiyu., J. Macinko, B. Starfield, J Xu, J Regan, R. Politzer and J Wulu. "Primary Care, Infant Mortality, and Low Birth Weight in the States of the USA." *Journal of Epidemiology and Community Health*. 2004. 58: 374-380.

primary causes of infant mortality, and pre-term births often contribute to low birth weights. Aside from infant mortality, even when low birth weight infants survive, they are at a much higher risk for long-term medical conditions, such as, cerebral palsy, mental retardation, vision and hearing impairments, etc. Additionally, there are excessive financial costs associated with treatment of low birth weight infants.⁶ The Centers for Disease Control and Prevention (CDC) estimates that the average extra cost of treating each low birthweight baby during the first year of life is \$15,000.⁷

Early enrollment into prenatal care is considered to be an important determinant of healthy birth outcomes. Prenatal care patients receive routine health exams that monitor fetal growth and development, receive advice on proper nutrition, and get medical attention for any health issues that may arise throughout the course of their pregnancy. Access to prenatal care also provides the best opportunity to identify and address behavioral practices such as tobacco, alcohol, and drug use that can contribute to poor birth outcomes.⁸ In a report released by the Center for Health Statistics, New Jersey Department of Health and Senior Services (NJDHSS), 2003 infant mortality rates were found to be six times higher for women who received no prenatal care than women who received prenatal care. Given the significance of prenatal care on the health of women and their infants, what kind of impact are the FQHCs having on the overall health status of their prenatal care service users?

⁶ NJDHSS. *Healthy New Jersey 2010: A Health Agenda for the First Decade of the New Millennium*. Volume 1, p. 56.

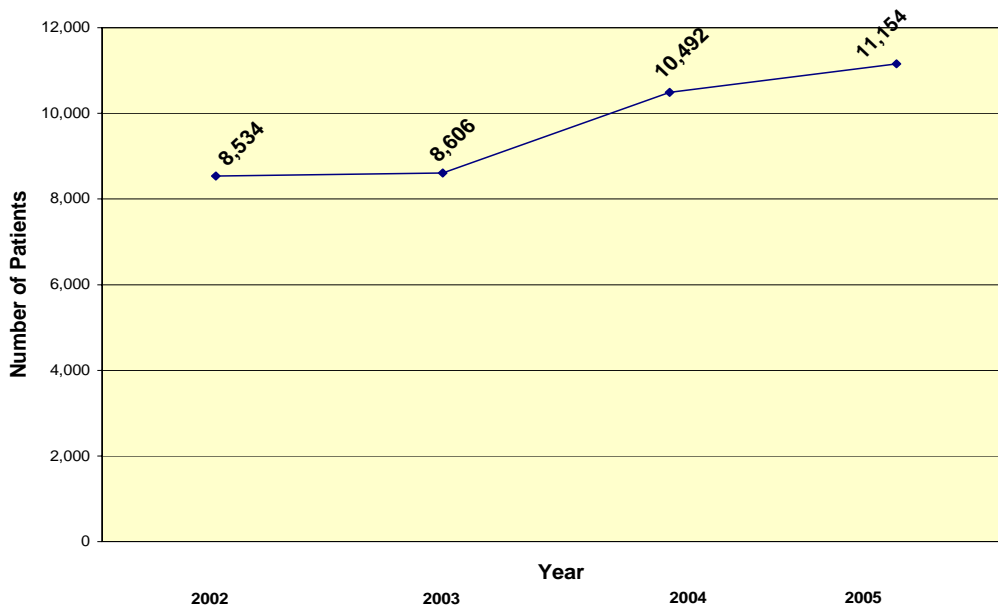
⁷ United States Department of Health and Human Services, Centers for Disease Control and Prevention. *An Ounce of Prevention, What Are The Returns*. 1999, p. 13.

⁸ NJDHSS. *Healthy New Jersey 2010: A Health Agenda for the First Decade of the New Millennium*. Volume 1, p. 47.

FQHCs and Prenatal Care

Among New Jersey's nineteen health centers, in 2005, thirteen health centers provided prenatal care services to 11,154 (12 centers reporting) expecting mothers statewide. However, this total is understated because data from one health center was not available for 2005. Additionally, the number of users in this category is likely to be higher for 2006 as one more health center has expanded its services to include prenatal care. Also, the total number of prenatal care patients served by the health centers over the past few years has been increasing gradually (see Figure 1).

Figure 1: Number of Health Center Prenatal Care Patients



It is important to note that by virtue of caring for a population that is predominantly low-income, uninsured and underinsured; the health centers extend prenatal care to a population that will otherwise go without such care. And as statewide and

health center specific birth data indicates, not only do these centers extend prenatal care to the disadvantaged and the disenfranchised, their quality of care is such that they produce comparable if not better birth outcomes for a predominantly high risk population.⁹

Evaluating Health Center Performance in Prenatal Care

Since prenatal care is assumed to have an important impact on birth outcomes, in the absence of a more direct measure for evaluating health center performance in provision of prenatal care, this report looks at birth outcomes of pre-natal care patients at the health centers. Health center performance in this area is best evaluated against the backdrop of birth outcomes state wide and also against the state goals in this area.

The ideal situation would be to compare all three birth outcomes, pre-term births, birth weights, and infant mortality rates of health center prenatal care patients in the overall context of statewide birth data. While both birth weight and term of birth data is available for statewide births, due to lack of reporting, the only birth outcome data available from the health centers is birthweight of babies born under health center provider care. The year for which complete data is available for both statewide births and births to health center prenatal care patients is 2005.

However, in the absence of other birth outcome data, birthweight of babies can provide an important criterion for evaluating health center performance in the provision of prenatal care. In fact, according to the Healthy New Jersey 2010 Volume 1, “infant

⁹ Health center patients are considered more at risk for poor birth outcomes due to lack of access to regular care, nutrition, harmful habits, lack of health education, etc.

birthweight is one of the strongest predictors of infant survival and subsequent quality of life”. As reported by DHSS, in 2005, there were a total of 108, 186 live births in New Jersey. Among these, about 6,611¹⁰ births were to health center pre-natal care patients. Compared to babies born under the care of other providers, babies born under the care of FQHC providers had a lower incidence of very low and low birth weights and a higher incidence of normal birth weights (please see table 1). For comparative purposes, statewide births¹¹, excluding health center births for 2005 were 101,575. It should be

Table 1: FQHC and Other Birth Weight Information

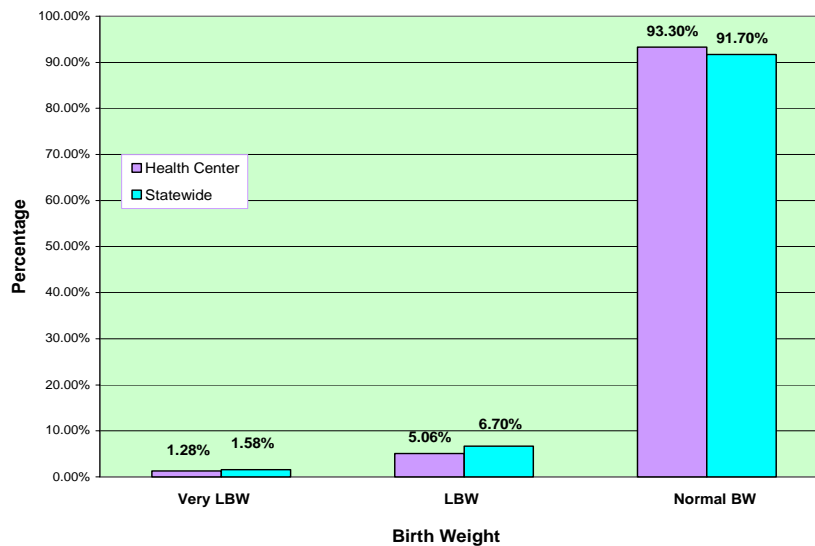
	Births (Other Provider Care)	Births (FQHC Provider Care)
Very Low Birthweight	1.58%	1.28%
Low Birthweight	6.7%	5.06%
Normal Birthweight	91.7%	93.3%

noted here that birthweight information for statewide births was unavailable for 23 new births. As a result, when the statewide number of newborns in different birthweight categories is added up, they do not equal 101,575 because of the missing data. So, statewide births (%) presented in Figure 2 was based on a total of 101,552 statewide births in three different birth weight categories.

¹⁰ Total number of deliveries (6,581) reported for 2005 on page 1 do not match the total number of births reported on page 7 due to multiple births to pre-natal care patients.

¹¹ Statewide birth data was provided by the Maternal and Child Health Epidemiology Program, Division of Family Health Services, NJDHSS. This data is available at the Center for Health Statistics, NJDHSS. <http://nj.gov/health/chs>.

Figure 2: % of Babies Born in Different Birthweight Categories



Among 2005 newborns throughout the state, about 1,604 (1.58%) were in the very low birthweight category (weighing less than 1500 grams); 6,807 (6.7%) were in the low birthweight category (between 1501-2500 grams); and 93,141 (91.7%) were in the normal birthweight category (more than 2500 grams). Among babies born under health center care, 85 (1.28%) were in very low birthweight category; 336 (5.06%) were in the low birthweight category; and 6190 (93.3%) were in the normal birthweight category. This comparison clearly indicates that babies born under health center provider care had lower incidence of both very low and low birth weights, and a higher incidence of normal birthweight babies.

When compared with state goals of reducing low birthweight and very low birthweight babies, health centers perform better than other health care organizations. The Healthy New Jersey 2010 program aims to reduce the percentage of low birth weight infants to 6.0% and very low birth weight infants to 1.0% of all infants. The percentage

of babies in the low birth weight category born under health center care is 5.06%, which is already lower than the stated goal (6.0%); and the percentage of very low birth weight babies is very close to the stated goal (1.28%). In this category also, the health centers perform better than other medical providers statewide.

The fact that health centers perform notably well in providing better health outcomes for their pre-natal care patients has also been reported in studies focused on community health center performance nationwide. In a study investigating whether community health centers reduce racial/ethnic disparities in perinatal care and birth outcomes, Shi et al. reported that despite serving a low-income, high-risk population, health centers produce better birth outcomes for their prenatal care patients compared to the general population.¹²

As indicated earlier in this report, a major difficulty in evaluating health center performance on all three birth outcome measures lies in the lack of availability and reporting of such information by the health centers. The only outcome reported by all the health centers providing prenatal care is birth weight information of newborns. This data requirement is mandated for all 330 grant funded health centers by the Bureau of Primary Health Care (BPHC) in the Health Resources and Services Administration (HRSA) as part of their annual data reporting system. This requirement helps the health centers obtain this information from the hospitals where most births take place. With regard to other birth outcome data, which are not part of the mandated reporting system; most health centers are unable to report these data because the affiliated hospitals do not

¹² Shi, Leiyu, Gregory D. Stevens, John T. Wulu, Jr., Robert M. Politzer, Jiahong Xu. "America's Health Centers: Reducing racial and Ethnic Disparities in Perinatal care and Birth Outcomes." *Health Services Research*. December 2004. 39:6, Part 1.

distinguish between health center patients and other patients when reporting such data (pre-term births and infant mortality).

The only health centers that were able to report pre-term birth and infant mortality data for 2005 through their own record keeping systems were Eric B. Chandler Health Center (Middlesex county), Newark Community Health Centers, Inc. (Essex County), and Southern Jersey Family Medical Centers, Inc (Atlantic, Salem, and Burlington Counties). In 2005, among Middlesex county births, 1.6% newborns were born in the very pre-term (less than 1500 grams) category; 9.1% were pre-term category (between 1500 and 2500 grams); and 89.3% were born in the full term category (2500 grams or higher). Compared to these numbers, Eric B. Chandler Center which operates in this service area, performs much better in all term/birth categories. For Eric B. Chandler, 0% of newborns were born in the very pre-term category; 1.6% was in the pre-term category, and 98.4% were born in the full-term category.

In the Essex county area, in 2005, 3% births were in the very pre-term category; 10% in the pre-term category; and 87% were born in the full term category. During that same period, Newark Community Health Center, Inc. (NCHC), which provides prenatal care services in the area reported 2.1% very pre-term, 11.7% pre-term, and 86.2% full-term births. While the very pre-term birth numbers are better for the health center, performance in other category of term-births is comparable to other service providers in the area.

The third health center which tracks pre-term births and infant mortality numbers for its prenatal care patients is the Southern Jersey Family Medical Center, Inc. (SJFMC). This health center provides prenatal care services to medically underserved populations

in the Atlantic, Burlington , and Salem counties. In 2005, in these three counties, 1.7% newborns were born in the very pre-term birth category; 8.7% were born in the pre-term birth category; and 89.6% newborns were born in the full-term birth category. For the same period, SJFMC reported less than 1% (.19%) births in the very pre-term birth category; 3.8% births in the pre-term birth category; and 96% births in the full-term birth category. In almost all cases of birth outcomes, overall health center performance is better than or comparable to other prenatal care providers in their service areas.

As indicated earlier, by virtue of providing health care services to the underserved populations in New Jersey, health centers extend care to a large segment of the population that may otherwise lack timely access to health care. While birth outcome data may not be the only criterion for measuring quality of care in prenatal care services, these data clearly indicate that health center patients' birth outcomes are generally better than birth outcomes throughout the state. Due to unavailability of data, this report is limited to comparison between health center birth outcomes and statewide birth outcomes data only. Future analysis focused on various components of the prenatal care programs at the health centers (nutritional guidance, education focused on health risk issues, ease of access to medical providers) can add qualitative value to this primarily quantitative assessment of health center performance in the prenatal care arena.

Appendix 7. PRENATAL CARE TASK FORCE MEMBERS

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New Jersey Primary Care Association

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Maternal and Child Health Consortia

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Jersey City, NJ 07302

Ilise Zimmerman
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Northern NJ MCH Consortium
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Appendix 8.

Hudson Perinatal Consortium, Inc. Obstetric Providers 2008

Site	Address	City	Telephone	# OB's or FP MD's	Current Wait For Appt.	High Risk Perinatology Services	Cutoff for entry into PNC (wks gestation)	Comments
Horizon Health Center	714 Bergen Avenue	Jersey City, NJ 07304	(201) 451-6300	3 FT Midwife 1 FTE MD	2 weeks	No	28 weeks	Referral to Columbus Health Center, Newark Beth Israel & UMDNJ
Horizon Health Center	412 Summit Avenue	Jersey City, NJ 07306	(201) 963-5774	7 hrs wk Midwife 4 hrs MD	1 week	No	28 weeks	Referral to Columbus Health Center, Newark Beth Israel & UMDNJ
Metropolitan Family Health Network	935 Garfield Avenue	Jersey City, NJ 07305	(201) 478-5800	(1) FTE MD (1) FTE Midwife	2 weeks	No	34 weeks	Referral for high risk to Columbus Health Center & Newark Beth Israel
North Hudson Community Action Corporation	324 Palisade Avenue	Jersey City, NJ 07307	(201) 459-8888	1.5 APN 1 MD 5 hrs, 4 days a week	2 weeks	Referral to perinatologist at PMC (Dr. Yeh)	28 weeks	Referral to Newark Beth Israel for high risk or Columbus.
North Hudson Community Action Corporation	5301 Broadway	West New York, NJ 07093	(201) 866-9320	1 FTE APN 1 FTE Midwife 1 FTE MD 1 FTE MD seeing patients, 6 days a week	1 week	Referral to perinatologist at PMC (Dr. Yeh)	28 weeks	Referral to Newark Beth Israel for high risk or Columbus.
North Hudson Community Action Corporation	714-31 st Street	Union City, NJ 07087	(201) 863-7077	1 FTE Midwife 1 FTE APN .5 FTE MD	2 weeks	Referral to perinatologist at PMC (Dr. Yeh)	28 weeks	Referral to Newark Beth Israel for high risk or Columbus.
Meadowlands Medical Center	55 Meadowlands Parkway	Secaucus, NJ 07094	(201) 392-3275	16-20 hrs MD a week (house staff)	1 week or less	Referral for consultation to Dr. Principe at Meadowlands	24 weeks	All high risk patients are referred to JCMC or St. Joseph's Medical Center.
Center for Family Health (HUMC)	122 Clinton Street	Hoboken, NJ 07030	(201) 418-3102	48 hrs per week (4 P/T MD's) Open every other Saturday	3-4 weeks	Referral for consultation to Dr. Principe at HUMC	26 weeks Attending makes decision	High risk patients referred to JCMC, Newark Beth Israel or St. Joseph's Medical Center.
Columbus Health Center	115 Christopher Columbus Drive	Jersey City, NJ	(201) 946-6887	1 FTE MD plus 4 hour MFM MD – 4hrs every other Wed.	2-3 weeks	Yes – 4 hours a week	None; appointments given based on medical priorities & availability	Major problem with space. They are also unable to do PE because they are not a Healthstart Provider. The number of providers has increased recently.
Parkside Medical Center	127 Lafayette Street	Jersey City, NJ 07305	(201) 434-1111	4 hrs every other Wednesday	1 week	No	12 weeks	Sending high risk to UMDNJ.

Deliveries: 600 Metropolitan 311 NHCAC at JC 50 Meadowlands 100 Columbus 200 NHCAC at UC 875 NHCAC at WNY 886 Horizon 10 Parkside 449 Center for Family

**Northern NJ MCH Consortium
Obstetric Providers 2008**

Site	Address	City	Telephone	# OB's or FP MD's	Current Wait For Appt.	High Risk Perinatology Services	Cutoff for entry into PNC (wks gestation)	Comments
Chilton Memorial Hospital	97 West Parkway	Pompton Plains, N.J. 07444	973-831-5491	4 that rotate coverage in our OB Clinic	4 weeks	Yes	No cutoff. Preference is for early as possible.	Full services are provided to OB patients by a multidisciplinary team that includes: Social Worker, Dietician, a Certified Diabetic RN Educator, and a Maternal Fetal Medicine specialist if needed.
St. Mary's Hospital Family Health Center	148 8 th Street	Passaic, NJ 07055	(973)470-3019	20 hours per week 2 PT MD'S 2 PT CNM's	3 weeks	No, Refer to St. Joseph's Hospital And Medical Center High Risk Clinic	No Cut Off	Process for transfer of Clinic licensure from St. Mary's Hospital to North Hudson Community Health Center is in progress.
Holy Name Hospital Outpatient Department	718 Teaneck Road	Teaneck, NJ 07666	(201)833-3174	4 OB/GYNs rotate daily, 1 GYN weekly	2 ½ weeks	No, refer to High Risk Clinic	At MD's discretion if late in pregnancy	OB Clinic meets 2X week GYN Clinic meets 2X week
Valley Hospital Community Care (clinic)	1114 Goffie Road	Hawthorne, NJ 07506	(973)427-7676	6 hr MD /wk 1 FT RN	3-4 weeks	Refer to MFM for consults	none	
Englewood Hospital and Medical Center Prenatal Clinic St. Joseph 's Prenatal Clinic	350 Engle St 21 Market St	Englewood NJ 07631 Paterson, New Jersey 07503	201 894-3254 973-754-4222	2 FT OB/GYN 5 OB/GYN & 4 OB/GYN Residents	2 weeks 1-2 weeks	Yes No, refer to High Risk Clinic	none 28 weeks then to high risk	Clinic meets 1 day each week Increase in volume about 22% over last year
St. Joseph's High Risk Clinic	703 Main Street	Paterson, New Jersey 07503	973 754-2717	Ft Perinatology coverage 24/7 on a rotating basis between 3 perinatologists	2 weeks	Yes	None	Increase of 16% over last year- space is a serious issue
St. Joseph's Teen OB clinic	703 Main Street	Paterson, New Jersey 07503	973-754-2720	6 CNMs	2 weeks	No, refer to High Risk Clinic	28 weeks – check with midwife	
Saint Barnabas Medical Center OB/GYN Health Center	94 Old Short Hills Road	Livingston, NJ 07039	(973)322-8284	1 OB/GYN attending, 5 OB residents, 1 Nurse Practitioner	6-7 weeks	Yes	none	We have seen increase in clinic volume related to area hospital closures.

**Gateway Northwest Maternal and Child Health Network
Obstetric Providers 2008**

Site	Address	City	Telephone	# OB's or FP MD's	Current Wait For Appt.	High Risk Perinatology Services	Cut off for entry into PNC (wks gestation)	Comments
Morristown Memorial Hospital	100 Madison Avenue	Morristown, NJ 07960	973.971.4182	5 MD's share 1 Midwife shared with Overlook & 3 PerDiem Midwives	2 months	Yes, MMH is an RPC	No cut off	
Saint Clare's Hospital	25 Pocono Road	Denville, NJ 07834	973.989.3605 973.989.3303	2 MD's 1x/wk 1 midwife 3days/wk	3-4 weeks	Yes Atlantic Health	No cut off	
Trinitas Hospital	225 Williamson St.	Elizabeth, NJ 07201	908.994.5500	1 FTE MD and ½ MD every day 1 Perinatologist 1x/week 1 Geneticist 1x / week 2 FTE Midwives	3 weeks	Yes NBIMC	No cut off	
Clara Maass Medical Center	One Clara Maass Drive	Belleville, NJ 07109	973.450.2339	4 MD's each has one day	2 weeks	No	24 weeks	Refer to NBI, St. Barnabas, UMDNJ for high risk
Mountainside Hospital	Bay and Highland Avenues	Montclair, NJ 07042	973.429.6812	MD Consultant 2 ½ days/week	2 weeks	Yes Atlantic Health	36 weeks	
Hackettstown Regional Medical Center	651 Willow Grove Street	Hackettstown, NJ 07840	908.850.6724	1 MD Thursday 8 to 12 Noon 3 Midwives Monday 8 to 12 Noon	4-6 weeks	No	No cut off	Refer to Morristown Memorial for high risk
UMDNJ/University Hospital	Bergen Street	Newark, NJ 07103	973.972.6216	20 FTE MDs	2 weeks	Yes	No cut off	
North Hudson Community Action Corp. Health Center *as of 8/1/08 for HUMC	25 East Salem St.	Hackensack, NJ 07601	201.996.4425	1 MD 1 Midwife/clinic 9/10 /week	1-2 weeks Walk-ins accepted	Yes HUMC	28 wks NPC 30-32 wks with previous PC	
Saint James Hospital	155 Jefferson St.	Newark, NJ 07105	973.465.2677	2 FTE MDs 1 PTE MD	1 week	Yes	No cut off	NBI does their deliveries

**Gateway Northwest Maternal and Child Health Network
Obstetric Providers 2008**

Site	Address	City	Telephone	# OB's or FP MD's	Current Wait For Appt.	High Risk Perinatology Services	Cut off for entry into PNC (wks gestation)	Comments
Overlook Hospital		Summit, NJ	908.522.5735	6 MDs rotate thru the clinic on Fridays 1 MD covers Thursday clinic 1 PTE Midwife covers two days/shares with Morristown Memorial	2 weeks	No	No cut off	Refers to Morristown Memorial for high risk
Coventry Health Center	755 Memorial Parkway	Phillipsburg, NJ 08865	908-454-6303	1 FTE MD covers the clinic	Less than 1 week	No	No cut off	Refer to St. Peter's and Morristown Memorial for high risk
Newton Memorial Hospital	175 High Street	Newton, NJ 07860	973.579.8351	Grp of MDs 4 afternoons/week	2 weeks	No	No cut off	Refer to Morristown Memorial for high risk
JFK Medical Center	65 James Street	Edison, NJ 08818	732-321-7000	7 FTE MDs	1-2 weeks	No	28 weeks	Refer to St. Peter's and Robert Wood Johnson for high risk
Newark Beth Israel Medical Center	166 Lyons Avenue	Newark, NJ 07112	073.926.3045	9 FTE 3 am Clinic 2 pm Clinic	4-5 days	Yes – NBIMC is a RPC	None	

Hunterdon Medical Center	No Hospital Clinic Patients receive care at Philips Barber											
Somerset Medical Center	110 Rehill Ave Somerville	908-685-2200	No CNM or Nurse Pract.	Family Practice Residents - high risk OB	2 wks will be seen prior to 11 wks per Health Start	Yes- High risk clinic-OB	No cut off	Appt for screening first to determine risk- low risk-family practice. High risk sees OB for assess.				
St. Peter's University Hospital	254 Easton Ave New Brunswick	732-745-8520	No CNM or NP	Attending OBS and residents	Depends on need but by 2 wks	high and low risk services	No cut off	Patient sees nurse at initial visit schedule with MD within 1 wk. If MD is available will see at initial visit.				
RWJ-High Risk Perinatal Center	1 Robert Wood Johnson Place See Joseph S. Yewasis Health Care Center	732-828-3000	NP, No CNM	Perinatologist, Residents, Fellows	within 2 weeks	High Risk Perinatology Services	No Cut off	Seen by physician first visit				
Raritan Bay Medical Center												
University Medical Center at Princeton	253 Witherspoon St.	609-497-4627	No NP, PA, CNM	OB (3 providers)	Guidelines Cooper to see within 2 wks. (fit patients in as necessary)	contract with Cooper to see patients necessary patients	no cut off	high risk transfer to CHS as necessary nurse at initial visit				
Capital Health System- Mercer Campus	446 Bellevue Ave.	609-394-4000	CNM, no NP, PA	Residents	2 weeks	Yes- High risk clinic-OB	cut off	MD within 1 wk. Nurse and MD at 1st PN visit				
Robert Wood Johnson University Hospital Hamilton	1 Hamilton Health Place				usually 2 wks. Sometimes 2 1/2	No- seen by OB at RWJUHH if high-risk-transfer prn.	No cut off	See RN at first visit. Two weeks later see CNM.				
Plainfield Health Center (NHSC Neighborhood Health Services Corporation)	1700-58 Myrtle Ave Plainfield	908-752-6401	CNM- main staff	OB/GYN is necessary Mon.- Fri. attending phy. Mon. Tues. and Thurs family practice resid. From RWJ (with a physician)	Based on need 1 week		No cut off	Pt. sees RN & CNM at 1st appt. If risk initial OB resch when MD present.				
Eric B. Chandler Health Center	277 George St. New Brunswick	732-235-6700	No CNM or Nurse Pract.	OB/ and residents	3 weeks (try 2 weeks)	No- refer to RWJ high risk	No cut off	PatientPt. Initial visit with nurse then appt with physician within 10 days unless medically warranted				
Joseph S. Yewaisis Outpatient Center-RBMC	530 New Brunswick Ave.	732-324-3317	1 CNM, no NP, PA	OB 3	Health Start 2 wks. Prot.	High risk to RWJ High Risk Clinic	No cut off - if 39 to 40 weeks will try to see if have appt.	Depend on pts. MED. Usually seen by nurse then provider within 1 to 2 weeks. See mdcowrm@initial.visit				
Henry J. Austin Health Center	321 North Warren St.	866-884-9968	2 CNM, no NP,PA	5 OB providers	2 wks. After preg. test. Current wait ASAP - next day appt. available	High risk Mercer/NB - per cond.	30wks entry	Will take transfer fllow risk after record rev.				
Phillips Barber Health Care Center	72 Alexander Ave.	609-397-3535	NP/PA	Private MDs- FP & OB		High risk referred out or to HMC	No cut off	Leave appts open for pbs can be seen in 1 or same day pis sees MD at initial visit.				

**Regional Perinatal Consortium of Monmouth and Ocean Counties, Inc.
Obstetric Providers 2008**

Site	Address	City/ County	Telephone	# OB's or FP MD's	Current Wait For Appt.	High Risk Perinatology Services	Cutoff for entry into PNC (wks gestation)	Comments
VNACJ Community Health Center - Keyport	35 Broad St.	Keyport / Mon.	(732) 888-4158	3 VNACJ centers share 2 FT CNM's and one per diem CNM	1 - 4 weeks depending on situation	Referral to perinatologist at Mon. Med. Ctr. (MMC)	>36 weeks	Refer to Mon. Family Health Center if >36 wks Proof of preg. req.
VNACJ Community Health Center - Red Bank	176 Riverside Ave.	Red Bank/Mon.	(732) 224-6852	"" ""	1 week	Referral to perinatologist at Mon. Med. Ctr.	none	Proof of preg. req.
VNACJ Community Health Center - Asbury (FQHC)	1301 Main Street	Asbury/ Mon.	732-774-6333	"" ""	2 weeks	Referral to perinatologist at Mon. Med. Ctr.	none	Proof of preg. req.
Riverview Medical Center -Family Health Clinic	One Riverview Plaza	Red Bank / Mon.	(732) 741-2700 x 3800	OB attendings rotate thru clinic held 1x/wk.	1-2 weeks	Referral to perinatologist at JSUMC or MMC	none	Proof of preg. req.
Jersey Shore University Medical Center - Family Health Clinic	71 Davis Ave.	Neptune /Mon.	(732) 776-2464	12 OB residents and 1 FTE OB	none	Referral to perinatologist in house (JSUMC)	none	
Ocean Medical Center - Family Health Clinic	425 Jack Martin Blvd.	Brick /Ocean	732- 840-3290 (732) 836-4339	3 private OB's rotate 4 hrs. /wk	3 - 4 weeks	Referral to perinatologist at JSUMC	none	
Monmouth Family Health Center (FQHC)	270 Broadway Long Branch, NJ 07740	Long Branch /Mon.	(732) 923-7280	1 FT OB/Med. Dir., MMC OB residents and CNM's provide coverage 4 days / week	1-2 weeks	High Risk perinatol. Clinic 1x wk. Referral to services at Mon. Med. Ctr.	> 38 wks. w/ no PNC refer to MMC for inpt. NST etc.	
Ocean Health Initiatives - Toms River	301 Lakehurst Rd.	Toms River / Ocean	(732) 552-0377	2 FTE CNM's and 2 FTE OB's (One of the OB's is also MFM)	none	Referral for consultation to in house perinatologist or to MMC	none	
Ocean Health Initiatives - Lakewood	201 Second St.	Lakewood /Ocean	732-363-6655	Share same staff as OHI above	none	Same as above	none	
CentraState Family Medicine Program	1001 W. Main St., Suite B	Freehold /Mon.	732-294-4008	Family Practice coverage Mon.thru Fri. and OB coverage 3 days /wk	1 week	Refer to UMDNJ in New Brunswick	none	Sending high risk to UMDNJ; proof of preg. req., open for PNC M-F
SOCH	1140 Rt. 72 W.	Manahawkin	609-978-3167	All 5 OB attendings at SOCH rotate at 1xwk (4 hr.) clinic	2-3 weeks, at times longer	Refer out to Shore Memorial or Jersey Shore Univ. Med. Ctr. or Cooper depending on where mom lives	none	Can start care without any insurance

'07 Deliveries: 4022 MMC 1622 RMC 1602 JSUMC 1726 CMC
316 SOCH 1987 CSMC 1834 KMC 1026 OMC

5-12-08

**Southern NJ Perinatal Cooperative, Inc.
Obstetric Providers 2008**

Site	Address	Telephone	List # of OBs CNMs or FPMs	Current Wait For 1st Appt.	Wait For 2nd Appt	High Risk Perinatology Services (Y/N)	Cutoff for entry into PNC (weeks gestation)	Comments
Shore Prenatal Services	1 East New York Ave. Sommers Point, NJ 08244	(609) 653-4624	Obs 3 CNMs 0 FP MDs	Within 2 weeks	7-10 Days	Yes	No Cutoff	No Gyn Services
Southern New Jersey Family Medical Center Atlantic City Office	Atlantic Avenue. Atlantic City, NJ 08401	(609) 572-0000	Obs 3 CNMs 2 FP MDs 3	1 Week	1-2 weeks	NO	NO cutoff	
Southern New Jersey Family Medical Center Pleasantville Office	932 S. Main Street Pleasantville, NJ 08232	(609) 383-0880	Obs 0 CNMs 0 FP MDs 3					No Gyn or OB Services
Southern New Jersey Family Medical Center Hammonton office	860 White Horse Pike Hammonton, NJ 08037	(609) 567-0200	Obs 3 CNMs 2 FP MDs 3	1 Week	1-2 weeks	NO	No Cutoff	
Atlaticare Women's Health Services	4 East Jimmie Leeds Road Suite 7 & 8 Pomona, NJ 08240	(609) 748-0149	Obs 3 CNMs 2 FP MDs 3	2 weeks	Within 1 week	YES	No Cutoff	
Virtua Center for Women	1636 Route 38 & Eayrestown Road Lumberton NJ 08048	609-261-7023	Obs 3 CNMs FP MDs	1week	none	Not on site send to Hospital	No	PA-1 NP-1
Rancocas Women's health care- Lourdes	OB/GYN Clinic, 220 Sunset Road, Suite 1B Willingboro NJ 08046	609-835-5204	Obs 1 CNMs FP MDs	1-2 weeks	none	Not on site send to Hospital	No	NP-1; Residency program 4-5 Residence at a time
Southern Jersey Family Medical Centers Inc.	665 High Street Burlington NJ 08016	609-386-0775	Obs 1 CNMs FP MDs	1-2weeks	none	N	No	PA-1
Southern Jersey Family Medical Centers Inc.	600 Pemberton-Brown Mills Rd PO Box 248 Pemberton NJ 08067	609-894-1100	Obs 1 CNMs FP MDs	1-2weeks	none	N	No	PA-1
CamCare Gateway	817 Federal Street Camden, NJ 08103	856/541-2229	Obs 2 CNMs FP MDs	1-3 weeks	3 weeks	N	35 wks	2nd appt. depends how far along the patient is.
CamCare East	2610 Federal Street Camden, NJ 08105	856/635-0212	Obs 2 CNMs FP MDs	3-4 weeks	4 weeks	N	35 wks	
Osborn Family Health Center	1601 Haddon Ave NJ 08103	856/757-3700	Obs: 5 CNMs FP MDs	1 week	1 weeks	Y	None	1 wk wait for initial PN appt. and confirmation appt.

**Southern NJ Perinatal Cooperative, Inc.
Obstetric Providers 2008**

Site	Address	Telephone	List # of OBs CNMs or FPMs	Current Wait For 1st Appt.	Wait For 2nd Appt	High Risk Perinatology Services (Y/N)	Cutoff for entry into PNC (weeks gestation)	Comments
Kennedy Family Health Services at Somerdale	1 Somerdale Square NJ 08083	856/309-7700	OBs: 1	1 week	1 week	Y	None	
			CNMs					
			FP MDs					
Planned Parenthood of Southern NJ	317 Broadway Camden, NJ 08103	856/365-3519	OBs 1	4 weeks	1 week	N	None	
			CNMs					
			FP MDs					
St. Johns	6 & Erie Street Camden, NJ 08102	856/757-9540	OBs 5	1-5 days	1-5 days	Y	None	Appt. available that same week that patient calls for appt.
			CNMs					
			FP MDs					
Women's Care Center	3 Cooper Plaza Camden, NJ 08103	856/342-2959	Obs 5+	3-7 days	depends on trimester	Y (Tues. only)	None	16 residents attending
			CNMs					
			FP MDs					
Cape Community Women's Center	410 Rt 9 NJ 08210	609-465-0258	Obs 2	1 week	no wait, normal rotation	N refer to cape regional	no cut off	1 NP clinic M-F Friday new pts only
			CNMs 1					
			FP MDs					
South Jersey Healthcare women's center	105 Manheim Ave suite 789 Bridgeton, NJ 08302	856-451-0708 or 856-507-2759	Obs	2-3 weeks	within 2 weeks for physical	Y seen at hospital doctor from OLOL	none	rotating doctors from staff in OB department 2 NP
			CNMs 5					
			FP MDs					
South Jersey Helathcare Women's Center	1038 E Chestnut Ave Suite 250 Vineland, NJ 08360	856-451-0708 or 856-507-2759	OBs	1 wk or less	within 2 weeks	Y seen at hospital	none	rotating doctors from staff in OB department 2 NP
			CNMs 5					
			FP MDs					
Kennedy Family Health	100 Kingsway East Sewell, NJ 0880	856-218-2312	Obs 1 ft	1 wk or less	1 week after 1st	Y	none	Thur morn new ob intakes see all but md. 2nd appt is with MD
			CNMs 1					
			FP MDs					
Underwood Prenatal Program	543 N. Board St NJ 08096	856-686-4757	Obs 3	1 week intake	10 days	Y	due date	residents for couple months, high risk Debbs & Marciano
			CNMs 0					
			FP MDs					
CamCare - Paulsboro	1315 No Delaware Ave Paulsboro, NJ 08066	856-687-2200	Obs 1	up to 4 wks	1 week	Y	none	intake once a month, clt who have pos. preg. results get appt 1st
			CNMs					
			FP MDs					