NEW JERSEY

STATE HEALTH IMPROVEMENT PLAN

New Jersey's 2020 State Health Improvement Plan (SHIP) consists of action plans and strategies collaboratively developed by the state health department, sister agencies, community-based stakeholders, and local public health agencies to address shared priority health issues.

JANUARY 2020

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ACKNOWLEDGMENTS

The New Jersey Department of Health (NJDOH) would like to thank the following agencies, groups, and individuals who were involved in developing and providing feedback on the State Health Improvement Plan and State Health Assessment:

Subject Matter Experts & Key Informants

- Center for Food Action
- Central Intake Workers
- Children's Interagency Coordinating Councils
- Community Health Assessment Partners
- Community Health Workers
- County Drug and Alcohol Directors
- Food pantry clients
- Health Communities
- Law Enforcement
- Local health officials
- Mayors Wellness Campaign
- Mental Health Administrators
- Municipal Alliances
- Regional Substance Abuse Prevention Coalitions
- Rutgers Cooperative Extension
- SNAP recipients
- State Epidemiological Outcomes Workgroup
- YMCA
- Youth Advocates
- Cross-sector leaders from transportation, housing, community development and design, anti-poverty, environment and conservation, climate change, workforce development and education

Healthy New Jersey 2020 Advisory Council

- **Tamara Cunningham**, Barnabas Health
- **Candice Davenport**, New Jersey Society for Public Health Education
- **Sandy Festa**, AtlantiCare Regional Medical Center
- **Xiomara Guevara**, Morris County Organization for Hispanic Affairs
- **Aline Holmes**, New Jersey Hospital Association

- **Chris Kirk**, North Jersey Health Collaborative
- **Margaret Koller**, Rutgers Center for State Health Policy
- **Kevin McNally**, New Jersey Public Health Association
- **Mary LaMar Bentley**, Sickle Cell Association of New Jersey
- **Keri Logosso-Misurell**, Greater Newark Healthcare Coalition
- **Paschal Nwako**, Camden County Department of Health and Human Services
- **Gregory Paulson**, Trenton Health Team
- **Daniel Regenye**, Ocean County Health Department
- **Lisa Scheetz**, Cumberland Cape Atlantic YMCA
- **Jagdish Vasudev**, United Way of Central Jersey

Healthy New Jersey Coordinating Committee, NJDOH

- **Lisa Asare**, Family Health Services
- **Maria Baron**, Office of Population Health
- **Loretta Kelly**, Office of Population Health
- **Yannai Kranzler**, Office of Population Health

In Memory of, and With Gratitude to, **Colette Lamothe-Galette, MPH**, former NJDOH Director of Population Health and Healthy People State Coordinator.

Background

HEALTHY NEW JERSEY 2020

Healthy New Jersey 2020 is the State's health promotion and disease prevention agenda for the decade, including both the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP). It is modeled after the federal Healthy People 2020 initiative and is the result of a multiyear planning process that reflects input from a diverse group of individuals and organizations.

The purpose of the State Health Assessment (SHA) is to:

▶ describe the health status of the population,

▶ identify areas for health improvement,

▶ determine factors that contribute to poor health outcomes, and

▶ define assets and resources that can be mobilized to achieve overall population health goals.

The purpose of the State Health Improvement Plan (SHIP) is to:

▶ describe how the state health department, sister agencies, community-based stakeholders, and local public health agencies will work together to address shared priority health issues

▶ identify and utilize state and local-level resources and assets to develop and implement priority health projects, programs, and policies

▶ achieve measurable objectives and deploy strategies by using a planned set of action steps

The 2018 SHA

The 2018 SHA, published in August 2018, is based on over 100 public health objectives in 20 health topic areas that were identified when Healthy NJ 2020 was launched in 2011. It represents a review of each objective's progress toward target values set to be attained by 2020, as well as opinions expressed at the six regional stakeholder meetings in 2015 and from written public comments on the draft report in early 2018. The SHA also contains data and information on:

▶ demographics,

▶ socioeconomic characteristics,

- quality of life,
- health disparities,
- other social determinants of health, and
- emerging public health issues.

The full 2018 SHA report is accessible online here.

2019 SHIP

As the final SHIP of the Healthy New Jersey 2020 cycle, this document includes Actions Plans for New Jersey's leading health priorities. Each of the SHIP's action plans were informed by data, inter-agency collaboration and community engagement, including listening sessions, focus groups and interviews with state and community stakeholders between March 2018 and April 2019.

METHODOLOGY

NJDOH defined three critical work groups per priority to guide the process:

- NJDOH Core Team: Comprised primarily of state employees (mostly DOH personnel), the Core Team, led by a staff supervisor and including both programs and data experts coordinated the engagement process and helped translate stakeholder feedback into action plans.

- Partners: Stakeholders identified by the Core Team provided guidance regarding community engagement, as well as action plan development. Effort was made to utilize existing committees as the SHIP's intersectoral action teams.
- Experts: Including both field-level staff and community members, individuals directly impacting or directly impacted by the work collaborated on the development of the action plans by participating in focus groups and one-on-one interviews. Summaries of focus groups, listening sessions and interviews appear as appendices to this SHIP report.

OVERVIEW OF CHAPTERS

The following chapters outline the **SHIP's six Action Plans and Next Steps:**

- Chapter 1: **Health Equity**
- Chapter 2: **Birth Outcomes**
- Chapter 3: **Mental Health & Substance Use**
- Chapter 4: **Nutrition, Physical Activity, and Chronic Disease**
- Chapter 5: **Immunizations**
- Chapter 6: **Alignment of State and Community Health Improvement Planning**
- Chapter 7: **Next Steps-Healthy New Jersey 2030**

New Jersey State Health Improvement (SHIP) Planning Timeline

2018
Stakeholder Engagement

2019
SHIP Report Writing

2020
SHIP Draft Report Public Comment Period

Spring 2020
Final SHIP Report
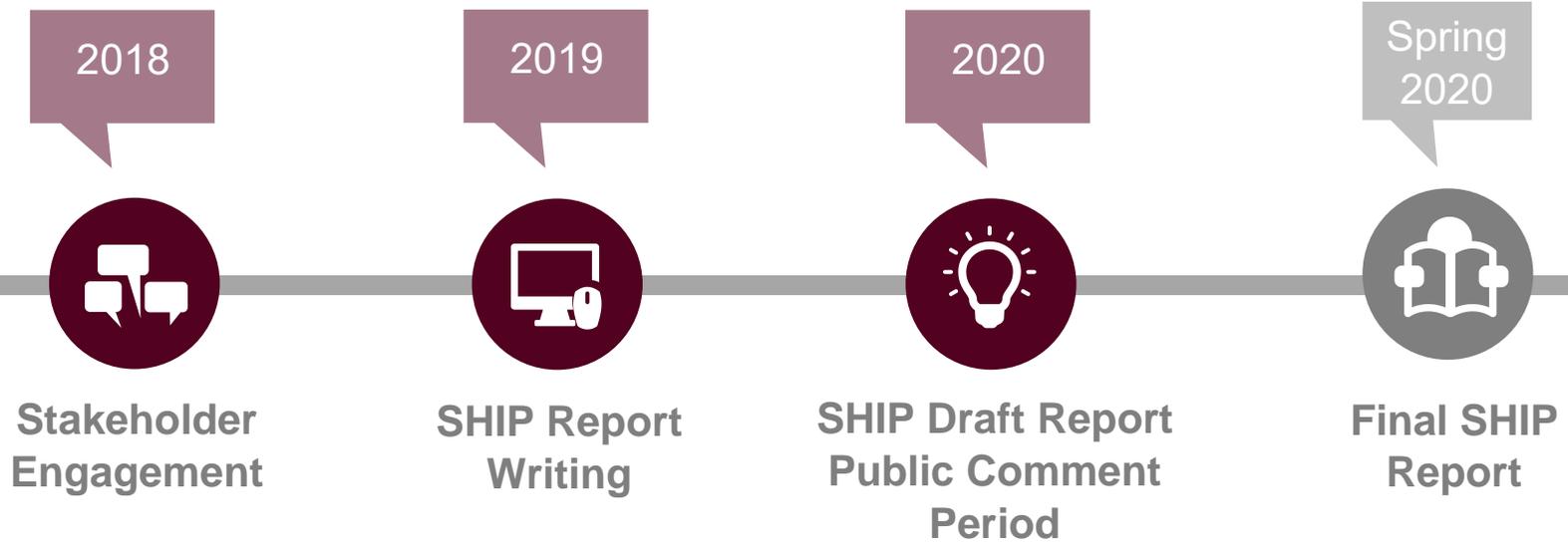
Health Equity - Introduction

As we approach the end of the decade and examine the trends of over 40 health topics tracked during the Healthy New Jersey 2020 cycle, critical improvements in a small set of health indicators point to the possibility of greater **health equity** in our State:

- Diabetes and stroke among Black residents are decreasing much faster than among other groups.

- Teen birth rate among Hispanic females aged 15-17 years declined 75% between 2000 and 2017. Among black females, the teen birth rate declined 83% during the same time period.

- Cigarette smoking among Asians aged 18 years and over declined 16% between 2011-2017.

- Mammography rates among Hispanic women rose 12% between 2011 and 2017.

- Breastfeeding Between 2010-16, the proportion of infants ever breastfed increased from 77.1% to 88.8%, and exclusive breastfeeding at 3 months increased from 34.2% to 43.7%.

However, our residents continue to experience devastating **health disparities:**

- The number of **uninsured New Jerseyans** is approximately 700,000.

- **Pregnancy-related death** rate among Black women (45.5 deaths per 100,000 live births) is nearly five times higher than it is for White women (8.6 deaths per 100,000 live births; 2013-15)

- **Neonatal abstinence syndrome (NAS)** rate is highest among whites.

- **Drug-related hospital visits** are highest among those in their 30's and early 50's.

- **Opioid prescription rates and NAS rates** are higher in New Jersey's southern counties, including Salem, Cape May, and Cumberland.

- **Black infant death** occurs at a significantly higher rate than other infants. In 2017, the rates were 9 per 1,000 births for Black infants compared to 3 (White), 5 (Hispanic) and 3 (Asian).

- **Teenage births** among Hispanic mothers in 2017 were 13 times higher than teenage White mothers.

- **Childhood vaccinations** are lower among Blacks, compared to White, non-Hispanic children.

- **Suicides** are highest among middle-aged White men (45-54 years old). This population is also less likely to seek help.

- **Youth suicide** rate is highest among males (15 to 24 yrs. old), increasing substantially from 2016 to 2017.

- **Geography of suicide:** Sussex and Atlantic counties have the highest suicide rates (2015-2017).

- **HIV transmission** rates were significantly higher among Blacks (42.5) and Hispanics (23.0), compared to Whites (4.8) in 2016.

Towards Health Equity in New Jersey

OVERVIEW

All individuals deserve an equal opportunity to attain and sustain good health. However, unequal or unjust circumstances, viewpoints, or policies have led to marked health inequities between population groups in New Jersey. Poverty, exposure to prejudice, lack of access to good jobs with fair pay, low quality education and housing, unsafe environments, and poor healthcare put too many New Jerseyans at risk.

The national Healthy People 2020 initiative emphasizes that "Health disparities adversely affect groups of people who have systematically experienced greater **social or economic obstacles** to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Determined to do better by the people we serve, the New Jersey Department of Health (NJDOH) is committed to striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk, based on social, economic, historical or political conditions.

To promote health equity, State leadership, as well as our deeply committed sister agencies and community partners are embedding social, economic and health justice in their work. State advancements such as increasing the minimum wage, providing paid family leave, restoration of support for family planning and ensuring continued access to affordable healthcare are encouraging steps. As our State builds its vision of Health in All Policies, shared leadership, collaboration and meaningful, sustained partnership with our residents will be critical toward eliminating disparities, appreciating community-specific needs, and ensuring access for all to the determinants of good health.

Health Equity

ENGAGEMENT PROCESS

CORE TEAM

PARTNERS

EXPERTS

- **Office of Minority and Multi-Cultural Health (OMMH),** New Jersey Department of Health

- **Bloustein School of Planning and Public Policy;** Rutgers, The State University of New Jersey

Leaders from *transportation, housing, community development and design, anti-poverty, environment and conservation, climate change, workforce development and education, convened by the Bloustein School of Planning and Public Policy*

ACTION PLAN

Health disparities in NJ persist and continue to punish populations based on factors largely beyond their control. Lessons learned, we aim to strengthen partnerships, provide better data, and listen more intentionally to the communities we serve. NJDOH will support the State's movement toward health equity with the following steps:

1 Office of Health Equity

NJDOH will develop an Office of Health Equity, building on the expertise of the Office of Minority and Multicultural Health (OMMH). The newly established office will ensure that decision-making at NJDOH is shaped by the pursuit of health equity and a commitment to ending disparities in New Jersey based on race, ethnicity, gender identity, income and locality.

2 Health in all Policies

The Office of Health Equity will support state and local partners as they pursue a Health in all Policies (HiAP) agenda by identifying regulatory, legal and policy obstacles and opportunities to strengthen health equity; providing data to identify short-term and long-term priorities; and ensuring the active participation of our diverse communities in policy decisions.

3 Health Equity Metrics

NJDOH will utilize and disseminate health equity metrics, such as the United Way's Asset-Limited, Income-Constrained, Employed (ALICE) measures and National Collaborative for Health Equity's Health Opportunity and Equity (HOPE) measures, to assess New Jersey's strengths and weaknesses in relation to national targets and state-by-state comparisons.

4 Health Equity Assessment

NJDOH will promote health equity assessments and promote opportunities for

cross-sector collaboration to develop or repurpose polices, programs and strategies for health equity.

5 Priority Populations

The Office of Health Equity will closely work alongside other divisions and partners to support priority populations and geographic regions, such as racially/ethnically diverse populations, LGTBQ, youth, children with disabilities, seniors and rural populations. NJDOH will promote collaboration between local agencies such as Federally-Qualified Health Centers (FQHCs) and academic institutions to design, implement and test research-based pilot projects that will examine social determinants of health among historically-marginalized populations in NJ.

6 Health Equity Training

NJDOH will design and implement health equity-related training modules on implicit bias, cultural competency, sensitivity and humility and trauma-informed care, starting with its own employees.

7 Data Collection

NJDOH will increase data collection and analysis that addresses determinants of health. Community stakeholders and other content experts will be critical toward identifying and helping explain data and findings. In addition to the expansion of data collection, NJDOH will conduct data-sharing within and between state agencies to better identify health disparities, target interventions, examine upstream factors, strengthen program evaluation, and inform decision-making. Alongside quantitative data, NJDOH will increase use of qualitative methods such as interviews and focus groups. Annual health equity forums will be conducted as town hall-style meetings where residents of NJ are provided the opportunity to engage directly with NJDOH staff about the challenges that lead to health disparities and opportunities for increasing health equity.

8 Local Coalition-Building

NJDOH will emphasize the importance of cross-sector, community-focused coalitions when providing support for local health priorities. Inter-agency coalitions reduce barriers by addressing determinants of health through environmental and policy changes, such as in schools, local government, and local businesses. NJDOH will continue to support and strengthen evaluation of local initiatives to

ensure continued improvement and collaborative learning in the shared pursuit of health equity in New Jersey.

Birth Outcomes

HEALTHY NEW JERSEY 2020 OBJECTIVES

▶ **Reduce infant mortality per 1,000 live births**

New Jersey rate: 4.1 (2016)

Goal: 3.7

▶ **Reduce C-sections among low-risk women**

New Jersey rate: 29.7% (2017)

Goal: 27.9%

ENGAGEMENT PROCESS

CORE TEAM

PARTNERS

EXPERTS

Irvington *New Brunswick* *Pennsauken*

- Division of Family Health Services, New Jersey Department of Health

- Partnership for Maternal & Child Health of Northern NJ

- Central Jersey Family Health Consortium

- Southern NJ Perinatal Collaborative

- Community Health Workers

- Central Intake Workers
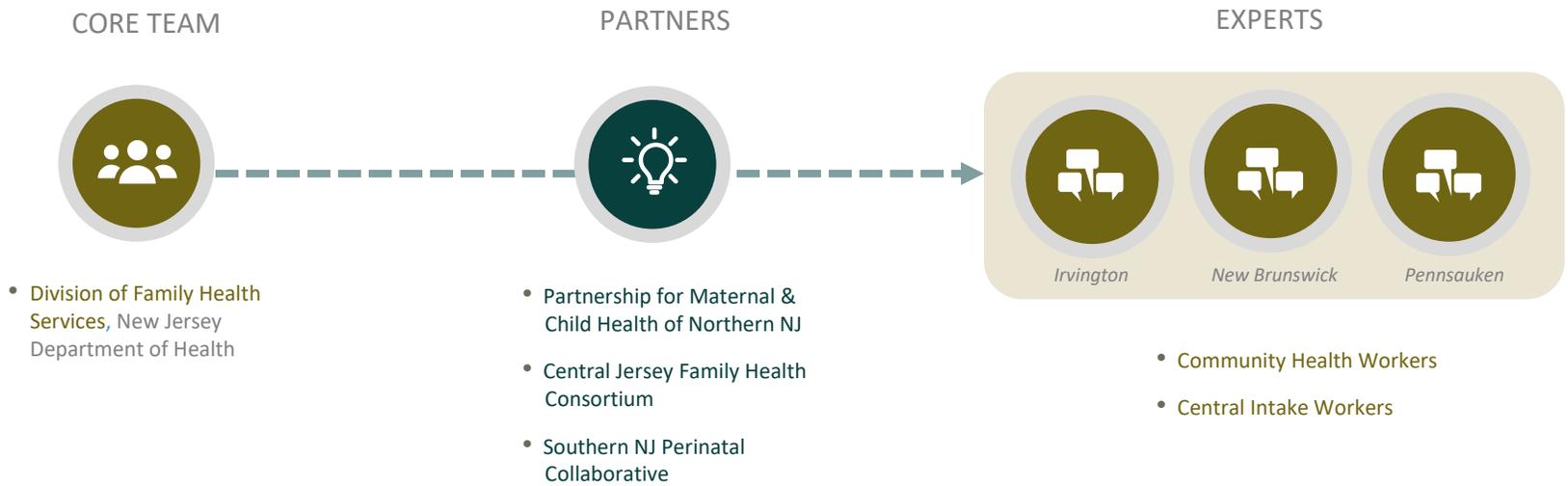
ACTION PLAN

STRATEGY #1:
Ensure universal, equitable, high quality care in New Jersey's health systems

The New Jersey Maternal Care Quality Collaborative (NJMCQC)

NJDOH is statutorily mandated to establish the New Jersey Maternal Care Quality Collaborative (NJMCQC). To effectuate clinical best practices and improvements in outcomes, the NJMCQC will work collaboratively and leverage efforts of state agencies, clinical and advocacy stakeholders, and other entities. Membership prescribed under P.L. 2019, c. 75 ensures broad representation from key health systems stakeholder groups.

Action Steps

▶ NJDOH will establish the New Jersey Maternal Care Quality Collaborative by 2020, to join state, health systems and community stakeholders on the same team to work with shared purpose and coordinated action.

Strategic Plan

The New Jersey Maternal Mortality and Morbidity Blueprint 2019–2022 utilized a statewide needs assessment process to identify Goals, Targets, and Indicators to avert maternal mortality, reduce maternal morbidity, and promote health equity, which will guide collaboration, data collection and innovation efforts in the years to come. The Blueprint will be the health strategy to improve maternal outcomes and will be part of a broader statewide strategic plan involving other sectors.

Action Steps

▶ Pursuant to P.L. 2019, c. 75, the NJMCQC will adopt and recurrently update a strategic plan to combat maternal mortality, morbidity, and disparities. The Blueprint developed by NJDOH and associated workplans will be first adopted by the NJMCQC in 2019. Priority for action will be led by various stakeholder groups within the state, including government officials, healthcare

organizations and professionals, community leaders, and the public.

▶ Promote a requirement for annual implicit bias training as a condition for maintaining physician and registered nurse licensure in New Jersey. NJDOH will develop best practices for meeting the proposed mandate. Through partnerships under the NJMCQC, an implicit bias multi-module webinar, with continuing education credits for maternal health providers, will be explored.

▶ Establish four designation levels for health care facilities licensed to provide prenatal and maternity services in accordance with recommendations published by the American College of Obstetricians and Gynecologists (ACOG). Whereas Level 1 facilities will present capability to provide appropriate care for pregnant and postpartum patients who lack medical, surgical or obstetrical conditions that present a significant risk of maternal morbidity or mortality, Levels 2 to 4 will have increasing infrastructure and

capacity to manage patients with increasing maternal risks.

Value-Based Payment

New Jersey is working to implement a Medicaid value-based payment program to advance maternal outcomes across the state, leveraging data and performance information from the Maternal Data Center to the extent possible. Building off of the Delivery System Reform Incentive Payment (DSRIP) program, which has operated in NJ for more than seven years, with a broad focus on chronic disease management in the acute care hospital setting, the new Quality Improvement Program in New Jersey (QIP-NJ) provides a framework for achieving this objective.

Action Steps

▶ Pivot DSRIP's value-based payment efforts through QIP-NJ to address maternity and behavioral health.

▶ Implement a perinatal episode of care pilot program in Medicaid (mandated in P.L.2019, c.86). NJDOH staff will work closely with NJ Medicaid through a shared staffing arrangement to ensure careful alignment between delivery system

payment reform efforts and the other maternal health initiatives seeking health systems changes.

Shared Decision-making

Recognizing that bias and discrimination has historically compromised the capacity of women, especially women of color, to fully participate in their medical decisions, there is opportunity for innovation to strengthening shared decision-making. Tools must be developed and deployed to moderate power imbalances and support reproductive autonomy.

Action Steps

▶ NJDOH will design a shared decision-making tool consisting of patient decision aids to increase the informed involvement of patients in decisions around childbirth at New Jersey's birthing hospitals and birthing centers.

▶ NJDOH will develop a "My Life, My Plan" program to support reproductive planning under P.L. 2019, c. 236. Tools will be formulated to inform users about available services and options while supporting their reproductive autonomy.

Promote Meaningful and Affordable Insurance Access

Since 2018, the Governor's Office has worked to stabilize New Jersey's health insurance system through preserving minimum essential coverage and a state-level shared responsibility payment (P.L.2018, c.31) and is pursuing a state-based health insurance exchange (P.L.2019, c.141).

Action Steps

▶ To better inform the residents of New Jersey about the Affordable Care Act (ACA) marketplace, as required by the Governor's Executive Order 4 on 01/21/2018, the New Jersey Department of Health will examine reasons for insurance among New Jersey residents; develop overarching, statewide outreach and enrollment recommendations; and inventory and identify Department-specific recommendations to optimize current Departmental screening, outreach and enrollment activities.

▶ NJDOH will promote the Get Covered NJ campaign during the ACA's Open Enrollment in the fall of 2018.

▶ DOH continues to implement Public Law 2017, chapter 153, which requires health care professionals engaged in prenatal care to provide parents of newborns with information on health insurance coverage for newborn children.

STRATEGY #2
Improve the collection, analysis, and application of state-level data on maternal mortality and morbidity

Maternal Data Collection

The starting point for improving the quality of data for benchmarking, planning, informational, and quality improvement purposes is to refine data collection processes. During 2018 and early 2019, NJDOH mapped the flow of maternal outcomes data and identified opportunities to correct deficits and to increase efficiencies.

Action Steps

▶ NJDOH will develop best practices for training of healthcare facility clerks in the timely and accurate completion of the pregnancy checkbox on maternal death certificates. Rollout will be statewide, and the training produced with external partners must have consistent content and, given staff turnover, be readily available on an ongoing basis.

Maternal Data Analysis

To move with shared purpose, the State of New Jersey must be the trusted source for maternal data and best methods. This requires employing national best practices and elevating relevant expertise.

Action Steps

▶ Enhance the New Jersey Maternal Mortality Review Committee (NJMMRC) through representative membership from relevant disciplines and meaningful investigatory powers. Bolstering the NJMMRC is essential to ensuring that pregnancy-associated deaths are correctly categorized and that useful and actional quality improvement recommendations can be generated.

▶ NJDOH will ensure that the NJMMRC receives all pregnancy-associated death cases and relevant data is checked for accuracy and completeness.

Maternal Data Infrastructure

Legislation P.L.2019, c.75, approved 5/1/2019, requires NJDOH to build the data infrastructure for facilitating a data-driven approach towards addressing maternal mortality and morbidity. Technology must be leveraged to increase the pace of data analysis for quality improvement purposes, to connect disparate members of care teams, and to make state data readily available and useful for consumers. Outcomes and progress tracking data generated through the New Jersey Maternal Mortality Review Committee, the New Jersey Maternal Data Center, and other NJDOH data sources will be available to the New Jersey Maternal Care Quality Collaborative and reported broadly at least annually.

Action Steps

▶ For hospital quality improvement purposes, the NJDOH Maternal Data Center (MDC) will publish key maternal healthcare indicators to be shared via a restricted-access portal to subscribed birthing hospitals. The recurrent dissemination of data on a public dashboard will enable multiple stakeholders, researchers and consumers

to understand statewide and hospital-level performance in key birth outcomes. Using the analytic dataset produced in the Maternal Data Center, which contains both the Electronic Birth File and hospital discharge datasets, DOH will perform a thorough data mining process to disseminate hospital-specific outcomes via the Maternal Dashboard and the New Jersey Report Card of Hospital Maternity Care.

▶ The NJDOH Office of Minority and Multi-Cultural Health (OMMH) will ensure that the data published by the MDC is available in both English and Spanish.

Strategy #3
Strengthen community support and improve coordination between community providers and health systems

Perinatal Risk Assessment Expansion

The Perinatal Risk Assessment (PRA) is a universal screening tool used to determine risk factors that could affect a pregnancy, including psychosocial factors, alcohol and drug use,

depression and domestic violence. The PRA supports efficient care coordination and is currently utilized by agencies across the state to refer patients to essential services to support a healthy pregnancy and positive birth outcomes. With the Perinatal Risk Assessment, maternal health conditions, behaviors and experiences before, during, and after pregnancy associated with adverse health outcomes for both the mother and the infant are being identified. The PRA provides information regarding maternal health, behaviors and experiences vital to monitor trends, enhance the understanding of the relations between health conditions, behaviors and health outcomes as well as identify target populations in need of services to prevent adverse pregnancy outcomes.

Action Steps

▶ Increase the utilization and accessibility of the Perinatal Risk Assessment (PRA) to connect families to needed health care, mental health and addiction and community-based services by developing and piloting a re-designed PRA in collaboration with DOH's Healthy Women Healthy Families Program, New Jersey Department of Children and Families, Home Visiting, Central Intake, Health Care

Providers and other service providers. Under P.L. 2019, c. 88, PRA completion will be mandated starting in May 2020 for all pregnant Medicaid recipients and for all pregnant individuals eligible for Emergency Medical Services for the undocumented population.

▶ Advance the integration of the Perinatal Risk Assessment (PRA) as a use case of the New Jersey Health Information Network (NJHIN). Data interoperability can enhance knowledge sharing between different providers of prenatal, labor and delivery, and postpartum care and alert clinical staff of a person's current or recent pregnancy status to inform appropriate care and accurate completion of the pregnancy checkbox on death certificates.

▶ Utilize the Health Women Healthy Families Community Health Worker Workforce to redesign the Community Health Screening Tool for community-based providers to complement the PRA.

Healthy Women Healthy Families Community Health Workers (CHWs)

NJDOH Healthy Women Healthy Families (HWHF) program is essential to improving birth

outcomes statewide. The deployment of Community Health Workers in the community is a component of the HWHF program designed to target populations at risk for adverse birth outcomes. HWHF is a program for childbearing pregnant and non-pregnant women and their families from all races and backgrounds to improve their quality of life. Participants of the program receive individual support from a Community Health Worker. CHWs link families to community resources through a Centralized Referral System. Services provided by the CHW include, case management, the enrollment of women into health-related services such as health insurance, prenatal care, family planning, general health care services, mental health and substance abuse support services and companionship to health care provider appointments. In addition, CHWs are key to connecting families to health and non-health related programs and services such as Doula support (Birth support), Centering Pregnancy (Group Prenatal Care), Breastfeeding and Fatherhood support groups, Home Visiting, Temporary Disability and Family Leave insurance enrollment, WIC services, employment, education and transportation resources, and other programs to empower families for self-care and self-advocacy for

navigating the health care system and community resources.

Action Steps

▶ NJDOH will increase the CHW workforce statewide, establish a standardized training curriculum and certification, and create a payment structure for reimbursement. NJDOH will partner with the New Jersey Department of Labor and Workforce Development to establish a standardized CHW training curriculum and career pathways.

Supportive Case Management

Increased case management through dually trained doulas and community health workers to improve the quality of preconception, interconception, perinatal and postpartum care.

Action Steps

▶ NJDOH will increase enrollment through Central Intake (CI) to Home Visiting/CHW Case-Management statewide with a special focus in areas with high rates of infant mortality.

▶ NJDOH will expand the NJChart Case Management Data Collection System to track case management services and referrals provided by the Community Health Worker.

▶ In accordance with P.L.2019, c.85, signed by the Governor's Office on 5/8/2019, NJDOH and NJ Medicaid, New Jersey Department of Human Service will enable Medicaid reimbursement for doula services.

▶ NJDOH will establish an NJ Doula Statewide Learning Collaborative to facilitate doulas' professional development.

▶ Establish a training mechanism to cross train Community Health Workers and Doula to promote the continuity of care and services for families in New Jersey.

Breastfeeding Initiation and Continuation

Breastfeeding initiation rates are lower for Black women during hospital discharge than other racial/ethnic groups. The federal Patient Protection and Affordable Care Act requires employers to provide reasonable time and space for breast milk expression and requires

insurers to provide coverage of breastfeeding supports and supplies. WIC supports pregnant and breastfeeding women through individual and group education, support from peer counselors and lactation consultants, and online breastfeeding lessons. WIC also offers breast pumps and vouchers for the largest food package to breastfeeding women. P.L. 2019, c. 242 requires certain onsite public lactation rooms, for DOH to provide information and room availability, and for DOE to provide policies in educational settings.

Action Steps

▶ NJDOH will ensure that areas with high rates of infant mortality have at least one "Baby-Friendly Hospital" by 2020. Conduct and publicize evaluation in HWHF sites to assess whether hospitals are continuing to comply with "Baby-Friendly Hospital" requirements.

▶ NJDOH and the New Jersey Breastfeeding Coalition will facilitate the drafting of a State-wide Breastfeeding Strategic Plan to be completed by February 28th, 2020.

▶ NJDOH will collaborate with the NJ Department of Labor and Workforce Development, Office of Strategic Planning

and Outreach to promote breastfeeding legislation in the business industry.

Implicit Bias

DOH has prioritized addressing racism and structural inequities in healthcare settings that adversely impact prenatal, labor and delivery, and postnatal care. The New Jersey Health Equity Tour has already trained over 120 CHWs and is gearing up to equip CHWs with the skills to educate medical providers in their areas to incorporate health equity.

Action Steps

▶ NJDOH will implement "The New Jersey Health Equity Training Tour and Train the Trainer Initiative: Expanding and Scaling Efforts to Lower Infant Mortality Rates in New Jersey". This project will support the New Jersey Department of Health in achieving their goals to provide health equity training for health care providers, staff, stakeholders, partners, and grantees; and to eliminate disparities in birth outcomes across the state. This will be achieved through a training and education tour where participants will learn how to incorporate equity concepts

into their programs, policies, and practices-making them more equitable and effective in improving health outcomes for mothers, infant and families in the state of New Jersey.

▶ NJDOH will work lead an effort to develop best practices for training healthcare providers about effects of racism, implicit and explicit bias on maternal health outcomes through a didactic learning mechanism, with a focus on the case study of maternal care during the prenatal, labor and delivery, and postnatal periods.

Community Supports

Expecting and new parents, especially younger ones, often feel marginalized in their communities. HWHF fosters a community support system so that they can better meet the challenges of pregnancy and new parenthood.

Action Steps

▶ Support community workshops, doulas, fatherhood groups, breastfeeding support groups and community child care in BIM hotspots, through HWHF and other grants.

- Establish community partnerships, such as Community Advisory Boards, through HWHF and other grants.
- HWHF grantees are creating breastfeeding support groups for African-American women in the 8 targeted areas.

Strategy #4
Address the Intersection between Maternal Health, Mental Health and Substance Use

Behavioral Health Support

According to the World Health Organization, Mental Health Conditions ranked seventh (8.9%) among the Leading Underlying Causes of Pregnancy-Related Deaths. These Mental Health Conditions are categorized as Provider Factors and Patient Factors. WHO further classified factors that contribute to Maternal Mental Health Conditions. "The most common classes of provider factors were provider assessment at 25.0% and provider communication at 20.1%. The dominant themes that emerged related to provider assessment were failure to screen and the use

of ineffective treatments. The most common themes for communication were a lack of communication between providers to support coordinated care and a lack of communication between providers and patients/families.

Patient factors comprised 42.1% of the total contributing factors for mental health deaths. There was not a predominant class of patient factors, with classes split across substance use, social support, knowledge, environment, and adherence. Themes that emerged from these classes included lack of adherence to medications or treatment plans, abusive relationships and unstable housing, substance use, absence of social support systems, and not recognizing warning signs and the need to seek care. While these factors were labeled as patient factors, they are often dependent on providers and systems of care". Untreated mental health conditions and substance use are a pathway to adverse Maternal Health Outcomes. Drivers such as racism has been linked to stressors that potentially leads to poor health outcomes.

Action Steps

- NJDOH will collaborate with state agencies such as the NJ Division of Mental Health and Addiction Services (DMHAS), NJ Department of Children and Families (DCF) to integrate Maternal Wraparound services (MWRAP) for women with Substance-Exposed Infants (SEI), DCF Plans of Safe Care program and the NJDOH Postpartum Depression and Mood Disorder (PPDMD) and Fetal Alcohol Syndrome (FAS) Programs.
- State agencies will improve policies regarding prevention initiatives, including screening procedures and substance use prevention or treatment programs.
- DCF, DHS, DOH and the New Jersey Hospital Association (NJHA) will establish non-punitive, uniform screening guidelines for identifying substance-exposed infants and facilitating transitions to Plans of Safe Care.
- NJDOH will facilitate trauma-informed care training for all Maternal and Child Health programs.
- NJDOH will collaborate with stakeholders to enhance increase access and treatment in Maternal Mental programs as well as participate in National initiatives such as the Moving on Maternal Depression Initiative and the Reach Out, Stay Strong, Essentials for mothers of newborns (ROSE) program.

▶ Advance Health Equity, Racism, and Implicit training and in all Maternal and Child Health Programs through a multidisciplinary Train-The-Trainer Model approach.

Strategy #5
Ensure that Social Services and Policies cultivate and support positive birth outcomes

Comprehensive Care for Homeless Women and Families

Pregnancy/childbirth can lead often leads to displacement. There is limited shelter space available which is appropriate for pregnant women and infants. Rigid criteria root out many women who need housing assistance, either because of past housing assistance or limiting definitions of homelessness.

Action Steps

▶ Establish a sub-committee of the State's Homelessness workgroup to facilitate solutions for new/expectant parents and their children, such as broadening definition of homelessness, pilot "Housing

First"-type strategies and exploring including pregnancy in ACO eligibility.

▶ Collaborate with the Department of Community Affairs to establish policies to prevent housing discrimination for families with children and explore a Housing Set Aside structure for families with children.

Social Services

Stressors/implications of pregnancy/new parenthood make meeting the demands of Board of Social Services, such as appointments and paperwork difficult and disrupt/delay services and supports.

Action Steps

▶ Collaborate with the Board of Social Services to address needs of pregnant women/new parents, and change policies to enable easier and more flexible access for new and expecting parents to apply for and receive social services, including transportation services.

Child Care

Parents must work for at least 30 hours per week to be eligible for childcare support. Women looking for a job or who work less than 30 hours per week are ineligible.

Action Steps

▶ Collaborate with state agencies to expand policy or policy flexibility around childcare eligibility, facilitate referrals to Child Care Resource and Referral Agencies, and support community childcare solutions.

Food security for pregnant and lactating women

Hunger and poverty render pregnant/breastfeeding women and their infants vulnerable to malnutrition.

Action Steps

▶ Increase enrollment to SNAP, WIC and SNAP-Ed for expecting and new parents.
▶ Train HWHF grantees in enrolling new/expectant parents to WIC, SNAP and SNAP-Ed

Promote laws that protect nursing mothers in the workplace

The responsibility of breastfeeding while at work falls primarily on the new mother, often leading to challenges with employers or difficulties with continuing to breastfeed.

Action Steps

▶ Increase awareness about workplace breastfeeding legislation and enforce compliance with legislation mandating access to breastfeeding space in public buildings in collaboration with DOL.

Strategy #6
Establish schools as a supportive environment for pregnant teens

Assess current approaches for pregnant and parenting teens

Teen pregnancy often leads to dropping out of school, which leaves young, expecting parents and their babies vulnerable to multiple health risks. Support differs drastically from school to school.

Action Steps

▶ Establish DOH-DOE workgroup to set policies around school supports and conduct needs assessment of school-based supports for pregnant teens by 2020.

Use school-based resources to connect pregnant and parenting teens with needed services

Many CHWs do not have access to schools in their neighborhoods.

Action Steps

▶ Make CHWs accessible to students and school staff through policy change and/or DOE-DOH collaboration.

Increase access to high school and college campus child care

There are limited childcare options at or near schools and colleges.

Action Steps

▶ Ensure that existing programs, such as DCF's Parent Linking Program, are accessible in BIM hotspots.

Strategy #7
Ensure Access to Contraception, in particular LARC methods

Promote immediate postpartum Long-Acting Reversible Contraception

Patients who give birth and wish to immediately begin usage of contraception may choose to have a long-acting reversible contraceptives (LARC) method, such as an IUD or contraceptive implant, inserted in post-partum setting immediately after delivery, as this could be an ideal time for insertion as it is known that the patient is not pregnant.

Action Steps

▶ Medicaid (DHS) has unbundled reimbursement for Labor and Delivery services, thereby enabling reimbursement for LARC insertion in the immediate post-partum period. Now, patients who wish to

have a LARC inserted in the immediate post-partum period can do so without any administrative inhibitions on the part of the payer.

▶ DOH will collaborate with DOBI in order to ensure that all insurance plans unbundle the reimbursement for Labor and Delivery services to enable reimbursement for LARC in the immediate post-partum period.

▶ DOH and the NJ Hospital Association will collaborate to enable providers and hospitals to stock LARC devices so that if a patient wishes to use LARC as her method of contraception and wishes to have it inserted immediately after delivery, there are device on hand at the hospital.

Reduce access barriers to LARC at family planning agencies

Patients who do not wish to become pregnant may seek contraception, such as a LARC device, at publicly-funded family planning provider agencies that are part of the New Jersey Family Planning League.

Action Steps

▶ DOH, through an appropriation in the State Budget combined with other funds, will continue providing grants-in-aid to family planning agencies that provide high-quality, comprehensive reproductive health and family planning services. In State Fiscal Year 2019, DOH provided $9.553m in grants in aid that allowed for 4 sites to add family planning services and 1 completely new site to open, bringing the total of state-funded family planning providers to 46.

▶ DOH will facilitate partnership between the family planning providers and the producers and distributors of LARCs to eliminate the waiting period patients may experience between the decision to use LARC as their contraceptive method and when the clinician is able to insert the LARC. Often, because of the high up-front cost of LARC devices, providers do not keep LARCs stocked on site, and thus a patient could have to return for a second visit in order to have the device inserted. This can be a barrier for patients who wish to have a contraceptive method that can be active immediately.

▶ DOH will explore opportunities to implement telehealth for contraceptive counseling so patients who choose LARC as their method of family planning can have their contraceptive counseling appointment virtually, and then only present once at a service site for the insertion, thereby eliminating the barrier of multiple appointments.

Increase Provider Education in Contraceptive Methods, including LARC methods, and shared-decision making

Increasing practitioner knowledge of contraceptive products, especially LARC products, for which patients could be eligible, and how to properly administer the method or insert the devices will help ensure that patients are able to access their chosen method of contraception, including LARC methods, without inhibition by a practitioner who is not education on a particular method of contraception or its administration or insertion. Included in provider education should be training on the shared decision-making model to ensure patients are

exercising autonomy in selecting their preferred method of contraception.

Action Steps

▶ DOH, in collaboration with the Board of Medical Examiners (BME) and NJ Healthcare Quality Institute, will offer CME credits to providers on topics such as LARC product innovations, insertions, contraception counseling, and shared-decision making.

▶ DOH will work with external partners to conduct grand rounds at hospitals and at publicly-funded family planning agencies to educate physicians about LARC insertion in the post-partum period.

Ensure a range of contraceptive options are available

Increasing patient knowledge of contraceptive options will lead to patients selecting a contraceptive method that works best for their life style and contraceptive needs.

Action Steps

▶ DOH will conduct a series of social media awareness campaigns to inform the public

about contraceptive options and where to access contraceptive counseling.

▶ DOH will update the website of the Office of Women's Health to include resources about how to access contraceptive counseling, as well as contraceptive services.

Strategy #9
Create and support access to 17 Alphahydroxyprogesterone Caproate (17P)

Increase availability of 17P communities with high rates of preterm birth

The risk of early spontaneous preterm birth (sPTB) is of particular concern secondary to high morbidity and mortality between 25 weeks to 34-36 weeks gestation. The two counties in New Jersey with highest rates of spontaneous preterm birth (sPTB) are Atlantic and Essex.

Action Steps

▶ DOH will increase administration of timely initiation of alpha-hydroxyprogesterone caproate/17P Makena therapy.

Increase awareness about 17P as a treatment option

Decrease barriers to medication initiation and adherence and increase patient adherence. Increase patient awareness of the benefits to treatment to prevent preterm birth.

Action Steps

▶ DOH has assembled a Leadership Team of Perinatologists and Obstetricians serving Essex and Atlantic Counties. This core group is responsible for distribution and overseeing prescription dispensing and administration to eligible patients. The group will also perform Grand Rounds at their respective hospitals and Medical Societies to ensure provider education is consistent among physicians.

▶ DOH has initiated conversations with NJ Transit ACCESS Link to enable patients seeking the 17p intervention to access

free transport services pilot target counties (Essex and Atlantic).

▶ DOH will work with of Mahmee to increase patient awareness of the intervention. Mahmee is a web-based software product that supports pregnant women to access and share medical information with providers across the platform throughout their pregnancy and post-partum. Mahmee has been shown to be effective in other jurisdictions, especially given its web-enabled platform.

▶ DOH will continue to work with Medicaid (DHS) to identify and implement cost-saving measures to ensure that cost will not prohibit patients from receiving 17P. Additionally, DOH will continue to work with pharmacies to deliver a more cost-effective version of the injection to providers and patients.

▶ Improve identification through screening among obstetricians, perinatologist, nurse practitioners and certified nurse-midwives.

Mental Health & Substance Use

HEALTHY NEW JERSEY 2020 OBJECTIVES

▶ **Reduce suicide rate per 100,000 population**

New Jersey rate: 8.7 (2017)

Goal: 5.9

▶ **Reduce drug-induced deaths per 100,000 population**

New Jersey rate: 30.7% (2017)

Goal: State agencies are currently developing milestones to increase access to evidence-based interventions to prevent substance use, misuse and addiction; enhance protective factors and reverse or reduce risk factors; and decrease the supply of opioids.

ENGAGEMENT PROCESS

CORE TEAM

PARTNERS

EXPERTS

Regional Coalitions

Municipal Alliances

Youth Advocates

Mental Health Administrators

State Epidemiological Outcomes Workgroup

County Drug and Alcohol Directors

Children's Interagency Coordinating Councils

Law Enforcement

- Division of Mental Health & Addiction Services, *New Jersey Department of Human Services*

- New Jersey Behavioral Health Planning Council, *Division of Mental Health & Addiction Services, New Jersey Department of Human Services*

ACTION PLAN

STRATEGY #1:
Strengthen and support community prevention

Advance existing collaborative mental health care partnerships

New Jersey boasts an extraordinary network of community substance use prevention and mental health support professionals and volunteers, including Regional Prevention Coalitions, overseen by the Division of Mental Health and Addiction Services in the Department of Human Services (DMHAS) in collaboration with the New Jersey Prevention Network (NJPN) and the Municipal Alliances, overseen by the Governor's Council on Alcoholism and Drug Abuse (GCADA), as well as County Drug and Alcohol Directors (CADADs) and County Mental Health Administrators. DMHAS provides staff support for each of these groups. DMHAS, GCADA, NJPN and Rutgers University Center for Prevention Science comprise New Jersey's Prevention Collaborative.

The combination of coalitions' professionalism and alliance volunteers' contextual knowledge and energy facilitates evidence-based, community-led efforts to engage NJ's diverse public in preventing/addressing substance use. DMHAS, NJPN and GCADA's prevention collaborative coordinates local planning, facilitates trainings, promotes sharing of data, engaging critical populations such as grandparents and youth, developing culturally sensitive resources and adapting local priorities to address emergent substance use trends.

Action Steps

▶ New Jersey's Prevention Collaborative will launch a prevention alignment process and mandate the use of state and county prevention logic models by August 2019, which will increase and improve tracking of coordination of prevention efforts statewide. The logic model will guide local prevention stakeholders with Evidence-Based Practices (EBPs) and grassroots solutions. The State will prioritize the integration of local representatives in

state-level committees and work groups that address challenges related to mental health and substance use.

Fight mental health stigma

GCADA's 2014 "Addiction Does Not Discriminate" campaign has helped communities and professional networks address substance use, trauma and mental illness, as well as overcome denial/disbelief around the existence of local substance use, ineffective prevention approaches, risk misconceptions and institutionalized stigma that negatively impacts individuals' likelihood of receiving quality services.

Action Steps

▶ DMHAS, NJPN and GCADA will continue to support expand stigma-free campaigns in new arenas, such as college campuses, and encourage local youth and parents to lead prevention efforts in their communities. NJDOH will support emergent stigma-related challenges such

as encouraging harm reduction, highlighting the relationship between trauma, substance use and mental health, and relapse as part of the process toward recovery. DMHAS and GCADA will continue to support expand stigma-free campaigns in new arenas, such as college campuses, and encourage local youth and parents to lead prevention efforts in their communities. NJDOH will support emergent stigma-related challenges such as encouraging harm reduction, highlighting the relationship between trauma, substance use and mental health, and relapse as part of the process toward recovery.

▶ DMHAS, led by the Disaster and Terrorism Branch (DTB) will provide training in Mental Health First Aid (MHFA) and Question, Persuade, and Refer (QPR) for Suicide Prevention to populations who interact and work with adolescents and young adults. Two Youth MHFA trainers and three MHFA trainers will be certified by September 2019. Between 09/30/2018-09/29/2021, there will be 24 sessions offered annually, with approximately 600 persons trained per year. At the end of three years, approximately 1,650 individuals will be trained on MHFA.

▶ DMHAS-DTB will provide training in Question, Persuade, and Refer (QPR) for Suicide Prevention to a variety of populations who interact and work with adolescents and young adults. Five trainers will be certified for QPR. Four QPR trainings will be offered each month between 09/30/2018-09/29/2021 with an approximately 960 participants trained annually. By September 2021, a total of 2,640 individuals will be trained in QPR suicide prevention.

▶ To enhance mental health awareness and suicide prevention among veterans and first responders, DTB will offer a forum annually to at least 80 Active duty military, Reservists, veterans and first responders. By September 2021, over 240 participants will take part in the forums.

Support harm reduction for injecting drug users

NJDOH provides support and oversight to seven harm reduction centers in areas with high concentrations of injection drug use. Harm Reduction Centers include syringe access programs (SAPs), as well as outreach and drop-in services for at-risk populations.

Action Steps

▶ NJDOH will provide staff support and continued education so that harm reduction centers can continue and increase their work with specific and/or marginalized populations such as LGBTQ youth, characterized by sharp increases in substance use and suicide.

▶ NJDOH will continue to promote harm reduction strategies with the goal of opening three new centers.

STRATEGY #2
Increase opportunities for early intervention

Integrate mental health into pediatric primary care settings

While mental health screening is increasing, pediatricians still do not sufficiently screen for mental illness, substance use or trauma.

Action Steps

▶ Increase use of standardized mental health screening tools such as Adverse Childhood Experiences (ACEs) in settings such as schools, Federally Qualified Health

Centers (FQHC) and harm reduction centers.

▶ NJDOH will provide support and continued education so that harm reduction center can continue to 1) increase the range of services offered at harm reduction centers so as to provide those who use drugs with connection to the medical and supports needed and 2) focus their work on specific populations who are marginalized and facing increased vulnerability to substance use and suicide.

▶ DOE and CSOC will increase mental health first aid and SBIRT trainings in schools

▶ Develop non-punitive, uniform NAS screening guidelines as a collaboration between DHS, DCF, DOH and the New Jersey Hospital Association (NJHA)

STRATEGY #3
Expand access to evidence-based, integrative, trauma-informed behavioral health services

Advance promising coordinated care service delivery models

The State successfully piloted multiple models for providing integrative behavioral health services, including Certified-Community Behavioral Health Centers (CCBHCs) and maternal Wraparound services (MWRAP).

Action Steps

▶ DMHAS will lead efforts to establish sustainable solutions for continuing integrative care models beyond the completion of their pilot dates. MWRAP, for example, will be scaled statewide by 2020.

Medication-Assisted Treatment and financing

MAT is an evidence-based approach to support individuals with SUD from treatment through recovery. The State has placed MAT at the heart of its opioid response, but to date, there have been a low incidence of PCPs participating in substance use disorder treatment, particularly MAT, due to lack of reimbursement, a lack of experience and knowledge treating these conditions and/or perceived barriers to providing treatment.

Action Steps

▶ Establish Office-Based Addictions Treatment (OBAT) as a Medicaid reimbursable service 2019. OBAT is designed to enhance access and improve utilization of non-methadone medication-assisted treatment (MAT) services for Medicaid beneficiaries by establishing additional supports and reducing administrative barriers such as prior authorization requirements for primary care providers (PCP) providing these addiction services.

▶ DMHAS will train 1,080 (540 North and 540 South) new prescribers (Physicians, APNs, Physician Assistants) to administer MAT through the DMHAS Buprenorphine Waiver Training Initiative.

▶ Medicaid will mandate behavioral health standards for Managed-Care Providers by 2020.

Promote OBAT as a Medicaid reimbursable service

Peer specialists and patient navigators work with patients with substance use disorder (SUD) to establish a comprehensive, individualized treatment plan that addresses

non-medical factors that have an impact on SUD treatment, such as connecting patients with social services organizations, recovery supports, family education and referrals to alternate levels of care, establish relationships with community addiction counselors and additional consultative services.

Action Steps

▶ Peer-support and navigator services will become covered by Medicaid on July 1, 2019 to address psychosocial issues related to SUD treatment and assist with recovery including housing, transportation or employment, as part of the OBAT MATrx service enhancements. DMHAS will train 1,080 (540 North and 540 South) new prescribers (Physicians, APNs, Physician Assistants) to administer MAT through the DMHAS Buprenorphine Waiver Training Initiative.

Streamline licensing processes for integrated care settings

Primary care practitioners cannot bill for mental health services and many psychiatrists do not accept insurance, rendering the

requirement for mental health parity insignificant. Currently, primary care, mental health, and substance use disorder fall under three separate licenses with separate and distinct regulations. The State has committed to developing an integrated medical license so that individuals can receive treatments for mental health, substance use and primary care under one roof and have their expenses covered by their insurance.

Action Steps

▶ NJDOH will authorize a single license system to allow provision of holistic and integrated care to those with substance use disorders by 2020. DOH is in the process of developing an integrated licensing system per NJSA 26:2H-5.1g. DOH performs a comprehensive regulatory review and reorganization that will streamline the licensure process for facilities and move towards integrated primary, mental health, and substance use care. By December 31st, 2019, DOH will release guidance for substance use and mental health facilities around licensure fees, the sharing of clinical space, and the granting of deemed status. DOH also is bolstering the technology infrastructure to support streamlining the processes for

licenses, fees, surveys, paperwork, staffing, strategic plans, long-term goals and technologies.

▶ NJDOH will provide waivers for Ambulatory Care Facilities to share clinical space for behavioral health services and to provide Medication Assisted Treatment by 2020 and explore making additional provider communities such as EMS first responders eligible to provide MAT.

STRATEGY #4
Ensure availability of detox and enhance detox services to treatment and recovery programs

Naloxone accessibility

The State's emphasis on Narcan availability has enabled all EMS first responders and police officers to carry NARCAN, preventing overdose deaths every day.

Action Steps

▶ The State will ensure continued availability and accessibility of NARCAN until the

epidemic recedes, and continue to train newer populations, such as peers in Narcan administration by 2020. NJDOH will provide waivers for Ambulatory Care Facilities to share clinical space for behavioral health services and to provide Medication Assisted Treatment by 2020 and explore making additional provider communities such as EMS first responders eligible to provide MAT.

5 Minutes to Help

The NJDOH Office of Emergency Medical Services (OEMS) developed and piloted "5 Minutes to Help" in 2019 to train EMS first responders to more effectively refer non-fatal overdose victims to treatment.

Action Steps

▶ OEMS will provide "train the trainer" workshops in each of the State's 21 counties by August 31st, 2020, through the CDC-funded Data-to-Action initiative. OEMS will supplement these workshops by posting an online version of the training OEMS' website.

Opioid Overdose Recovery Program

The Opioid Overdose Recovery Program (OORP) ensures that overdose victims in all of NJ's 21 counties have access to recovery specialists' peer support and patient navigators.

Action Steps

▶ OORP demonstrates a successful model of treatment and recovery. The State will make OORP 24/7, and increase availability for all substance use-related admissions, not just emergency department/overdose victims by 2020.

Treatment rather than incarceration

NJ's law enforcement community increasingly emphasizes treatment over incarceration for substance use, facilitating treatment through initiatives such as Operation Helping Hand and Blue HART. The Heroin Addiction, Recovery and Treatment (HART) program enables individuals actively using substances to walk into police stations and request to be taking in to treatment. Ocean County initiated Blue HART in January 2017. Additional counties, including Bergen and Burlington, currently

implement the program, as well. The program provides a pathway toward treatment prior to overdose, with the local police station arranging for clinical assessment and space in a treatment center (in limited instances, Ocean has flown users to treatment when local facilities lacked space). : Individuals from five counties – Union, Bergen, Sussex, Morris and Passaic – who are arrested for possession of heroin and other narcotics are offered access to recovery specialists and treatment.

Action Steps

▶ The Attorney General's Office will expand Operation Helping Hand to all 21 NJ Counties through the CDC-funded Overdose Data-to-Action initiative (OD2A).

▶ Blue HART allows individuals using illicit drugs to present at police stations to all counties. Once there, they are ushered into treatment. Police follow up for 48-72 hours once admitted. The HART program currently exists in Ocean and Monmouth counties. At least three more counties will expand Blue Heart by 2020.

Mental health and SUD care for inmates

NJ's law enforcement and criminal justice community has recognized its unique opportunity to provide inmates mental health and/or SUD with integrative health services. The Department of Corrections, in collaboration with DMHAS, currently offers multiple case management/integrative care programs for prison inmates; one prison (men) functions as a licensed treatment center, and another has a wing that provides full integrative care for women inmates.

Action Steps

▶ NJ's County Drug and Alcohol Directors (CADADs), in collaboration with their County Prosecutors, will integrate lessons learned from the successful integrative health prison program to county jails, including MAT and case management. All counties will have a MAT program by 2020.

STRATEGY #5
Increase and improve behavioral health support for children in schools and the community

Children's System of Care

NJ's Children's System of Care (CSOC) continues to integrate evidence-based practices across the service continuum in both the OOH and community-based services, facilitate better outcomes for youth through increased collaboration among system, family and other partners, disseminate CSOC principles and core values throughout the service array, strengthen and expand youth and family peer support and expand integrated physical health care and BH for youth by infusing integrated care and wellness activities across the CSOC continuum.aw enforcement and criminal justice community has recognized its unique opportunity to provide inmates mental health and/or SUD with integrative health services. The Department of Corrections, in collaboration with DMHAS, currently offers multiple case management/integrative care programs for prison inmates; one prison (men) functions as a licensed treatment center, and another has a wing that provides full integrative care for women inmates.

Action Steps

▶ Measure the # of SAMHSA Promising Path to Success trained providers in the State

▶ Revise the system partner training curriculum to meet learning objectives

▶ Convene an external advisory group to encourage stakeholder feedback and promote collaboration.

▶ Integrate the Child Adolescent Needs and Strengths (CANS) assessment tool to monitor outcomes

▶ Add Family Support Organization (FSO) activities to the Medicaid platform

▶ Provide a direct connection for youth and families to the DCF-Office of Youth and Family Voice

▶ Expand existing integration models and explore addition of new ones

School Substance Abuse Coordinators

Schools' Substance Use Coordinators (SACs) work with local youth coalitions and are adopting increasingly creative and less punitive approaches to build resilience, prevent harmful consequences of substance use, curb stigma and address mental health challenges in schools.

Action Steps

▶ Continue to Integrate substance use prevention programs for all years, k-12, engaging staff such as bus drivers, school librarians and nurses

Children's Interagency Coordinating Council

Children's InterAgency Coordinating Councils (CIACCs) enable families with children in CSOC to navigate the system. Still new, CIACC is not yet known to many families in need of its services.

Action Steps

▶ Continue CSOC will promote CIACC through its website, presentations at pediatric collaboratives and other educational partnerships.

In-school counseling

While counseling services for children and youth tend to be inaccessible due to both cost and geography, several counties provide in-school counseling through the mental health clinics and YMCAs, funded by Medicaid and/or grants.

Action Steps

▶ The State should publicize and incentivize county best practices for integrating counseling on school premises and during school hours, ensuring that each county adopt best practices from others.

STRATEGY #6
Increase data capacity and coordination to enable surveillance and identify emergent threats

Real-time surveillance of emerging substances

The substance use landscape is rapidly changing, and authorities are detecting emergence/re-emergence of substances like cocaine and methamphetamines. Data-sharing efforts such as the Drug-Monitoring Initiative (DMI), IPHD, and DOH's Opioids Data Dashboard enable real-time surveillance.

Action Steps

▶ The State will publish guidelines and standard data-use agreements (DUA) for data-sharing by 2020.

▶ The Opioid Data Dashboard will incorporate three additional datasets by 2020

▶ DOH will incorporate emergent threats in the Behavioral Risk Factor Survey (BRFS)

▶ The NJDOH Center for Health Statistics, in collaboration with the Office of the State Medical Examiner, will enhance analysis of death data and toxicology to improve surveillance of overdose deaths, through ESOOS

▶ The NJDOH Communicable Disease Services Unit (CDS) will integrate all 78 of NJ's emergency departments into the EpiCenter system, to ensure that triage data on substance use-related ED visits are provided to the CDC and inform local hospital prescription practices.

Fatality Review Teams

Fatality Review Teams utilize a methodological approach examining the interaction of the complex systems of residents including their

family history, environment, and autonomous agents of impact (experiences). The analysis of these collective systems provides a conceptual framework for local substance use disorder and overdose, using a "social autopsy" process which reviews individual and system trends experienced by an overdose decedent and countywide data collection efforts on the opioid epidemic.

Action Steps

▶ The NJDOH Office of Local Public Health (OLPH), in collaboration with HIDTA, will facilitate the launch of five Overdoes Fatality Review Teams (OFRT) in 2020, and strengthen the State's existing OFRTs in Ocean and Monmouth Counties. NJACCHO will facilitate integrating conclusions of OFRTs in local regional coalitions' substance use prevention efforts.

Services and support for homeless individuals with SUD

NJDOH-Healthcare Quality and Informatics (HQI) conducted a substance use needs assessment of the homeless population in 2019 in collaboration with seven facilities that serve the homeless statewide, to identify

critical areas of intervention for improving supports and services that strengthen linkages to care and help homeless individuals navigate the cycle between homelessness and substance use.

Action Steps

▶ NJDOH will provide recommendations to the State to improve services and supports for homeless individuals struggling with substance use, based on the 2019 needs assessment.

▶ NJDOH will focus on increasing Narcan availability in Narcan 'deserts', i.e., select, large NJ cities with a high percentage of low income residents and persistently high rates of opioid overdoses.

Monitoring of Substance Use among Youth

Schools' "Active Consent" requirement for surveying school children limits data collection. Currently, accessibility of Active Consent forms varies from school to school. State agencies and prevention stakeholders increasingly support a transition to "Passive Consent," allowing surveying unless parents opt out.

Action Steps

▶ The State Epidemiological Outcomes Work Group (SEOW), in collaboration with NJPN and the DOE, will form a sub-committee to provide recommendations to the State regarding whether and how to facilitate better data collection, including a transition to "Passive Consent."

Strategy #7
Provide evidence-based quality improvement in varying aspects of clinical care delivered across the State's psychiatric healthcare system (NJ State Psychiatric Hospitals)

Transition into a Single System of Care

The State of New Jersey's three (3) regional psychiatric hospitals (Ancora, Greystone Park, and Trenton) and one (1) forensic center (Ann Klein), which collectively comprise New Jersey's Psychiatric Healthcare System (NJPHS) predominately serves individuals who are involuntarily committed as they have been deemed a danger to themselves and/or others due to a mental illness. The NJPHS plays a

major role in the continuum of wellness and recovery services for the residents of New Jersey, which subsequently assists in the successful reintegration of individuals back into the broader society after rehabilitation.

Action Steps

▶ Creation of 18-month Action Plan geared to strengthening the system-wide oversight of the State's four (4) psychiatric facilities into a single psychiatric healthcare system.

▶ Establishment of the Division of Behavioral Health Services (DBHS) to provide oversight of the State's psychiatric hospital system.

▶ Identification of key staff to lead the transformation of the hospitals with the focus of transitioning to a unified system of care, while addressing system-wide and individual challenges in governance and administrative functions, clinical care, and physical plant maintenance.

Recruitment and Retention

Identify how staffing impacts the system's operation and provision of patient care, specifically as it relates to recruitment and retention.

Action Steps

▶ Conducted a full assessment of each hospital's staffing plans and needs as it relates to critical clinical positions and their relation to increased service levels and quality of care.

▶ Develop a recruitment and retention strategy geared to the identified critical positions.

Governance and Administrative Functions

Review and assess the structure and functions surrounding clinical and medical governance. As a result, set clinical governance initiatives that would assure that practice follows standards of care across the State's psychiatric healthcare system, regardless of the practitioner.

Action Steps

▶ Develop/Identify a systematic approach that will assist in reviewing current processes and determining if they are not benefiting the patients and subsequently replacing such services with those of value.

▶ Develop and implement a standardized credentialing process across the system that will establishing a standard practice for qualifying licensed physician specialists and psychiatrists as it relates to providing clinical services at the State's psychiatric facilities.

▶ Develop and implement quality assurance competency training that will ensure that all staff are trained in the same baseline skills and competencies as it relates to the Joint Commission and the Center for Medicaid & Medicare Services standards for improving patient safety.

Clinical Care

Ensure that patients are receiving clinical care that reflects the latest, evidence-based behavioral healthcare. Consistent adherence to the most up-to-date practice standards, while maximizing face-to-face time between clinicians and patients, speaks to the most important priority of enhancing clinical outcomes and ensuring safe transitions of care to community settings.

Action Steps

▶ Reengineering of varying clinical treatment services to assess treatment type and duration to assist in preparing

patients to reintegrate into the general population

▶ Enhancement of trauma-informed services to allow for treatment that will assist the patient in identifying and coping with past and current trauma as they prepare to integrate into the general population

▶ Enhancement of treatment and clinical services that assist patients in learning and implementing personal skills/coping mechanisms that will allow for them to successfully function in the broader community.

For additional information regarding the **NJDOH State Psychiatric Hospital Plan**, please reference the Division of Behavioral Health Services website at: https://www.nj.gov/health/integratedhealth/hospitals/.

Nutrition, Physical Activity, & Chronic Disease Prevention

HEALTHY NEW JERSEY 2020 OBJECTIVES

▶ **Prevent an increase in adult obesity**

New Jersey rate: 27.0% (2016)

Goal: 27.0%

▶ **Reduce current smoking by adults**

New Jersey rate: 14.2% (2016)

Goal: 12.4%

▶ **Reduce coronary heart disease deaths per 100,000**

New Jersey rate: 101.4% (2017)

Goal: 94.3

ENGAGEMENT PROCESS

CORE TEAM

PARTNERS

EXPERTS

- New Jersey Supplemental Nutrition Assistance Program Education (SNAP-Ed), *Division of Family Health Services, New Jersey Department of Health*

- State Nutrition Action Council (SNAC), *New Jersey Department of Human Services*

SNAP recipients

Food pantry clients

Healthy Communities

YMCA

Mayors Wellness Campaign

Rutgers Cooperative Extension

Center for Food Action

ACTION PLAN

STRATEGY #1
Increase access and consumption of fresh fruits and vegetables by low-income families

Promote farmers' market fruit and vegetable purchases

NJ has over 130 Farmers' Markets; currently only 50 are registered SNAP vendors and of the over 10,000 farmers, only 183 are WIC approved vendors. As of 2017, WIC is open access; there are no longer restrictions on the number of stores that accept WIC. SNAP-Ed, The Healthy Communities Network and others support farmers markets as critical to the mix of local sites supplying access to local fresh fruits and vegetables. Activities, such as food demonstrations, offer market customers an opportunity to taste seasonal produce and bring home recipes. Governor Phil Murphy signed an act establishing a two-year pilot program aimed at providing increased access to fresh and affordable produce in food desert communities. The act mandates partner markets accept food vouchers, offer reduced priced produce packages, and donate any surplus produce.

Action Steps

▶ As of 2019, Farmers Markets will be able to approve "non-traditional farmers," e.g., farms that are less than 5 acres as WIC vendors

▶ Increase SNAP redemption rates at Farmers Markets.

▶ Increase WIC Cash Value Voucher redemption rates.

▶ Increase the amount of affordable produce in food desert communities.

▶ Promote initiatives that support local fresh fruits and vegetable sales and consumption such as the Department of Agriculture's Jersey Fresh and Sustainable New Jersey's Buy Fresh Buy Local programs.

▶ Increase the number of SNAP/WIC recipients that participate in nutrition education at Farmers' Markets.

STRATEGY #2
Increase access to healthy food options at food banks and food pantries.

Invest in client choice pantries

NJ has three major food banks that serve hundreds of food pantries across the state. A small percentage of pantries offer consumers the opportunity to select the products they will bring home to their families. This consumer "choice" model supports best practices to promote and distribute nutritious foods. The Community Food Bank of NJ, for example, draws new residents to the area so that they will be eligible to access a "choice" food pantry. Farms in NJ partner with food pantries and SNAP-Ed providers. For example, food pantries, local programs and farms will plan summer crops together and coordinate distribution. Specific farms in the State grow produce for the sole purpose of donating it.

Action Steps

- Increase the number of consumer "choice" food pantries
- Explore additional funding to support the purchase of items such as, shelving and refrigeration units for the display and storage of fresh fruits and vegetables.
- Increase the amount of healthy food options donated to food banks.
- Increase the number of mobile food pantries offering healthy food options in rural and urban areas.
- Explore funding/legislation offering incentives to farmers that donate to local pantries.
- Increase the number of low-income children and families who participate in nutrition education programming.

Teach nutrition education to low-income families and individuals

SNAP-Ed, YMCA, Greater Newark Healthcare Coalition, the Rutgers Cooperative Extension and others coordinate and provide nutrition education, recipe demonstrations and cooking classes at WIC centers, health clinics, farmers markets, schools, community organizations' mobile food pantries and food banks. There are classes targeted toward children, teens,

adults and seniors, in multiple languages. Mayors Wellness Campaign provides curricula so community members can lead and adapt classes to local needs.

Action Steps

- Increase the number of nutrition education classes targeted toward populations in need, in multiple languages.
- Increase the number of recipe demonstrations in mobile clinics, in multiple languages.
- Expand social networks, so that classes and services can spread through word of mouth to additional populations in need.
- Increase the number of students that participate in nutrition related activities such as Farm to School/Preschool, cooking classes and nutrition education.
- Increase the number of schools/Preschool that provide Farm to School/Preschool activities.

STRATEGY #3
Increase enrollment in SNAP and WIC.

Address hunger among college students

Governor Phil Murphy signed the "Hunger-Free Kids Act" on May 9th, 2019. The Hunger-Free Kids Act address food insecurity among students enrolled in public institutions of higher education. The act mandates the establishment of Hunger-Free Campus Grant Program that will allow for campuses to address student food insecurity by supporting enrollment in SNAP, creating food pantries, and developing meal credit sharing program.

Action Steps

- Increase the number of students enrolled in SNAP.
- Increase the number of "Hunger-Free Campuses".
- Increase the number of food pantries located on college campuses.
- 12 Increase the number of campus credit sharing programs.

Streamline WIC and SNAP eligibility and enrollment processes

Completing the application process for WIC and SNAP can be cumbersome and redundant for vulnerable individuals and may lead to

lower participation rates. Many states have streamlined the income eligibility process for various benefit programs including, WIC, SNAP, Medicaid and Temporary Assistance for Needy Families (TANF).

Action Steps

▶ Explore opportunities to streamline the enrollment process for various benefit programs including WIC and SNAP.

Minimize barriers to recruiting WIC- and SNAP eligible non-participants

Awareness of programs is often dependent on word of mouth, so specific communities or marginalized individuals get left out.

Action Steps

▶ Publicize information about programs and enrollment in additional languages, at different locations and among additional age and population groups

▶ Encourage partner organizations to promote SNAP/IC enrollment.

STRATEGY #4
Increase the number of children participating in the USDA Child Nutrition Programs

Nutrition assistance to children and adults through meal service programs.

The National School Lunch Program, School Breakfast Program, Child and Adult Care Food Program, Summer Food Service Program, Fresh Fruit and Vegetable Program, and Special Milk Program are critical food security interventions. For some, they offer the only full meals they receive daily. The "breakfast after the bell" act requires public schools with 70 percent student eligibility develop a "breakfast after the bell program". Currently, only 44 percent of low-income children in New Jersey receive breakfast from this program.

Action Steps

▶ Increase the number of schools offering breakfast after the bell.

▶ Increase participation rates in the School Breakfast program.

▶ Increase participation rates in the National School Lunch Program.

▶ Increase participation rates in the Child and Adult Care Food Program.

▶ Increase the number of Wellness Policies that include "standards and nutrition guidelines for all foods and beverages" in schools that participate in the USDA Child Nutrition Programs.

Provide nutritious meals to low-income children during the summer

A recently enacted NJ statute requires every school district in which 50 percent or more of the students enrolled in the school district are eligible for free or reduced priced meals under the national School Lunch Program or the School Breakfast program must become a sponsor of the Summer Food Service Program.

Action Steps

▶ Increase participation in Summer Food Service Program.

▶ Increase the number of feeding locations.

▶ Increase the number of approved sponsors including school districts and local organizations.

▶ Increase tracking of the implications of hunger on student health and academic performance.

STRATEGY #5
Strengthen community food security supports

Assess the impact of community gardening projects

Communities can reduce some barriers for local residents by providing access to affordable fresh fruits and vegetables. Although many community gardens are prevalent in NJ, low-income communities could benefit from addition gardens. Participants appreciated them and expressed hope that they would continue and be expanded.

Action Steps

▶ Conduct a needs assessment of NJ's community garden.

Improve delivery of information about healthy eating habits

Poor childhood eating habits are related to lack of parental information around how to cultivate and sustain healthy eating habits among children. While there are programs for parents, it can be challenging to get busy parents to come out to events and workshops. Grandparents, as well, are often responsible for preparing foods for grandchildren, but many are unaware how to make healthy foods they'll agree to eat in current food environment. SNAP-ed and other education programs can address these needs.

Action Steps

▶ Parenting classes should integrate nutrition and food preparation. Prizes and incentives have been effective at increasing participation in events and workshops. Program staff should continue to engage community members to understand how to increase participation.

▶ Involve fathers, who are taking on an increased role in parenting. Groups targeted toward grandparents raising grandchildren would be helpful, as well.

▶ Utilize partnerships with FQHCs to help increase participation in groups, such as SNAP-Ed classes. FQHCs will include SNAP-

Ed staff in clinical meetings to inform medical staff of existing programs.

STRATEGY #6
Increase healthy food options at corner stores, and transportation to supermarkets

Access to healthier food retail

The Healthy Corner Store Initiative works with small retailers to expand the number of healthy food options, and currently includes over 150 stores. State and private organizations such as the Department of Health, Department of Human Services, Department of Agriculture, The Food Trust, The Mayors Wellness Campaign, the American Heart Association/ American Stroke Association, The NJ YMCA State Alliance, and the New Jersey Healthy Communities Network have worked to expand efforts throughout the state. The Healthy Small Food Retailer Act passed, although no funding was attached.

Action Steps

▶ Align the development plan for The Healthy Small Food Retailer Act with the corner store work of SNAP-Ed and

advocate for funding to support implementation.

▶ Develop a system for, and partnerships with, participating corner stores to track the purchase of healthy foods.

▶ Explore options to engage supermarket in Food Deserts.

▶ Partner with the local municipalities and the New Jersey Department of Transportation to explore low-cost/free transportation to supermarkets for residents living in Food Deserts.

STRATEGY #7
Increase Access to Opportunities for Physical Activity

Transportation systems and active transportation

Transportation is a barrier to physical activity; areas lacking good public transportation limit people's ability to reach gyms/parks. In general, walkability is limited in rural and suburban areas. Many towns lack bike paths; many lack sidewalks. County Master Plans offer opportunities to address these barriers.

Action Steps

▶ The State should be more engaged in promoting Complete Streets and Safe Routes to School.

▶ Encourage health insurance/Medicaid to cover the transportation to the gym, as well!

▶ Partner with the local municipalities and the New Jersey Department of Transportation to explore low-cost/free transportation to recreational activities for resident living in low-income communities.

Physical activity participation for persons with limited mobility

Many individuals with disabilities and seniors have time for physical activity, but often cannot get to activities. In absence of healthy recreation, solitude leads to sitting at home, watching TV and eating. Lack of social engagement and physical activity can lead to isolation and negative health outcomes. Family Success Centers and faith-based organizations are great resources and can partner with other local organizations to enable physical activity, especially during winter months or for

populations with limited access to gyms/parks, like seniors.

Action Steps

▶ Increase the number of community partners and housing facilities that offer opportunities for modified physical activity.

▶ Partner with the Division of Disability Services to increase opportunities for individuals with disabilities to have access to modified physical activity.

▶ Partner with the Department of Aging Services to increase opportunities for individuals with disabilities to have access to modified physical activity.

Parks after dark

NJ has hundreds of thousands of acers of state and national parks. However, many residents in low-income or high-crime areas are nervous about being or allowing their kids to use the community parks, especially after dark. Some neighborhoods will have a community police car stationed next to the park. This, residents say, makes them feel safer.

Action Steps

▶ Increase the number of communities that partner with local resources, such as the police, community organizations, and local neighborhood watch groups to monitor parks for safety after dark. Increase the number of parks that offer well-lit and accessible walking paths after dark.

State-led worksite wellness programs

Programs like Rutgers Extension Collaborative, MWC and others provide resources for worksite wellness programs. Select workplaces implement initiatives such as installing small fitness centers or providing vouchers to local gyms and offering incentives through which employees can exercise during their work day. Program staff from these organizations have accumulated expertise in these areas and should be encouraged to promote these programs in their own organizations.

Action Steps

▶ The State should recommend and provide solutions and incentives for integrating worksite wellness programs in each of its agencies. State should lead by example!

STRATEGY #8
Strengthen Inter-agency collaboration and community partnerships to support Active, Healthy Lifestyle

State Nutritional Advisory Committee

The State Nutritional Advisory Committee (SNAC) was re-launched in 2019. As an intersectoral body, it provides the space for increasing inter-agency collaboration, for example, between government programs, such as SNAP-Ed, WIC and the School Lunch Program. Additionally, non-governmental agencies such as YMCA-Trenton, Newark Healthcare Coalition, Mayors Wellness Campaign (MWC), and Sustainable Jersey are activity seeking to break down silos and increase inter-program referrals, problem-solving and overall tracking of progress.

Action Steps

▶ Engage community representatives to participate on the State Nutritional Advisory Council (SNAC). Integrate additional programs such as MWC, the Healthy Communities Network, Regional Health Collaboratives such as Newark

Healthcare Initiative and others in the SNAC.

▶ Increase coordination through consistent and intentional SNAC meetings, by dividing SNAC into sub-committees by June 2019 and incorporating non-governmental members by June 2019.

Incentivize partnerships

Partnerships have helped enable programs to expand their reach. Participation in county continuum of care committees, advisory boards, coalitions such as the South's Tri-County Alliance and the North Jersey Health Collaborative enable pooling resources. Staff will attend open community events to seek out new partners. Staff of organizations that do not collaborate at the State level have successfully overcome tension over time through sustained collaboration at the local level, "in the field."

Action Steps

▶ Incentivize partnerships through grant arrangements and tracking measures.

Tracking of processes and outcomes

Tracking tends to be program-specific. Meaning, each program tracks its own progress – number of participants, quantity of food delivered, etc., as opposed to the extent of overall progress experienced by the population. The gap between hyper-specific programmatic process tracking and larger outcome measures, such as the Track Trenton Families study, is too large to understand what is working and what is not, why and when.

Action Steps

▶ The SNAC will facilitate increased macro-level tracking of both process and outcomes.

Reach previously unengaged community members

Community members often feel excluded from the process of planning programs. While programs intentionally engage the community, often the same groups of people are involved or attend "community engagement" events. It seems hard to reach new and especially marginalized members of the community.

SNAP-Ed tracks specifically for community engagement.

Action Steps

▶ Add specific tracking measures for adding groups/people to community engagement. Mayors Wellness Initiative incentives engagement through the "Healthy Town Award." YMCA is making special effort to engage youth voice in health planning.

Publicize best practices

Collaboration increases participation and reporting of best practices. People, and the incredible organizations leading the movement towards healthy communities deserve credit for their good work!

Action Steps

▶ Publicize best practices through organizational newsletters, such as DOH News Clips, social media, press releases. Celebrate State initiatives like the Governor's recess program, schools that have innovative health projects, farms that donate food to food pantries, etc.

STRATEGY #9
Improve Case Management to support individuals with chronic disease

Linkages to Care

Action Steps

▶ Federally Qualified Health Centers (FQHCs) have engaged in an assessment of their capacity for treating patients with high blood pressure and diabetes with a focus on electronic health record (EHR) functionality, the use of health information technology and evidence-based clinical care protocols, covering all 21 counties in New Jersey which accounts for 87 total sites. Changes to team-based care in ten FQHCs (grant funded in two cohorts) have led to improvement in hemoglobin A1c levels for patients with diabetes, improvement in blood pressure control for patients with hypertension and improvement in medication compliance. This work has also created linkages to programs that provide support and self-management (diabetes and faith-based programs).

► Regional Planning Collaboratives (RPC) are currently planning to implement clinical decision support (CDS) projects to enhance healthcare and health outcomes by delivering patient information to the right person, using the right intervention and channel.

► The Diabetes Prevention Program created a model using programs called Diabetes Resources Coordination Centers (DRCC). The DRCCs were embedded in hospital and pharmacy associations to increase access, referrals to, and utilization of community-based diabetes self-management education programs. DRCCs partner to facilitate the development of policies and/or practices to refer patients with diabetes to self-management programs. The DRCCs also implement communication strategies to allow consumers and healthcare providers to easily access information about available diabetes self-management resources in targeted communities. As a result of this work 81 community-clinical linkages were created Statewide. Age-adjusted prevalence estimates of diabetes among New Jersey adults have remained stable from 2011 through 2016 at approximately 8%. Death rates in New Jersey due to

diabetes as an underlying cause and kidney disease have trended down slightly in recent years.

Chronic illness care coordination

Transportation challenges limit the extent to which individuals with chronic disease can attend self-management programs. In rural areas, for example, programs are spaced far from each other, and only those with cars and time can follow through with the demands of programs. This inhibits the consistency critical to managing chronic disease and limits the effectiveness of self-management.

Action Steps

► There is a need for more and better care coordination for people with chronic disease, as well as more geographically dispersed programs for self-management. Community Health Workers can help bridge these gaps, addressing transportation and other logistical challenges, ensuring receipt and tracking of medication, facilitating additional supports, such as coordinated treatment for navigating the cycle between chronic disease and mental illness.

Chronic disease prevention and management

Participants with chronic diseases such as diabetes described a lack of information related to nutrition and physical activity specific to their condition.

Action Steps

► The Regional Health Collaboratives, such as Greater Newark Healthcare Coalition, excel at providing chronic disease case management, which includes coaching individuals with chronic disease in maintaining healthy eating habits and physical activity regiments specific to their conditions.

► MWC provides municipalities with toolkits for improving coordinated care, with a focus on health equity.

Immunization

HEALTHY NEW JERSEY 2020 OBJECTIVES

Vaccines recommended by the age of 3

▶ **4 DTaP**
NJ rate: 82.8%
(2017)
Goal: 95%

▶ **4 PCV**
NJ rate: 84.1%
(2017)
Goal: 90%

▶ **4 DTaP, 3 Polio, 1 MMR, 3 Hepatitis B, 3 Hib, 1 Varicella, 4 PCV series**
New Jersey rate: 69.3% (2017)
Goal: 80%

Vaccines recommended at birth

▶ **Hepatitis B**
NJ rate: 60.0% (2017)
Goal: 75%

ENGAGEMENT PROCESS

CORE TEAM

- Vaccine Preventable Disease Program, *Division of Communicable Disease Services; New Jersey Department of Health*

PARTNERS

- Office of Local Public Health, *Division of Public Health Infrastructure, Laboratories, and Emergency Preparedness; New Jersey Department of Health*

EXPERTS

Ocean County   *Monmouth County*   *Passaic County*

- Local Health Officials
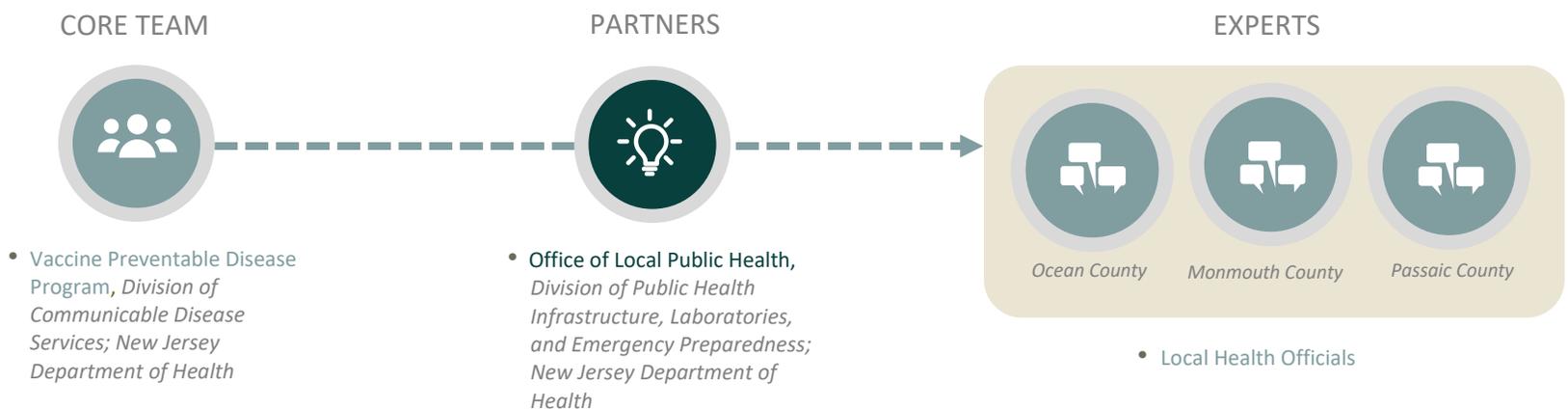
Strategy #1
Ensure universal vaccine availability and accessibility, regardless of insurance status or ability to pay

Increase vaccine availability

The VFC and 317 program provides access to vaccines across the lifespan regardless of a person's ability to pay. Between 1994 and 2016, routine childhood vaccines have prevented an estimated 855,000 premature deaths, 381 million illnesses, and saved nearly $1.65 trillion in total societal costs. In 2017, NJ VFC provided 1.6 million doses of vaccine to approximately 900 providers throughout NJ.

Action Steps

▶ Sustain or recruit more providers to enroll in the VFC program.

▶ Eliminate missed opportunities to vaccinate by developing and/or updating - administrative policies based on evidence-based strategies.

▶ Support direct immunization efforts and expand access points (i.e. back to school immunization clinics). Track number of children immunized during community

outreach events as a result of VPDP supported activities.

Accelerated immunization schedules for communities at risk vaccine

Visits to healthcare providers provide opportunities to ensure children are age-appropriately vaccinated or are up- to-* date with the recommended childhood and adolescent immunization schedule

Action Steps

▶ Implement accelerated schedules where all vaccines can be administered by 12 months especially in areas where populations are transient.

Strategy #2
Improve provider participation in the statewide immunization registry, the New Jersey Immunization Information System (NJIIS).

Immunization Registry reporting

The Statewide Immunization Registry, the New Jersey Immunization Information System (NJIIS), enables providers to track and improve performance related to immunization.

Action Steps

▶ Educate providers on their responsibility to complying with NJIIS requirements for documenting administered doses within 30 days across the lifespan. Promote the benefits and optimal use of NJIIS, such as the reminder recall function, to increase and/or sustain high immunization coverage across the lifespan, in collaboration with local health departments and Maternal and Child Health Consortia.

▶ Deliver 15 NJIIS trainings to school nurses and childcare facilities, including education regarding the benefit of utilizing New Jersey's immunization registry to assist with assessing immunization status of students.

Strategy #3
Engage community members in efforts to increase immunization coverage

Collaboration and capacity building

Providers, LHDs and CBOs have developed collaborative approaches toward increasing vaccination rates at the community level, to ensure that at-risk populations get age-appropriately vaccinated.

Action Steps

▶ Add 30 participants in the Hot Shots for Tots Campaign (a point-based incentive program for child care and preschool facilities) to implement immunization best practices and to work toward increasing or maintaining high immunization coverage levels at their facilities.

▶ Support community-based immunization programs to assess vaccination status and identify children behind on recommended immunizations.

▶ Provide education on the importance of timely immunizations to parents/guardians and health care providers in collaboration with LHDs, FQHCs, CBOs, NJ's Maternal and Child Health Consortia and DOH grantees.

▶ Increase immunization rates in pocket of need areas, by supporting direct immunization efforts and expanding access points (i.e. back to school immunization clinics).

Strategy #4
Increase school compliance with immunization requirements

School-based immunization practices

N.J.A.C. 8:57-4 requires minimum immunization requirements for school attendance or documentation of acceptable exemptions. Children who do not comply with the requirements may be excluded from school until proper documentation is received.

Action Steps

▶ Educate school officials on the importance of timely age-appropriate immunizations and the requirements for childcare and school attendance.

▶ Inform parents that in the event of a vaccine preventable disease outbreak, children with exemptions may be excluded. Depending on the disease, children may be out of school for a length of time.

▶ Assess New Jersey's immunization coverage and exemption rates for child care and school-aged children through the collection of the Annual Immunization Status Report from ~6300 schools.

▶ Increase the reporting rate of the Annual Immunization Status Report to 90%.

Vaccine religious exemptions

The number of religious exemptions filed in New Jersey schools have continued to increase over the past 10 years.

Action Steps

▶ Advance policy change to address the increase/prevalence of religious exemptions in New Jersey in collaboration with local health care providers, NJIN, advisory committee, immunization advocates, LHDs.

**Strategy #5
Increase audits and surveillance in areas with outbreaks of Vaccine Preventable Diseases (VPDs)**

Vaccine-preventable disease control and collaboration

The DOH Vaccine Preventable Disease Program (VPDP) surveillance unit coordinates appropriate public health activities, in collaboration with local health officials, for the control and prevention of VPD cases and outbreaks in accordance with the CDC Manual for the Surveillance of VPDs.

Action Steps

▶ Implement and maintain surveillance systems to investigate and document cases and/or outbreaks of vaccine preventable diseases, and ensure appropriate clinical specimens are tested and relevant epidemiologic information is collected.

▶ Increase number of VPDS responded to by the State VPDP and Local Health Departments.

▶ Track percent of schools audited by LHDs annually by an external advisory group to encourage stakeholder feedback and promote collaboration.

Aligning State & Community Health Improvement Planning

ENGAGEMENT PROCESS

CORE TEAM

PARTNERS

EXPERTS

Camden   New Brunswick   Morristown

- Office of Local Public Health, New Jersey Department of Health

- New Jersey Public Health Associations' Collaborative Effort (NJPHACE)

- Local Health Officials

- Community Health Assessment Partners
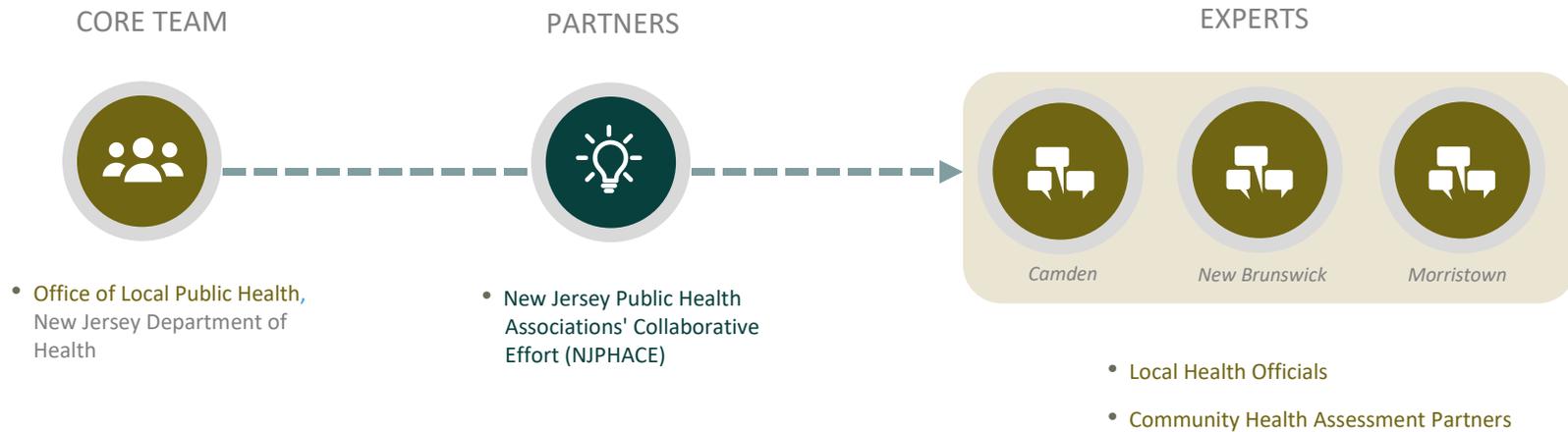
ACTION PLAN

Strategy #1
Improve community health through hospital – public health collaboration

Build collaborative teams between local health departments and hospitals

Non-profit hospitals contribute extensively to local health planning by conducting Community Health Needs Assessments (CHNA), as mandated by the Affordable Care Act. While CHNAs predominantly address hospital network priorities, several hospitals have adopted population-health approaches and lead regional partnerships with local health departments (LHD) and other local stakeholders, including universities, community-based organizations and insurance representatives.

Action Steps

▶ Develop new guidelines for developing, implementing, coordinating and evaluating CHNAs, CHAs and CHIPs in collaboration with the New Jersey Hospital Association (NJHA), based on PHAB standards and successful examples of regional, LHD/hospital-led collaboration.

▶ Build a joint training curriculum on implementation and evaluation of the guidelines for CHNA-contributing hospital administrators and LHD health officers/health educators

Strategy #2
Strengthen the effectiveness and sustainability of CHAs/CHIPs

Increase use of CHA/CHIP data and priorities in DOH grant making and local support

CHAs and CHIPs offer a wealth of information, including data sourced in multiple languages and diverse settings that address health and health determinants. DOH supports and partners with numerous local stakeholders that can benefit from utilizing CHAs and CHIPs in their local health planning.

Action Steps

▶ Set internal NJDOH policy that starting in 2020, grantees must utilize CHA/CHIP for planning and/or evaluation. NJDOH will provide LHDs with a list of DOH grantees in their respective counties and give grantees contact information for LHDs

Long-term CHIP sustainability

By necessity, LHDs often prioritize public health responsibilities such as inspections, emergency preparedness and licensing over long-term health planning. While DOH does not set priorities for LHDs, it supports local programs, communicates local success stories and has oversight through performance reviews. These can be leveraged to strengthen CHAs/CHIPs.

Action Steps

▶ Incorporate CHAs/CHIPs in LHD performance review

▶ Re-assess existing resources allocated to LHDs to examine how to support CHA/CHIP

▶ Add CHA/CHIP marketing to Commissioners' LHD External Goal and communication messages, such as press releases and tweets.

Strategy #3
Enhance state and local health department collaboration, coordination, communication of health improvement planning activities

Strengthen CHA-SHA and CHIP-SHIP linkages

Local CHA and CHIP prioritization processes account for contextual constraints, address the needs of diverse populations, reflect emergent health issues and propose locally-driven solutions. Their analyses are critical to the SHIP.

Action Steps

▶ In the Healthy New Jersey 2030 planning cycle, establish a process for incorporating CHAs and CHIPs in SHAs and SHIPs, including outreach to LHDs to ensure that each county has one or more CHA-identified priority in the SHIP, and that the SHIP draws upon local successes as examples for scalable action.

Foster collaboration between DOH and local health departments

PHAB guidelines emphasize the importance of SHIP and CHIPs as ongoing processes. Currently, most SHIP-CHIP coordination occurs around the publication deadlines of SHAs/SHIPs and CHAs/CHIPs. The in-between stages, though, offer opportunities for collaboration and mutual learning.

Action Steps

▶ Beginning in 2020, allocate time to discuss CHA/CHIP/SHA/SHIP at the annual League of Municipalities meeting and appoint a DOH employee to coordinate collaboration on an ongoing basis.

Online repository for health assessments and improvement plans

Cumulatively, CHAs, CHIPs, SHA and SHIP paint a comprehensive picture of statewide and local public health planning. They are all part of the same process! While each report is – and should be - published independently, they can be made readily available via one source, as well, to reinforce their inter-dependence.

Action Steps

▶ Make CHIPs/CHAs and SHIP/SHA, as well as methodological resources, summaries of yearly meetings and annual reports accessible via one website.

Next Steps

HEALTHY NEW JERSEY 2030

The New Jersey Department of Health (NJDOH) launched Healthy New Jersey 2030—the next iteration of the multidecade initiative—in February 2019. Every decade, the Healthy New Jersey initiative develops a new set of evidence-based, 10-year objectives with the goal of improving the health of all New Jerseyans. As in previous decades, the effort's framework (see Figure 1) is modeled after the federal Healthy People initiative.

For the development of HNJ2030, NJDOH drew from the lessons of the *Healthy New Jersey 2020* initiative, such as reduce the overall number of measurable objectives; incorporate evidence-based interventions and health equity goals in HNJ objective selection criteria; include external stakeholders from the outset and in a phase of decision-making; and improve internal and external HNJ communication and buy-in. With lessons learned from previous decades, and new recommendations from the federal Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030, Healthy New Jersey 2030 will focus on macro-level conditions or upstream determinants rather than using a disease-based model.

Formed in 2019, the Department's *Healthy New Jersey Advisory Council (HNJAC)*, which is comprised of 12 external cross-disciplinary and cross-sector stakeholders who work in partnership with the internally-based HNJ Coordinating Committee, established the following four, broad **HNJ2030 Topic Areas** that represent the key elements that influence health:

1) Access to Quality Care

2) Healthy Communities

3) Health Families

4) Healthy Living

Each Topic Area will be assessed through two cross-cutting lenses: Equity and Policy.

TIMELINE

As of the writing of this report, next steps for the HNJAC in **2020** include:

1. Topic Area Teams recruitment

2. Develop SMART objectives and 2030 targets by Topic Area

3. Public Comment of proposed HNJ2030 objectives

4. Release Final HNJ2030 objectives

5. Propose new long- and short-term plans, policies, initiatives to help achieve the 2030 targets

6. HNJ2030 action plan implementation & ongoing Topic Area Team recruitment

Appendices – Focus Group Summaries

Appendix A: Health Equity Focus Group Summary

Advancing Health Equity in New Jersey through Health in All Policies

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Introduction

Economic, environmental and historical forces contribute substantially to our health – as much, studies show, as genetics, individual behavior and access to healthcare.[1] Examples of these **Social Determinants of Health** include quality of housing and schools, access to healthy foods, living-wage jobs, transportation mobility, environmental exposure free from pollution and stressors, social support networks and community safety.[2] These factors are distributed unevenly across populations, effectively determining length and quality of life and causing health inequities.

Healthy People 2020 emphasizes that "**Health disparities** adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic -status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[3] **Health equity** is "the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions."[4] By focusing on both health disparities as well as the social, physical and economic determinants of health, efforts to advance Health Equity include policies, programs and strategies to address underlying factors that are unjustly and unfairly preclude all people from access to the systems and conditions that support health and well-being. Examples of underlying factors include: structural racism, poverty, healthy and safe environments, transportation mobility, living wage jobs, affordable quality housing, racism and access to quality health care.

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[1] http://www.countyhealthrankings.org/what-is-health

[2] https://www.cdc.gov/socialdeterminants/

[3] https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

[4] Braveman P. What Are Health Disparities and Health Equity? We Need to Be Clear. *Public Health Reports*. 2014;129(Suppl 2):5-8.

[5] https://www.cdc.gov/policy/hiap/index.html

Health in All Policies (HiAP) is a collaborative approach to reducing disparities and improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.[5] As the most densely populated state in the United States, with a population both ethnically and socioeconomically diverse, New Jersey faces striking public health challenges. Aging infrastructure, our industrial past, still-segregated schools and the high cost of living entrench and increase health disparities. Governor Phil Murphy's administration has made Health in All Policies a cornerstone of the State's vision for a healthy New Jersey, with a focus on the "enhancement of agency coordination and establishment of health goals, including in population health, promoting equity and achieving better health outcomes for all."[6] The State Health Improvement Plan reflects our commitment to this vision.

Health Disparities in New Jersey

New Jerseyans experience positive health outcomes overall. Our health disparities, though, call us to action. The State Health Assessment (SHA) highlighted inequalities through state, Census, and other federal data sources, as well as the United Way's ALICE (Asset-Limited, Income-Constrained, Employed) Project. ALICE draws attention to 28% of NJ's employed households, whose income is above the federal poverty level, but below the cost of basic, modern living expenses[7]. The Health Opportunity and Equity (HOPE) measures, described in the following section, further elucidate the impact of health inequalities, and present pathways toward addressing them through a health equity approach.

Released in 2018 by the National Collaborative for Health Equity (NCHE), the HOPE Measures include indicators related to health outcomes, socioeconomic factors, social conditions, the physical environment and access to health care, enabling states to assess in-state strengths and weaknesses in relation to national targets, as well as conduct state-to-state comparisons.[8] They identify key opportunities for cross-sector stakeholders to come together and develop or repurpose policies, programs and strategies that address shared goals and further health equity.[9] The HOPE measures indicate that New Jersey fares relatively well when compared to other states on key measures of health and conditions for health. The State is ranked sixth in the nation in the incidence of low-birth weight, ninth in infant mortality, and third in food security as measured by the share of households that do not live in USDA-designated "food deserts." While there are surely pockets of poor performance within those indicators among certain

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[6] Report of the Healthcare Transition Advisory Committee, State of New Jersey, (2018)

[7] Source: https://www.unitedwayalice.org/new-jersey (Chart: "Households by Income, 2010-2016")

[8] Wong Croal, N., Smedley, B., Andrulis, D., Woolf, S., Siddiqui, N., Wilson, K., Turner, M., & Stelter, A. (2018). The HOPE Initiative: Brief Report.

[9] Woolf, S. (2018). What RFK's Coalition Teaches Us About Healing A Divided Nation. In Spotlight on Poverty & Opportunity. Retrieved from: https://spotlightonpoverty.org/spotlight-exclusives/rfks-coalition-teaches-us-healing-divided-nation/

[10] Siddiqui, N., Stelter, A., Turner, M., Wilson, K., Andrulis, D., Smedley, B., Wong, N., Chapman, D., Woolf, S., Hill, L., & Whitley, J. (2018). The HOPE Initiative: Data Chartbook.

[11] Wilson, K., Turner, M., Chapman, D., Woolf, S., Smedley, B., & Andrulis, D. (2018). The HOPE Initiative: Technical Summary.

populations and in certain geographic regions of the state, the overall statewide rankings reinforce the

concept that Jersey has the potential to achieve outstanding health outcomes for all residents of our state. However, New Jersey is faring less well on other critical indicators, such as the share of households with affordable housing – defined as the proportion of households spending less than 30% of their monthly income on housing expenses. Asians and Pacific Islanders (66%) and whites (62%) in our State have significantly more access to affordable housing than communities of color, including African American (48%), Latinx (45%), and American Indian/Alaska Native (48%) households. Overall, New Jersey is 44th on this measure. [10, 11]

Listening Sessions

To help inform the development of a Health in All Policies agenda, the Department of Health (DOH) and the Rutgers University Bloustein School of Planning and Public Policy conducted listening sessions In June and July of 2018 with invited leaders throughout New Jersey. These listening sessions were not meant to be an exhaustive inventory of opportunities to advance Health in All Policies, but rather an opportunity for leaders from transportation, housing, community development and design, anti-poverty, environment and conservation, climate change, workforce development and education to have initial discussions about strategies for improving New Jerseyans' physical environment, supporting social networks and fostering socioeconomic wellbeing. Participants identified areas of need and provided a vision for the future, reflecting the creativity and shared sense of mission critical to incorporating a health equity lens in state planning.

Listening session participants urged DOH to demonstrate leadership in supporting efforts that integrate health considerations in other policies and that are mutually beneficial to the public health community, other sectors, academic institutions and the private sector. Emphasizing DOH's potential as a **convener and catalyst** of Health in All Policies, they described how DOH could elucidate connections between poor health outcomes and other sectors, assess effectiveness of specific multi-sector initiatives and highlight projects that demonstrate the benefits of Health in All Policies. Participants emphasized DOH's role as **an advocate and catalyst of health equity**, an important high-level "voice" for highlighting connections between upstream factors in sectors such as housing, transportation mobility, community development, workforce and economic opportunities, education, environmental stressors, lack of transportation options, built environment and infrastructure.

Participants proposed the value of building upon existing initiatives that further advance health equity, highlighting opportunities such as Governor Murphy's Executive Orders, long-term investments in low-income rural and urban communities and the State's economic development strategic plan. DOH, they argued, can more **actively participate in advisory committees** such as the New Jersey Bicycle and Pedestrian Advisory Council, the State Planning Commission or the Clean Water Council, and examine existing reviews such as those conducted for state infrastructure spending or regulatory impact to incorporate impacts to health.

Municipal Master Plans (also known as comprehensive or general plans) and county-level Hazard Mitigation Plans, as well as open space, stormwater, wastewater and transportation planning, all present **windows of opportunity for incorporating health considerations**. Trenton, for example, adopted a Master Plan Vision Element that, among other goals, imagines a city where its residents have the opportunity to live a healthy life in a healthy environment, and have incorporated a Health and Food

Systems Element for the Trenton 250 Master Plan. The 2018 update to the *Complete Guide to Planning in New Jersey* published by the New Jersey Chapter of the American Planning Association includes a chapter on planning practice that can foster "healthy communities."[12] Participants in the listing sessions also envisioned the potential for collaboratives between local health departments, local health-based collaboratives and hospital systems to undertake innovative demonstration projects. Chapter 6 of the SHIP, which focuses on the importance of Community Health Improvement Plans (CHIPs) and Community health needs assessments (CHNA), describes how alignment between local health planning can leverage and anchor intersectoral integration, as well.

Strategic Action Items

Promoting healthy communities and health equity across different population groups is rooted in principles that ensure all residents have a fair opportunity to attain their optimal health. This belief is at the heart of our shared values and is the foundation of a vibrant, prosperous and sustainable state. Undertaking an agenda to advance health equity and Health in All Policies is a major new direction for the Department of Health that will take leadership, collaboration and partnerships, research-based evidence and vision. The Department of Health intends to begin its efforts to more systematically advance health equity and Health in All Policies by undertaking several initial actions that are intended to inform the development of a more comprehensive and long-term path forward. The Department of Health views the next 18 months as a learning period to better understand the opportunities and challenges associated with advancing health equity and Health in All Policies in order to subsequently develop a long-term comprehensive strategy for the future. The following actions, based on the listening session participants' recommendations, describe opportunities and challenges, allies and resources for pursuing Health in All Policies and health equity in the short-term with the intention of applying them to inform the development of a longer-term priority direction:

1. Develop a comprehensive Health in All Policies (HiAP) agenda:

   Create a Commissioner's Task Force on Health Equity and Health in All Policies to advise the Commissioner and the Department of Health on longer term, more comprehensive actions that can be undertaken in New Jersey to systematically advance health equity. The Task Force will include thought leaders from the health care and public health sectors as well as sectors that have direct and indirect impacts on health including but not limited to: transportation, housing, environment, food security, anti-poverty, immigration rights, energy, community development and redevelopment, labor and economic mobility, criminal justice reform, and civic engagement, among others. The Task Force will be charged with:
   - Reviewing best practices in other states to inform policy development in New Jersey;
   - Articulating short and long-term goals for the Department of Health's leadership on health equity;
   - Identifying regulatory, legal and policy obstacles in New Jersey to advancing HiAP;

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[12] Complete Guide to Planning in New Jersey. Fourth Edition. New Jersey Chapter of the American Planning Association. 2018. https://njplanning.org/complete-guide-to-planning-in-new-jersey/

   - Engaging with the Department of Health and local public health agencies, educators and

others to better understand the extent to which the state's public health infrastructure has adequately capacity to advance health equity and Health in All Policies strategies;

- Creating opportunities for state and community officials and leaders, multi-sector non-governmental organizations, private sector businesses, health care and public health leaders, academics and others to offer suggestions on actions the New Jersey Department of Health can take to advance health equity and advance Health in All Policies;

- Examining current data available to measure and track New Jersey's progress with regard to advancing health equity and make recommendations on strategies to systematically monitor gaps, trends, and improvements in health equity;

- Making recommendations on an approach that the Department of Health can undertake to develop a systematic and comprehensive health equity and Health in All Policies strategic plan as part of the Healthy New Jersey 2030 planning process.

2. Identify 3-5 initiatives with sister state agencies to serve as "proofs of concept" designed to demonstrate health equity and HiAP benefits at the state and community level:

The Department of Health will work in collaboration with other state agencies to better understand mechanisms that can serve to integrate consideration of health and health equity into the policies and processes of other agencies. These efforts may include but not be limited to:

- Identifying existing partnerships, collaboratives, programs and committees at the state, county, municipal and neighborhood levels that are implementing an HiAP-like approach and that can serve as partners in statewide efforts;

- Enhancing access to environmental and chronic disease health data, including data available through the state's participation as a pilot state in the National Environmental Public Health Tracking Network[13] by forming partnerships with communities to access and use data for local planning efforts;

- Exploring further opportunities for advancing health outcomes and health equity, such as state investment in specific efforts of state agencies including public infrastructure projects, state support for community development and redevelopment, prioritization of long-term investments into low-income rural and urban communities, implementation of the Governor's economic development strategic plan, and advancement of a climate change and public health initiative,

- Assessing enhancements needed to state programs that contribute significantly to health equity, such as Temporary Assistance to Needy Families (TANF), the Supplemental Nutritional Assistance Program (SNAP/SNAP-Ed), energy efficiency and housing assistance programs, and others;

- Demonstrating use of the practice of Health Impact Assessment (HIA) by integrating health elements into or conducting HIAs on a set of key state-level initiatives such as community schooling demonstration projects, climate change and clean energy actions, capital and infrastructure investments, resilience planning;

- Partnering with other state agencies to maximize the integration of health equity considerations into signature initiatives of Governor Murphy such as those outlined in the Governor's Executive

Orders, including Executive Order 23 that addresses Environmental Justice, Executive Order 5 that requires a financial audit of New Jersey Transit, Executive Order 41 that focuses on the future of work in New Jersey and others.

3. Promote collaboration with local agencies, health care systems and others that demonstrate the value of systematic integration of social determinants of health into local health programs:

The Department of Health will work in collaboration with other local partners to better understand mechanisms that can serve to support and advance efforts at the local effort to advance health equity and Health in All Policies. This will involve working with local communities and agencies, public health providers and educators, health care systems, agencies and leaders in sectors not traditionally thought of as health-related such as housing, transportation, environment, community development and others. These initial efforts are not intended to serve as a comprehensive Department of Health initiative but, rather, to undertake several pilot efforts to demonstrate opportunities associated with advancing health equity and Health in All Policies as well as to work with local agencies, communities and leaders to understand the obstacles and challenges they face in advancing health equity. These efforts may include but not be limited to:

- Partnering with other state agencies to maximize the integration of health equity considerations into signature initiatives of Governor Murphy such as those outlined in the Governor's Executive Orders, including Executive Order 23 that addresses Environmental Justice, Executive Order 5 that requires a financial audit of New Jersey Transit, Executive Order 41 that focuses on the future of work in New Jersey and others.
- Collaborating with voluntary local communities and the state's healthcare and public health systems to integrate health and health equity into local planning through the alignment of Community Health Improvement Plans (CHIP) and Community Health Needs Assessments (CHNA) with local master and other planning;
- Collaborating with local health programs and agencies to consider ways in which incentives to promote HiAP can be integrated into local public health planning, including but not limited to the DOH periodic evaluation of local boards of health to determine municipal and county health agency compliance with Standards of Performance;
- Engaging 1-2 Federally Qualified Health Centers to advance demonstration programs related to social determinants of health.
- Partnering with 1-2 New Jersey counties that are exploring pursuing "Age-friendly" "Domains of Livability" status[14], in collaboration with the New Jersey Chapter of AARP, the Rutgers Bloustein School and School of Social Work, and the Department of Human Services (DHS).
- Expanding existing initiatives and exploring new strategies for equipping the state's public health infrastructure to advance HiAP, including support for health professions that foster health equity, such as health educators and community health workers;
- Designing or expanding existing health equity, cultural sensitivity and trauma-informed care training modules for stakeholders, agencies, and systems who impact health and its determinants;

[14]http://www.who.int/ageing/projects/age-friendly-cities-communities/en/

4. Conduct critical analysis to inform development of a systematic HiAP agenda:

To complement demonstration and pilot efforts at the state and local levels, as well as statewide stakeholder engagement efforts, the Department of Health will undertake strategic analysis to inform the development of a systematic and comprehensive health equity and Health in All Policies agenda for New Jersey.

- Examining the adequacy of New Jersey's public health infrastructure to advance a HiAP agenda in New Jersey and offering recommendations to enhance and strengthen it;
- Identifying priorities for data-sharing between state agencies, to identify social determinants and upstream factors affecting health, engage stakeholders to identify policy opportunities, utilize health data for evaluating programs in other agencies and non-DOH data to inform health decision-making;
- Examining best practices from other states that have adopted systematic and comprehensive strategies to advance a statewide HiAP and health equity agenda;
- Fostering and hosting dialogue among and between multi-disciplinary groups, such as the Population Health Summit, New Jersey State League of Municipalities, public health and public health educator associations, multi-sector leaders at the state and local levels, and others to identify opportunities to promote addressing social determinants of health.

Appendix B: Birth Outcomes Focus Group Summary

BIM/MM Focus Groups from 3.8, 3.12 and 3.14: Summary of Barriers, Root Causes and Solution
Pathways

On March 8th, 12th and 14th, 2018, FHS held regional focus groups for Community Health Workers (CHWs) and Central Intake (CI) Workers, to inform FHS' root cause analysis for black infant mortality (BIM) and maternal mortality (MM) and help design a DOH Action Plan on BIM and MM.

The following tables divide their input between health sector-related insights and social determinants of birth outcomes.

Table 1: Medical and Health Resources: The following summarizes the challenges and solution pathways CHWs and CI workers identified in medical and health care settings for pregnant teens and women, including prenatal care, IPO, mental health and community health resources.

Policy Sphere	Root Cause	Policy Problems	Solution	Notes
Prenatal Care and Hospital Treatment	Lack of health insurance	Medicaid admission process takes months. Women often give up and no longer seek prenatal care, or they miss critical early stages of prenatal care.	Re-visit process given consequences.	
		HMOs are not allowed to enroll pregnant women	Re-visit policy given consequences.	
	Wait times at appointments	Up to 5-6 hours	Give CHWs tools to engage with providers about how to improve wait times.	

`	Language barriers and lack of cultural competency	Providers may be bi-lingual, but do not speak other common languages in NJ	Develop policy beyond giving patients the option of bringing an ally, like phone translation, printed materials, identify list of translators in building	One non-English speaker had her pre-term birth baby kept at hospital for 5 days, but did not understand why, said nobody explained to her. CHWs identified specific needs for Haitian Creole, Arabic and African languages
			Add cultural competency training, or ensure pregnancy and childbirth are included in current trainings	
	Undocumented clients are fearful of engaging with medical system (and other systems)	They avoid critical processes like prenatal care	Establish Sanctuary Medical System/identify existing best practices	
	CI/CHWs begin care process with insufficient information about women's needs	Report CI receives from the hospital is inadequate and does not include women's specific needs	Establish protocol for hospital to seek out information from providers and deliver it to CI	
	Women are discharged from hospital without knowledge of available services, or IPO resources.	Women are either not notified at all upon discharge of IPO resources, or resources/available services are buried in a thick packet which they are unlikely to read postpartum.	Establish protocol for informing postpartum women and/or partners/family about IPO and available services. Perhaps prepare one pager with contact information.	Hospitals differ on case by case basis. Holy Name in Bergen has working relationship with CHW because of supportive hospital social workers. Other two hospitals in county do not.

CHW Mandate and Potential	CHWs are under-utilized	The three months CHWs care for new/expectant mothers is sometimes inadequate, or CHWs need ability to reopen closed cases when women need their help a second time beyond the three-month period. The CHWs do not have flexibility in terms of extending their duration of time or reopening cases	Re-visit CHW care period: Increase from three to six months, combine CHW with doula service to extend time and broaden/deepen relationship, or give more flexibility to CHW to determine duration of case management or request exceptions to "3-months and you're out."	
			Doula Program enables CHWs to know "more of the person", to be a more effective ally/advocate at perinatal appointments, during labor and post-birth.	Doula program currently only in Essex. Other CHWs expressed desire for program in their counties, and said it would help them better meet their clients' needs beyond specific doula responsibilities.

		They're training can be increased to focus on meeting specific needs of new/expectant mothers – they feel that their job is to connect the dots for women to facilitate health pregnancy/birth/post-partum period, and to alleviate immediate stressors on pregnancy/new motherhood, but say they are missing up-to-date information to do so effectively. State/county websites are often not-updated, and it can be challenging to find information that is up to date about eligibility for social services. They do extensive Google searching, but need official information so they can deliver it authoritatively to women	Add training on topics like: - Financial independence/ survival - Medical rights/ insurance - Social services - Housing Rights	CHWs and CI workers described feeling like they were not adequately informed about specifics of social services and rights – they wished they could be more specific and accurate. Felt sometimes like they were just sending women to wait in line to be told "No."
		Agencies and providers still are unaware of CHW and CI work and IPO resources like HV, and therefore do not recommend IPO resources, prepare patients for IPO resources, or freely disseminate information to IPO resources. CHWs try to establish connections in community, at hospitals, and are successful on a case-by-case basis	DOH should explicitly express support for CHWs, establish policies for their involvement in process. They need "backing from higher up"	

		There is a stigma around receiving CHW support	Normalize CHW support beyond vulnerable populations. Should be part of general pregnancy checklist. Use marketing techniques like social media and videos to publicize role of CHWs. Re-brand CHWs as a potential resource for everybody. Give CHWs/CI more tangible "products" to offer, either in the form of education/coaching services, or objects, like prenatal vitamins, clothing, pre-prepared "baby box"	CHWs said they feel like they need to "sell themselves" to their clients.
		There is not enough dialogue between DOH and community health workers. CHWs attempt to navigate system on their own/with each other's help and consortia, but could use DOH support/backing	CHWs requested more focus groups/routine dialogue to process challenges, discuss solutions.	
		There are counties without CHWs	Expand CHW program to all counties.	
Screening and Assessment Procedures	Community Health Screening questionnaire is intrusive and lengthy, leading to women withhold information and preventing CHWs	Questions ask for intimate details like previous pregnancies and whether they are "low income," and revealing information like address and race, which women are uncomfortable providing upon initial consultation with CHW or in	Re-evaluate Community Health Screening form, from its design, to the number of questions, to the content of questions and the timing of when it needs to be filled out.	Women will ask them suspiciously, "what do you need this information for?!" In some cases, they refuse to provide information for fear of being

	from connecting with more women	public settings where they meet CHWs for the first time, before they have developed a relationship.	Screening process should be more simple, warm and sensitive, while allowing CHWs to reach out to as many women as they can. Perhaps one-page friendly form to get them signed up, and more information to be reported after CHWs establish rapport.	"revealed" to ICE or other government officials. Some information is obvious – like whether the women are low income – and asking about it is degrading. Or they'll say, "I just need utility support – why do you need to know if I've had a miscarriage?"
		The form is lengthy. CHWs, who seek out women in public spaces or waiting rooms, are able to reach out to fewer women because it takes a long time to fill out each questionnaire with each woman		Questions may be complex for some, and guiding women through questionnaire is time consuming
Community (Health-related resources)	Lack of accessible preventative education in community.	Education is primarily disseminated through pamphlets, which tend to be in English only.	Written materials should be in multiple languages and delivered through more accessible media than lengthy pamphlets.	
			CHWs give workshops in schools, community centers, libraries and elsewhere – these can be increased and/or matched to neighborhoods with high levels of infant/maternal mortality. New/expectant mothers are more likely to come to workshops when there is an incentive, like food baskets or an exciting speaker at the event.	Atlantic County hosts two baby showers per year, which they report are successful in drawing attendance
				They rely heavily on resources like Robin's Nest, but this is not sufficient for entire county.

			One CHW reports setting up an information desk in the medical clinic. She specifies the information she gives, like where to seek support, and written materials, according to age, religious preferences/sensitivities	
		Lack of Fatherhood groups - CHW will refer clients to parenting groups in the community, but groups targeted to fathers are more rare	Set up more fatherhood groups in areas with high infant/maternal mortality	
Home Visits	Women eligible for HVs do not receive it	Some women who qualify for HV express lack of desire or fear of having medical practitioner come into their home, and refuse	In discussing resources, CIs emphasize that HVs do not have to take place in the home – they can take place in a public setting. Inform all CIs of this protocol	
		Lack of bi-lingual NFPs to conduct HVs (Cumberland and Cape May, for example, have no bilingual NFP).	Renewed push for additional CHWs	
		Burlington HV is full	Increase quota of available HVs	
Mental health	Mental health issues go untreated and are a pathway to unwanted or high-risk pregnancy. Specific mental health challenges in Black community, among black women, around racism, violence, mass incarceration, poverty.	Not enough mental health care providers in South Jersey, including residential services, and especially for teens.	Document the disparities between counties/regions. Add services like telemedicine? Transportation solutions.	CHWs reported sensing high levels of mental health struggles, and they believed there was a significant connection between mental health and birth outcomes
		Providers are too far away. Speak Up When You're Down is a reliable resource, but CHWs do not know about follow up		
		Poor substance abuse surveillance and support	Establish protocol where CHWs/CI can act upon mistakes or gaps in care	CHWs reported medical errors

	Internet bullying is playing a role, as well	Lack of baby items and preparation of home increases stress pre-birth	CHWs prepare equipment like car seats, strollers, etc. and this helps, but not all counties have access to these items. Jersey City and Passaic have good resources.	

Table 2: Beyond Healthcare: The following summarizes the gaps CHWs and CI workers identified between the status quo and pregnant teens and women having access to the social determinants of healthy pregnancy and healthy new motherhood.

Policy Sphere	Root Cause	Policy Problems	Solution	Notes
Housing	Pregnancy leads to housing insecurity, which leads to vulnerability for mothers and infants For example: - New baby means exceeding resident limits in current housing - Pregnant teens get kicked out of parents' home - Can't afford current housing framework or upgrade to baby-appropriate housing - Must quit job, leading to income loss and eviction	Insufficient and inappropriate shelter space for mothers and children.	Develop policy that ensures sufficient regional shelter space for mothers and children in their counties. Establish shelter policy to ensure appropriateness for pregnant women and accessibility to prenatal care.	Burlington does not have a shelter for mothers and children. Churches can find temporary shelter during extreme cold and hot periods, but that's not enough, and not reliable. In North, Garden State Episcopal has policy of supporting two months of housing, which CHW says is effective. Morris County has 3-6 month waiting period for shelter space to open up.
		New and expectant mothers in counties without shelters, like Burlington, are often afraid to	Do not disqualify new mothers from assistance if they refuse to move into a shelter far from	

		move into shelters in Camden or Mercer, where there tends to be more space.	home, or if which they feel will be unsafe for them or their babies.	
			Address stigma around shelters.	
		When new shelters are authorized, communities resist having them built "in their neighborhood"	Publicize data which suggests shelters do not adversely affect neighborhood safety	Burlington has struggled with this, in particular
		Rigid criteria root out many women who need housing assistance, either because of past housing assistance or limiting definitions of homelessness. New mothers may make more efforts to secure emergency shelter than single adults, but they get punished for it because once they do so, they are no longer qualified as homeless and therefore do not receive shelter or assistance.	Explore possibility of broadening definition of homelessness in case of at-risk pregnancy or presence of infant.	One-time housing assistance policies make women with subsequent pregnancies vulnerable to being ineligible for assistance if they received it during previous pregnancies.
Community (beyond health resources)	African American community lacks supportive community infrastructure for new and expectant mothers, especially teens.	Faith-based organizations, which usually provide community support, are often either hostile or are judged as hostile toward pregnant teens. Pregnant teens feel looked down upon by church.	Seek out explicit declaration from faith-based organizations about accepting and supporting pregnant teens with open arms, or establish more discrete channel through which they can support new/expectant mothers as vulnerable members of their communities.	Pastors in Monmouth County (Sea Coast Ministries) are very supportive of pregnant teens, and have become a critical resource for them, and for the CHW caring for them. Existing, supportive faith-based organizations can help others become more supportive, as well

		Existing community organizations provide neighborhood events like block parties, but not basic community services. Pregnant teens are off their radar as community members in need.	CHWs can work with existing community coalitions to learn to support pregnant teens.	For example, Monmouth's Community Action Alliance Network.
		Many communities do not have any community centers or coalitions for African Americans (in contrast with other groups, e.g., Hispanic community center, Jewish community center, Muslim community center, etc.). Community centers provide services critical to new/expectant mothers, like employment services/training, childcare, support frameworks, food pantry, housing advice.	CHWs will establish and facilitate Community Leadership Coalitions, which will start by meeting once a month in accessible location like public libraries.	CHWs expressed desire and ability to lead this process. New Brunswick as an example of an area without an African American community center. In other counties, major cities had better resources than smaller towns.
	Women lack basic baby equipment like cribs, stroller	Hospitals and organizations give smaller items like diapers, food, but larger items are harder to come by. Geographic inequality between counties – Passaic has Oasis, Hudson has good resources, but other areas do not have community resources that distribute	Incorporate best practices from Oasis as policy, or support presence of organizations in infant/maternal mortality "hot spots"	Some organizations place criteria on how and to whom to give items. Baby Basics in Bergen County will not give diapers or other items to women who are on food stamps

School	Lack of education and school support system. Teen pregnancy, which CHWs report is common, leads to dropping out of school, which sends girls/young women down path to adverse birth outcomes and other risks to their health.	Beyond a limited number of Impact schools or others with unique programs, there is a lack of preventative care at schools on subjects which lead to teen pregnancy and vulnerability to negative birth outcomes	Existing programs like Impact are effective: State policy can either implement best practices from existing programs in all schools, or expand Impact/other programs to neighborhoods with high levels of teen pregnancy	CHWs want to be more active in local schools. They have the training to do so but say that schools vary in their openness. There's a need, therefore, for a policy solution. Limited lectures from PE teacher are insufficient.
			Make CHWs accessible to students and school staff through policy change and DOH-supported collaboration. CHWs can hold workshops for each school in region before start of school year, establish point of contact at each school, give workshops for students during the year and establish a communication protocol between CHWs and students.	CHWs in Passaic high schools have established policy for caring for students with health needs, including pregnant teens. They have place to receive students across the street from school. Connection was established through the School-Based Youth Services. CHW in Hudson said no connection with schools.

Union City has childcare in school.

Some schools told CHWs "We don't have any pregnant teens." |

				There is frequently a disparity between the information given by teachers and students to the CHW
		In some schools with support, it begins only after teen is pregnant or has her baby. There is still a lack of preventative education from early ages like middle school, and support for vulnerable teens to curb levels of teen pregnancy	Increased health and sex education at schools, including about contraception, "five love languages," nutrition etc.	CHWs mentioned pathway between teen mental health challenges and pregnancy
		Lack of access to contraception. Some areas closed their Planned Parenthood centers.	Increase access to contraception and ensure that teens know where to find birth control. Advocate for re-opening of all Planned Parenthood centers.	
		There are conflicting messages at school (There are condoms in the bathroom, but students are not taught how to use them – some classes still tell them to abstain from sex). At school, pregnant teens have no safe and knowledgeable person to turn to for support and guidance	Make CHWs accessible to students and school staff. CHWs will hold workshops for each school in region before start of school year, establish point of contact at each school, give workshops for students during the year and establish a communication protocol	
	Lack of childcare for students	No childcare for mothers on site or within vicinity, both in high schools and college	Community Child Care? Rutgers Model as template for colleges?	

				Childcare volunteers on site in high school?	
Employment	Pregnant teens not receiving CHW care	Referral to CHW must be signed by someone at least 18 years old, meaning a teen under 18 who is pregnant does not get CHW help, unless their parent signs for them, and they may not want their parent to know at the beginning of the pregnancy, which is the most critical point for prenatal care.	Lower referral age to enable teens to be cared for by CHW.		Pregnant teens can sign for services for their babies health, but not for their own.
	Lack of childcare for working parents	Women must work for at least 30 hours per week to be eligible for childcare support. Women looking for a job, or those who work less than 30 hours per week, are ineligible.	Expand eligibility/establish alternative framework.		
		No weekend childcare, and many find/can only work weekend jobs.	Weekend Childcare.		
	Lack of vocational skills	Frameworks like Youthcore provide vocational trainings for women up to the age of 24, when women 25 and up need training, as well.	Increase age of existing programs or establish programs for adults.		
Transportation	Inability to get to services beyond medical appointments necessary for healthy	Services like Logisticare enable transportation to medical appointments, but not to social services and other needs, like job search, child care, college	Expand existing services to cover social determinants of health.		Passaic County offers bus tickets to women to attain services referred/recommended by CHWs

	pregnancy and healthy new motherhood		Identify existing solutions and community best-practices, like CHW-monitored distribution of free bus tickets and taxi service.	Monmouth has successful grant-funded cab service Other counties like Essex report no transportation solutions
Social Services, WIC, etc.	Disparaging treatment and lengthy bureaucratic process repel women from system that exists to support them. Mental illness, chronic disease or other factors which make it difficult to navigate complex social services process make it harder for high-risk groups to access services.	Board of Social Services/WIC workers who serve pregnant women/new mothers may either not trained in how to serve women with complex health needs, or are too overwhelmed to implement their knowledge.	Pursue resolutions in collaboration with both WIC and the Board of Social Services. Combine with introduction to CI/CHWs and their work, for all groups to learn how they can help each other.	Women suffering from obesity, or who give off impression of substance abuse, cognitive difficulty or mental illness are spoken to more harshly than others, even though they are of greater need. This may be one pathway through which high-risk pregnant women "fall off the radar" of those who can/are meant to take care of them. CHWs reported that they see an immediate difference in how they (the CHWs) are spoken to (with respect), versus how the women they care for are spoken to (with disrespect). Returning women will be received by social services with question

			like, "What do you want now?!" In North, CHWs reported that WIC treated them better. In Morris Medical Center, CHWs are invited to attend initial screening days.
		CI workers and CHWs say Board of Social Services resists their attempts to help clients.	DOH can pursue resolution at higher level, for in-the-field collaboration between CHW/CI and Board of Social Services. Help establish CHW and CI as allies, not adversaries, of Board of Social Services.	
		Requirements around presenting IDs disqualifies women without IDs from receiving assistance. Phones get disconnected, or they get evicted. Struggles like these make navigating the bureaucratic process challenging	Revisit policies around ID presentation and general social services accessibility.	

Appendix C: Mental Health & Substance Use Focus Group Summary

Behavioral Health Planning Council Focus Group Summary

On May 9th, 2018, members of New Jersey's Behavioral Health Planning Council participated in a sub-committee focus group-style discussion to advise the planning process for Healthy NJ's State Health Improvement Plan (SHIP).

The SHIP combines data, professional expertise and community feedback to identify health objectives, solutions and key partnerships. The next phase of the SHIP will include, for the first time, a chapter dedicated to addressing substance use and mental health. NJ's DMHAS identified the Planning Council as uniquely poised to inform the design of an Action Plan that would be both ambitious and realistic, while reflecting the strengths and needs of the Council's stakeholders and those they serve.

The focus group discussion immediately followed the Planning Council's primary May 9th meeting. It lasted approximately 40 minutes. During the discussion, participants emphasized pressing challenges in mental health and substance use and began to suggest potential solutions. The following summary, along with additional assessments guided by DMHAS, including regional focus groups, individual meetings and document analysis, will be presented to the Planning Council as the basis for designing the Action Plan.

Participant insights are divided into Root Causes and Strengths, Assets and Solution Pathways. Root Causes reflect specific barriers to meeting NJ's mental health or substance use needs. The Strengths, Assets and Solution Pathways column includes participants' assessments of existing resources and/or newer ideas for addressing Root Causes. The "Pathways" column is not intended to indicate formed proposals, but, rather, to help guide the planning process forward.

Policy Sphere	Root Cause	Strengths, Assets and Solution Pathways
How medical professionals and institutions navigate mental health and substance use systems	Medical professionals like pediatricians and other physicians, as well as schools and other institutions, still lack health insurance and treatment literacy, which prevents them from connecting their patients/students to existing support systems for mental health and/or substance use challenges.	CIACC is currently addressing this need for children. Participants agreed that CIACC could be made even more accessible through its website, presentations at pediatric
	They do not know how to navigate the ever-changing and currently emerging behavioral health system. Pediatricians remain unfamiliar with the Children System of Care. Medical systems can be resistant to change or education beyond specific professional spheres. Schools and other institutions struggle to navigate the system for their students and/or patients/clients, as well. CIACC is still unknown in many contexts. CIACC addresses this challenge for children. Adults, as well as Emerging Adults, are still vulnerable to institutional lack of treatment/insurance literacy.	collaboratives and other educational partnerships
How patients and their families navigate mental health and substance use systems	Patients and/or their families often have insufficient understanding of their treatment systems and potential supports. Youths are especially vulnerable.	Social media can be utilized to educate both youth and families about how to access services.
	Physicians and therapists are not actively seeking out patients' voice, especially youth patients.	In 2011, the NJ Youth Council summarized solutions to improve care for youth and increase youth

		voice/participation in care. Recommendations are still relevant.
		Patient and Family Advisory Councils at hospitals have been critical resources for individuals and families attempting to navigate system. One participant proposed mandating all hospitals to have them.
Mental Health Coverage	There is not yet universal access to evidence-based integrative care, especially in rural areas.	CCBHCs have been an effective model for providing integrative care in highly populated areas. The Wraparound approach has been incorporated successfully in specific NJ locations and in other states
	Many psychiatrists are not covered by insurance, so mental health parity is not as helpful as it could be	
	Pediatricians cannot bill for addressing mental health	
	Non-medical treatments are often not covered by Medicaid	
	Duration of services is too short	
	Medication-management is not covered by insurance	
	Early intervention exists in 11 counties. There is insufficient funding to make it accessible in all 21.	Early intervention has been a critical resource for families in the State. Participants agreed that it should be accessible statewide.

Lack of Coordination	There is still insufficient collaboration in mental health and substance use support systems. Often, the multitude of great services and programs do not communicate with each other.	OORP establishes a path to treatment for patients admitted to hospital with SUD. Legislation regarding EMT follow up would support progress in facilitating recovery, as well.
	There is often inconsistency between services. Example: Paid EMTs have different policies than volunteer EMTs. Paid EMTs, overseen by the DOH, must follow up with NARCAN recipients. Volunteers do not.	
	Patients end up receiving emergency treatment and are released immediately. They end up back in same cycle which led them to emergency treatment.	
	Mental health and substance use are still treated as acute conditions, not chronic.	
	There is still more room for coordination between criminal justice and mental health/substance use systems	
Workforce Challenges	There are not enough bi-lingual therapists.	There are existing efforts to streamline licensing, increase number of providers.
	There are not enough addiction psychiatrists.	

	There are not enough recovery specialists in the State. Being in recovery is fundamental to the job, but people in recovery have been conditioned to hide this aspect of their life. The job market is not set up to seek out people's being in recovery as indicative of a critical job skill.	Support and communicate increased use of peer-programs like OORP. OORP will be billable for Medicaid by 2019. RWJ/Barnabas is expanding OORP to all hospital departments (not just ER) and onboarding RSs as hospital employees will help in this direction, as well. Peer programs have been utilized extensively/effectively for treating chronic disease and can be utilized more often in mental health/substance use.
Screening/Assessments	Pediatricians still do not sufficiently screen for mental illness, substance use or trauma.	Integrate ACE into pediatric practice and schools. Participants agreed that ACE was an effective assessment tool and should be incorporated more extensively.
	Primary care doctors are currently required to ask one general question about trauma. This is not enough.	
	There is insufficient awareness of the Adverse Childhood Experience (ACE) Assessment tool.	
Emerging Adults	There is a lack of a systemic response for emerging adults.	
	There is a lack of continuity of care when children become adults. Information in the system on kids tends to get either lost or under-utilized when they become adults.	

Stigma	Stigma remains high, especially among specific populations and in specific contexts, like college campuses.	Promote NAMI-like resources among populations vulnerable to stigma
		On-campus advocacy/support groups have been helpful.
	The transition to "behavioral health" risks framing mental health and substance use as functions of individuals' choices and behavior, and, therefore, reinforcing stigmas.	
Monitoring and Research	Evaluations and research findings are not sufficiently focusing on outcomes, on distinguishing the practices that are effective.	The Learning Collaborative is working to establish evidence-based practices for Trauma-Informed Care. There is room, for example, to incorporate TIC lessons from treating children to adult therapeutic settings, as well.
		One participant advocated for re-establishing the support for Family Science
Housing	Supportive housing arrangements are ineffective. Vouchers are available but are not often compatible with existing rental arrangements.	One participant proposed taking a legislative approach to support building facilities in proximity to housing
Transportation/Geography	Transportation to services remains a challenge, especially in rural settings. As noted above, CCBHCs are one of the critical developments in the state, but do not address the needs of people that live far away from them.	

Poverty	Poverty interacts with mental health and substance use – without addressing poverty it will be impossible to fully address mental health and substance use.	

County Drug and Alcohol Director (CADAD)'s Recommendations for the State Health Improvement Plan (SHIP)

On June 23rd, 2018, New Jersey's County Drug and Alcohol Directors (CADADs) participated in a focus group to inform the Substance Use and Mental Health Chapter of the State Health Improvement Plan (SHIP). During the focus group, participating CADADs addressed resource-related dilemmas and barriers to collaboration, described innovative local initiatives and made recommendations.

The following summary divides participants' insights into four categories:

- Policy Sphere: A general description of the category under discussion
- Problems and Root Causes: A barrier to achieving a desired outcome in the policy sphere
- Strengths: Existing resources, processes, policies, and programs that address the root cause(s) or did so previously
- Recommended Actions: Participants' proposals for addressing root causes

CADADs' professional expertise, capacity for innovation and coalition-building experience positions them as critical resources for state-planning, in general, and the SHIP, specifically. The New Jersey Department of Health (DOH)'s SHIP team is deeply grateful to John Pellicane and his fellow CADADs for sharing both their time and insights, as well as Bob Culleton and the Division of Mental Health and Addiction Services (DMHAS) for recommending the CADADs as a critical group to advise the SHIP.

Please continue to send feedback, updates and additional recommendations to yannai.kranzler@nj.doh.gov. We are very excited to continue this process together!

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Partnerships	There is a lack of systematic, policy-driven collaboration between sectors. Stakeholders like school super intendants, prosecutor's offices and/or county freeholders are not sufficiently involved or invested in substance use prevention, treatment and/or recovery. They may attend meetings, but often do not feel compelled to take steps in their own domains.	Super intendents and others are members of their Local Advisory Council on Alcoholism and Drug Abuse (LACADA). They come to meetings, even if they are not sufficiently engaged. It's a step. CADADs have successfully facilitated partnerships with local non-profits and behavioral centers that share their mission.	Strengthen State-led inter-departmental collaboration with stakeholders like the Department of Education (DOE) and law enforcement. This type of Top-Down initiation of collaboration could foster stronger engagement at the local level.
	The policy landscape is siloed, with stakeholders "staying in their lane." They often partner or lead on more visible but less consequential initiatives, like site visits or contests. They contribute less to the details of policy formation and/or implementation. Partners are glad, of course, to accept funding, but more reluctant to invest their own resources in achieving what they perceive to be others' goals.	In Passaic, community police collaborate on both the "pretty and gritty," including working on gang prevention and engaging youth through the junior police force. In the South, one Prosecutor held a roundtable at Cooper University Hospital in Camden, which was attended by police officers and other stakeholders.	The State should involve people in the trenches in planning processes. For example, add a CADAD to the Opioids Core Work Group.
			State should inform CADADs of impending policy, programming or funding changes, so that they can plan in advance and provide members of LACADAs and other coalitions with more concrete expectations.
			Incorporate braided funding streams, which offer grants for collaboration between separate entities such as law enforcement, CADADs and local health departments.
	Programs in the state often become available to specific counties, for limited periods of	The Substance Abuse and Mental Health Services Administration (SAMHSA)	Integrate programs into existing systems of care, to ensure sustainability.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Partnerships	time (until the program is discontinued). The pilot-pattern and block grant funding dependence limits long term planning and innovation, and often leave specific counties without access to critical programs.	has added program sustainability to grant-making criteria.	Add program sustainability to grant-making criteria, using similar approach as SAMHSA.
Access to Integrative Care	There is still a lack of access to integrative care in the State in certain regions. Substance use treatment relies heavily on the mental health system due to co-occurrence between mental illness and substance use, but the mental health system is overworked and stretched too thin. Substance use programs, when funded, rely upon the same set of stakeholders and systems. The demands on them grow, but their capacity and infrastructure do not, which limits new programs' potential impact.	New Jersey's Certified-Community Behavioral Health Centers (CCBHCs) provide comprehensive care. The State does not yet have outcomes data thus far, but anecdotally, their work is promising. They remain geographically inaccessible, though, for residents of certain regions.	Additional state-supported transportation solutions for getting to and from CCBHCs.
			Alongside CCBHCs, mental health resources like PACT and Olmstead should be broadened to include Substance Use Disorder and provide integrative treatment for co-occurring mental health and substance use challenges.
	Primary care practitioners and pediatricians often do not know how, are not sufficiently incentivized or are afraid to address substance use.	The State has identified developing an integrated medical license, including primary care, mental health and addiction services as a priority.	Legislate and incentivize integrated license
	Lack of communication between stakeholders throughout the system disrupts the possibility of seamless system of care		Train providers to screen for, recognize and support treatment of Substance Use Disorder.
Lack of providers	The statewide (and nationwide) lack of psychiatrists is extreme in certain regions. Too few psychiatrists accept insurance, so even existing psychiatrists remain out of reach for many. Other psychiatrists gravitate toward hospitals, which can afford them. As a result, prospective patients have to travel long distances to reach	Federal and statewide programs incentivize priority professions, through debt-forgiveness and salary sliding-scales.	Incentivize medical students to choose psychiatry, and require those that accept the incentive to accept health insurance.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
	psychiatrists and endure long waiting lists in order to receive treatment. In the case of substance use, a 3-4 month waiting list can be the difference between life and death.		
Screening and Early Intervention	There is a lack of Early Intervention and mandatory screening mechanisms for substance use. Unless someone with substance use has a co-occurring mental illness or threatens harming themselves or others, they will not be steered toward treatment.	Screening laws and protocols exist for health and other conditions, including mental health.	Change current screening laws to include substance use.
Detox and Recovery	It often takes multiple episodes before individuals become aware that their substance use is indicative of a disease. This is especially the case among young people. They often want to detox and be discharged without initiating treatment to address addiction.	The Opioid Overdose Recovery Program (OORP) has been effective and now exists in all 21 NJ counties. Individuals admitted into the hospital – not just the ER – for overdose are now offered support by OORP's recovery specialists. Their treatment is then facilitated by hospitals' patient navigators.	OORP is promising, but as it evolves quickly, CADADs should be consulted in order to help shape local and statewide decision-making, prevent duplication and advise partnerships.
	There are geographic barriers to recovery. Burlington, for example, has no recovery center. Sussex's closest detox provider is 60 miles away, and the county does not have public transportation. Among individuals in Sussex, for example, who do get emergency detox, most return home, instead of staying for treatment. Many opt to do so because of the distance from home.	Organizations provide transportation solutions, but their service is inconsistent and does not represent a sustainable solution.	Patients seeking Substance Use Disorder should be eligible for transportation to recovery centers.
			Build community-based detox programs to capacity, in a way that makes them accessible and affordable to residents.
		Hope One's mobile recovery access vehicle has been an effective solution in Morris, boosted by strong backing from the Sherriff. Newark has a similar	Increase geographic distribution of mobile recovery access vehicles.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
		service (which does not serve the rest of the county). Atlantic will be launching mobile recovery, as well.	
	Lack of Case Management results in "losing" patients who are admitted for detox but do not follow up with treatment. It also contributes to the ER "revolving door" of individuals suffering from overdose.	Case management, which would ensure that patients do not get "lost" once they are discharged from the hospital, was planned but cancelled due to the gubernatorial election.	Adopt the existing proposed framework or another form of case management
Detox and Recovery	OORP has not yet been established at county jails, despite high rates of mental illness/substance use disorder co-occurrence among inmates.	The State Department of Corrections underwent a thorough learning process for integrating treatment and recovery, including OORP-like services. County jails can learn from and adapt their process and conclusions.	Add OORP and other treatment/recovery services to county jails.
	Housing insecurity among individuals in early stages of recovery increases the likelihood of relapse.	Gloucester offers first month's rent to people in recovery, as well as beds at Oxford House. They recently expanded sober housing by 30 beds, and continue to work with landlords to open property to additional sober living spaces.	
	CCBHCs administer Medication Assisted Therapy (MAT), but participants argued that not all are doing so yet. Mercer's CCBHC was raised as one example.	CCBHCs provide MAT as a matter of policy.	Evaluations of and updates regarding quickly evolving programs like CCBHCs and OORP should be sent to CADADs and other key groups, in order to keep them abreast of changes and improvements, and so that CADADs can provide the State with information "from the field" around policies which are not yet being implemented fully.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Detox and Recovery	There is a need for more MAT availability in the State. It is unfair to demand MAT for OORP support without increasing MAT capacity/availability/accessibility. In some areas, MAT may only be available in addiction clinics situated in neighborhoods residents view as dangerous, which prevents them from seeking out services.	The State has identified increasing MAT accessibility as a priority.	Allow hospitals to initiate MAT so that it is not a rush to find a provider following detox. Allow FQHCs to provide MAT, as well.
	Women are under-represented in substance use treatment in the State.		Conduct research in order to identify the barriers for women in need of treatment for Substance Use Disorder.
Youth	There is a lack of counseling services for children. Parents often do not have time to take kids after school, services may be located far from where they live and there are long wait lists.	Monmouth and Ocean Counties facilitated affiliation agreements between local YMCAs and schools, through which the YMCA, licensed to provide counseling services, does so in schools during school hours, and bills Medicaid. Passaic provides similar in-school counseling through the mental health clinics, which are funded by grants.	The State should publicize and incentivize county best practices for integrating counseling on school premises and during school hours.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Youth	Schools are resistant to incorporating substance use initiatives. Some schools do not view addressing substance use as central to their mission to educate children. Others lack awareness about substance use at school and/or among students, which presents as disbelief or denial. In the case of Marijuana, there are misconceptions about risks – even mistaken perceptions about marijuana being "healthy". "Juuling" is another pressing concern, as E-Cigarettes are accessible to youths, even middle school children, easy to order via the Internet and to conceal at home/school.	Evidence-based programs like Unique You and Footprints for Life address underlying issues which, ultimately, often lead to substance use. They are not focused on specific substances, but, rather, teach tools like communication, decision-making and anger management, which are all critical to substance use prevention.	Integrate evidence-based practices like Footprints for Life and Unique You into the core curriculum, in collaboration with the schools.
	There are education gaps among children's caretakers, grandparents, for example, who may be unlikely to recognize the signs of Substance Use Disorder.		Create educational materials and programs specific to caretaker groups such as grandparents raising grandchildren.
Stigma and Community Preparedness	Institutionalized stigma around substance use negatively impacts both the likelihood of receiving services and the quality of services received. This is still the case at hospitals, in schools and in the context of law enforcement.	There have been successful "Stigma-Free" campaigns in the State. Bergen County residents increased Stigma-Free efforts following the recent school bus accident, and it was an effective way of processing the tragedy as a community as well as reducing stigma.	Mandate education about stigma at medical (and other) professions' license renewal. Integrating screening tools like SBIRT universally would decrease the stigma around being screened for Substance Use Disorder.
	Stigma leads to communities refraining from admitting they have a substance use issue.	Substance use has gained more visibility as a disease, with health-related terms like "treatment" and "recovery" appearing increasingly often in advertisements and public announcements.	Utilize local events and news to initiate/strengthen Stigma-Free efforts. Research outcomes of specific Stigma-Free initiatives, in order to
Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions

Stigma and Community Preparedness		These trends hopefully address some aspects of stigma.	better understand gaps and best-practices.
	Mental Health First Aid has made significant progress, but specific populations and institutions have been hard to reach, including Emergency Medical Service (EMS) first responders, some Faith-based Organizations (others have been fantastic!) and schools.	Multiple organizations are teaching Mental Health First Aid, including YMCAs, county staff and others, giving both institutions and individuals a diverse mix of learning options.	Integrate Mental Health First Aid with existing trainings, like law enforcement's Crisis Intervention training.
		The State applied for a SAMHSA grant for Mental Health First Aid, which would make it accessible to additional populations.	Institute more Question, Persuade and Refer (QPR) training

Regional Prevention Coalitions' and Municipal Alliances'
Recommendations for the State Health Improvement Plan (SHIP)

On June 25th, 26th and 27th, staff from New Jersey's Regional Prevention Coalitions and Municipal Alliances participated in regional focus group to inform the Substance Use and Mental Health Chapter of the State Health Improvement Plan (SHIP). Participants discussed resource-related dilemmas and barriers to collaboration, described innovative local initiatives and made recommendations.

Focus groups aimed to address two topics: (1) local challenges and best practices in preventing the harmful consequences of substance use, and (2) how to foster collaboration and coordination between regional coalitions and municipal alliances. Participants' recommendations, summarized below, will help the State develop goals, objectives and strategies that will guide prevention across the continuum and throughout the prevention system.

The summary is divided into four columns:

- Policy Sphere: A general description of the category under discussion
- Problems and Root Causes: A barrier to achieving a desired outcome in the policy sphere
- Strengths: Existing resources, processes, policies, and programs that address the root cause(s)
- Recommended Actions: Participants' proposals for addressing root causes

The SHIP team is deeply grateful to the participants for sharing their expertise. We are especially thankful to Donald Hallcom and the Division of Mental Health and Addiction Services (DMHAS), Celina Levy and Rebecca Alfaro and the Governor's Council on Alcoholism and Drug Abuse (GCADA) and Diane Litterer, Janine Fabrizio and Courtney Sheibner at the New Jersey Prevention Network (NJPN) for organizing and advising these focus groups and providing guidance to improve the Mental Health and Substance Use chapter of the SHIP.

For further questions and information about the SHIP, please contact Yannai Kranzler, SHIP Coordinator, at yannai.kranzler@doh.nj.gov.

I.   Local Prevention Challenges and Opportunities

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Engaging the Public	Parents are busy. Especially in areas where they likely work multiple jobs, including weekends, event attendance can be scarce. Some of the parents that need the most support have the hardest time getting involved. Transportation constraints further complicate participation rates. Some areas have poor (or no) public transportation. When Alliances or Coalitions try to arrange carpools for parents, the parents they call sometimes judge that they are being targeted for a prevention program unfairly, and react defensively.	Alliances and Coalitions make use of "captive audiences." For example, they add substance use content to mandatory events like back to school night, or other popular gatherings like community policing or church events. Alliances will often bring food, which is appreciated by both attendees and the hosts. Some attendees will attend because of the food, as it offers the rare opportunity to "eat out." (one participant admitted that in more affluent areas, serving food deters community members who do not want to appear in need of food).	Use needs assessments as opportunities to understand what alliances and coalitions can do in order to increase participation of the most vulnerable populations.
			Continue to build partnerships with stakeholders like law enforcement, faith-based organizations and housing authorities to open up new channels and new communities for prevention efforts.
		One town's alliance held weekly breakfast groups at the school, with school cafeterias serving food. This catered especially to parents who do not maintain a 9-5 schedule, and enabled them to come to the breakfast immediately after dropping kids off at school.	Participants recommended investing more time and resources in small groups than large, one-time events, as small groups enable people to interact and build community, ask questions and share experiences.
	Local volunteers often want to invest in "keep kids busy" strategies. When events like these do not have an additional prevention focus, though, their effectiveness is often limited.	Alliances and Coalitions integrate prevention strategies like mentoring or community-building. For example, if it is a community basketball game, mentors will play, – as opposed to classic drug prevention style lectures.	Use grants and other structures/ incentives to encourage integrating prevention strategies in "keep kids busy" events.
			Refrain from serving alcohol at "keep kids busy" events.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
	Grandparents are currently often raising kids. They need information and support groups catered to them.	Coalitions and alliances have developed informational pamphlets specifically designed for grandparents, which they distribute at community events.	Develop programs specifically designed for grandparents raising children.
Engaging the Public	Stigma still prevents people from supporting or participating in prevention efforts. For example: People still see substance use as a moral failing not a disease. In suburban areas, residents often assert that substance use is not a problem in their neighborhood. They may be okay with alcohol or drunk-driving awareness, but not other drugs. In some areas, there is still a belief in hosting drinking parties for kids at home as a safety precaution. On the flipside, stories – some partly true, some more likely rumors - abound, about individuals who were excluded from sports teams or even military training due to past participation in substance use prevention programs.	Coalitions and alliances have succeeded in breaking stigmas when local youth and parents lead prevention efforts. Parents, for example, host trainings in their homes, where their friends and neighbors feel more comfortable. An additional example: one town's youth created poetry and drama performances on issues related to substance use and mental health from a youth perspective. Hundreds of people who had not previously engaged in explicitly defined "substance use events" came.	More Stigma-Free campaigns, such as Stigma-Free Zones and GCADA's "Addiction Does Not Discriminate" campaign.
	New Jersey's diversity makes cultural competency a challenge and language a barrier. Alliances and coalitions struggle to find leaders of events who speak languages like Farsi, Korean, Polish, Macedonian and others, which prevents them from reaching those communities.	Coalitions and Alliances identify community members to translate. Kids come to events to translate for their parents! Program content then must be adapted to be appropriate for youth. One alliance facilitated employment for Bengali graduates to be substance use peer educators.	Promote bringing in community members to translate, develop culturally sensitive materials and plan events/support groups for their own communities as a best practice.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Engaging the Public	Strong youth coalitions, participants reported, are critical to successful municipal alliances, but youth's transience can lead either to inconsistency or weaker periods.	Alliance coordinators have placed school Substance Abuse Coordinators (SACs) as heads of the local youth coalitions, which has added a sense of stability and sustainability and ensured the relationship with schools.	Ensure that working with youth is part of alliance coordinators' training.
			Include youth in needs assessments.
	Misconceptions develop around local initiatives. For example, a local survey demonstrated resistance to local prescription medication drop-boxes, due to misconceptions about their purpose, fears among elderly residents around disposing of old medication and the desire to share medication with friends and family.	Alliances and coalitions developed partnerships with groups like housing authorities, local supermarkets and the police, through which they were able to educate the community about how, why and where they could dispose of medication.	Encourage trusted, local partners to house drop boxes and host explanatory events for alliances/coalitions.
	Municipal buy-in to alliances can be stunted by resistance from town councils and other local elected officials due to stigma, politics, bureaucratic obstacles, or efforts that have purposes at odds with substance use prevention (like targeted enforcement of underage drinking)	Alliances have successfully involved local politicians, faith leaders and other community representatives with personal or family experience with substance use, who then become strong public allies and passionate advocates.	County coordinators can provide technical assistance to help municipalities looking to form new alliances address local obstacles.
			Partnering with local health departments can add institutional robustness and establish local legitimacy.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Schools	The Active Consent requirement for surveying school children limits local data collection capacity. It prevents being precise in identifying local substance use trends. Currently, accessibility of Active Consent forms varies from school to school. Participants noted two specific obstacles: On the content side, parents are hesitant to sign off on sex-related questions. On the logistical side, many parents just don't get around to signing Active Consent forms.	Some schools have made Active Consent forms more accessible and routine by placing on the school internet portal, adding it to existing "piles" of forms that parents sign at the beginning of school, such as athletic forms, book forms, etc.	NJPN's white paper on Active Consent outlines how the State can achieve a uniform standard for obtaining up to date information from school children on their substance use behavior.
	SACs have been given responsibilities beyond substance use, limiting their time to invest in substance use prevention.	In the past, Drug-Free programs enabled continued substance use prevention programming. The Department of Education (DOE) was more consistently involved then, increasing schools' sense of ownership and buy-in to prevention efforts. Several counties and municipalities reported having monthly meetings with SACs, which enabled them to coordinate prevention efforts.	Alliances and Coalitions should develop relationships and programs that involve school staff besides the SAC. Participants emphasized staff that have unique exposure to students outside the classroom, such as bus drivers and cafeteria staff.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Schools	Schools have so many pressing concerns, and they often do not see substance use prevention as central to their educational goals. Ultimately schools still tend often to use punitive responses to substance use.	Coalitions/alliances discussed developing school-by-school relationships. One participant noted that they now work with all schools, including private schools.	The State should design up-to-date policies through collaboration between DMHAS, DOH and DOE, which establishes schools' involvement in substance use prevention.
	Programs in schools often target specific age groups with little to no follow up. According to participants, these either begin to late – parents sometimes resist programs for middle school – or lack follow up for older kids	Several schools, with the help of alliances and coalitions, have designed their own programs or localized existing best practices.	Schools should start addressing prevention priorities even earlier than middle school. Every age from K-12 should have programming which addresses prevention priorities (programs for younger children would not address substance use directly, but, rather, touch on communication and coping skills that foster resilience)
	Focusing prevention efforts on schools excludes kids who do not attend school, who are often more vulnerable to substance use.	One municipality's youth groups draw those not in school and engages them in community participation and service. Often, they experience unstable conditions at home, including addiction, and the programming through the alliance provides them with community.

Out of school events are successful, as well, including events held at movie theatres, libraries and local book stores. | Alliance funding should be reserved for community/out of school projects. DOE policies and funds should support in-school programming. |

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Health Services	There are geographic disparities in access to Wraparound-style/ integrative care, especially for youth, either due to transportation, provider shortage or cost constraints (often it's all three).	Integrative services have expanded more recently; hopefully, the trend will continue.	Provide more mobile treatment services.
		Recovery centers have been launched in some locations, providing examples for others.	Train providers to treat youth.
	Hospitals, medical clinics and insurance companies are still reactive, focusing mostly on treatment of acute episodes like overdose. They focus less on prevention.	Recovery centers have partnerships with high schools, which has a powerful prevention effect and connects people in recovery with a larger, supportive community.	Coalitions and alliances can act as local bridges between sectors and institutions, for example, between schools and treatment/ recovery centers.
		Healthcare stakeholders have become significantly more involved in prevention and recovery. It's not yet enough, but progress has been significant.	State should support, train for and incentivize the integration of trauma-informed care in all hospitals and medical clinics.

II.   Regional Coalition and Municipal Alliance Collaboration and Coordination

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Joint Planning and Coordination	Alliances and coalitions are distinctly different entities, with their own strengths and challenges. Alliances are comprised of volunteer networks, cover municipalities as opposed to regions, and have relatively small budgets, while coalitions are professional institutions with paid staff. This presents both barriers and opportunities for collaboration.

Coalitions and alliances cover divergent geographical areas. Within coalitions, counties differ from one another, within municipalities, neighborhoods differ. It's a lot of diversity to manage and address! | Coalitions provide sustainability, resources and professionalism. Alliances provide local energy, diverse social networks and contextual knowledge. Successful collaboration, participants argued, occurs when, on the one hand, alliances are active members in their coalition, and when coalitions involve alliances in local programs and give them credit when programs are conducted collaboratively. | Increase contact between alliance and coalition members. The human relationships facilitate the greatest collaboration. One participant suggested quarterly meetings between the alliance and coalition coordinators. |
			Share credit by printing all logos, thanking partners publicly, etc.
		Effective alliance Coordinators act as bridges between the alliance volunteers and the regional coalitions.	Build committees that allow staff and volunteers to be active in their areas of expertise and interest, and which enable coordinators to delegate
	Coalitions and alliances have independent planning structures and schedules, which often lead them in divergent trajectories, limiting collaboration and at times, setting them up as competing entities. At the very least, each group does not always know what the others are doing.	NJPN has, in the past, requested that coalitions redo their needs assessments and involve alliances more in their planning.	Alliances and coalitions should continue to coordinate logic models and reporting formats. Each entities' materials should refer to the other's work and fit it into their work plans.
			Simplifying logic models may make them more transferrable between coalitions and alliances.
		Some coalitions and alliances will coordinate substances. If the Coalition, for example, is focusing on tobacco, the Alliance might focus on alcohol.	GCADA and NJPN should encourage data-sharing between alliances and coalitions. The State should create a data hub for all local substance entities.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Joint Planning and Coordination			The State should provide a blueprint for integrating prevention at the local level.
Training	Alliance members often lack training in prevention. Because they are volunteers, they cannot be expected or required to attend trainings or coalition meetings. In addition, they have a high turnover rate, which necessitates re-training and re-establishing a network.	Alliances are often coalition members, with county coordinators participating in coalition workgroups and coming to coalition meetings. Participants agreed that this was beneficial to both alliances and coalitions.	Mandate new member orientation for alliances, which would focus on prevention principles, how to reach youth, how to engage parents, etc. County alliance coordinators would facilitate the orientation, with the support of coalitions.
Funding Mechanism	The dependence on block grants inhibits stakeholders from planning long-term, and leads to competition between potential grantees, which prevents information sharing and collaboration. While treatment is consistently funded, prevention is grant-limited.	Block grants make new funding streams accessible, and allow programs to reflect updated policy and programmatic trends.	Promote five-year grant cycles, to allow for programs to grow and outcomes to be achieved, while allowing grantees the flexibility to establish new partnerships and make justified changes mid-grant cycle.
	Evidence-Based Practices (EBPs), increasingly required by grants, are expensive. Alliances, for example, may have to pay half of their annual budget on one EBP.

Limiting programs to EBPs also inhibits innovation and the possibility of designing new programs. Outcomes materialize slowly, so even when a new program has a planned evaluation, it may be many years before a good program can gain EBP status. | Alliances and Coalitions have developed metrics for measuring success of newer programs, which they can propose in grants, for example, if programs for youth have continued interest or attendance, then its success can be communicated, even if it has not formally gained EBP status.

Towns have gathered their own data, for example, on local school-based projects. | All participants recognized the importance of EBPs and saw the emphasis on EBPs in grants as a positive development. They recommended, though, that alongside EBPs, newer or grassroots programs be allowed, as long as they followed a set of evidence-based prevention principles like community engagement, follow-up and sustainability. |

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
		Alliance members have gained certification in administering expensive programs, so that they can save on the cost of sourcing them to others.	Increase flexibility on criteria for proving projects' effectiveness. Local participation data, for example, may not qualify a project as an EBP, but should still be valued.
			Participants requested a resource for existing EBPs from which they can choose.
Funding Mechanism	Current grant terms lock grantees into specific programs for specific substances and populations, which prevents them from responding to newer or unforeseen threats or trends, bringing more diverse networks who engage with substance use in different ways, or proposing broader community programs which focus more on building resilience and community.

"Juuling" and heroin addiction were issues that emerged mid-grant cycle, raising challenges around how to divert resources toward addressing them. | When the opioid epidemic emerged publicly, it drew new families into the prevention community and inspired further action and volunteerism. Making space for new substances to be addressed enabled a jolt of energy and community resources, which supported all prevention efforts, not just opioids. | Give Alliances and Coalitions more flexibility to update their needs assessment mid-grant cycle, to deviate from the needs assessment when justified, and/or to implement broader prevention programs which address community needs and individual wellbeing. Local prevention professionals are watching cocaine re-emerge, and warn of an upcoming wave, which they would like to begin addressing before it exacerbates. |
| Prevention Professionalism | There is an increasing prevalence of "prevention" practitioners who are paid for prevention services and programs, despite not being trained and running ineffective programs, such as single, no follow-up assemblies for schools. Schools may be amenable to these programs, which require less commitment | Some RFPs require certification or proof of suppliers' credentials. This reinforces the importance of professional-level prevention. | All grants and funding proposals should emphasize prevention's professional principles and favor sustained programs, as opposed to one-time events that have no follow up. |

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
	than more labor-intensive, 8-12-week programs favored by prevention professionals, but "one-off" events are not effective and often communicate counter-productive messages. The market, though, for these programs, ends up being a disincentive for others to make the effort to earn actual prevention credentials.	Coalitions and alliances can be successful as stewards of professional prevention standards.	
Prevention Professionalism	The hyper-focus on Opioids is welcome and long overdue, but can lead to mistaken professional approaches and take away the focus on community prevention, which often depends more broadly on the determinants of substance use than the specific substance taking center stage.	Coalitions and Alliances have developed strong communities and skills for prevention in the community, which should be critical resources as the State addresses its Opioid epidemic.	State decision-makers should understand the connection between building community resilience and wellbeing, and address daily stressors through upstream, policy-oriented approaches. The State should emphasize the importance of coalitions and alliances in establishing these principles.
	Communities and institutions often resist new programs, and local leaders often oppose State programs which may have been shown to be more effective. DARE, for example, has been replaced nation-wide by LEAD, but some Law Enforcement groups have stuck with DARE.	Some Coalitions and Alliances have threatened to withhold funding if communities or institutions do not adopt more effective approaches, but this has obvious risks, as well, and can alienate critical allies.	In some cases, new state policies, recommendations and high-level decision-making would help inspire changes at the local level.
	Local politics interferes with Alliances' work and ability to thrive broadly. In Newark, for example, local politics has complicated efforts to bring back their Alliance	Coalitions and alliances have overcome politics by mobilizing passionate, local leadership, who enable the prevention community to thrive despite local constraints	Continue mobilizing local leadership, like faith leaders, youth leaders, etc., even when formal structures and committees dissolve. Passionate leadership helps bridge lulls in formal support.

Policy Sphere	Problems and Root Causes	Strengths	Recommended Actions
Prevention Professionalism	Needs assessments and annual reports do not sufficiently ask for local surveying of residents and qualitative data like informant interviews, which limits their precision and overlooks local nuances. This approach risks overlooking or misunderstanding local crises which do not come up in routinely gathered county data.	One county found a local drinking trend among adults over the age of 65 by surveying local residents.	Request that needs assessments and reports include local data sources, both quantitative and qualitative. Value them similarly to county-based data. Community members like librarians, bus drivers and bartenders have important knowledge to contribute. Their insights should be appreciated as essential to needs assessments and reports.
	Insufficient coordination between federal, state and local prevention organizations lead to missed opportunities. For example, the recent Drug Enforcement Administration (DEA)'s "360" event was nationally funded, but a lack of collaboration with local prevention groups like alliances and coalitions, as well the lack of transportation support, resulted in a heavily under-attended event and a misuse of the kind of funding that rarely gets allocated toward prevention.	"Knock-Out Opioids Abuse Day", conducted with Partnership NJ, was a more positive example. Organizers reached out to local prevention groups; together, they planned a more successful event.	The State should facilitate connections between federal/ statewide programs and the coalitions/alliances that understand local needs and conditions. Collaboration between state departments, for example, the Department of Health (DOH) and the Department of Children and Families (DCF) would further collaborative efforts at the local level, as well.

Department of Children and Families – Division of Children's System of Care
Recommendations for the State Health Improvement Plan (SHIP)

Opportunity	Activity/Performance Measures	Lead	Partners	SHIP Cross-Reference
Increase access to evidence-based services and supports across the CSOC service continuum	Support evidence-based practices in the continuum - Increase EBP capacity in OOH - Increase EBP capacity in community-based services	CSOC	CMO, MRSS, OOH Providers, Community-based providers (IIC, IIH, etc.), DMAHS (NJ Medicaid), DMHAS	
Promote and sustain CSOC principles across the service continuum	Embrace CSOC principles and core values throughout the service array - Measure the # of SAMHSA Promising Path to Success trained providers - Based on outcome surveys and evaluations, revise the system partner training curriculum to meet learning objectives	CSOC	CMO, FSO MRSS, CIACC, OOH Providers, Community-based providers (IIC, IIH, etc.)	
Promote better outcomes for youth through increased collaboration among system, family and other partners	Encourage collaboration among all partners - Convene an external advisory group to encourage stakeholder feedback and promote collaboration - Measure improved outcomes for youth and family through the Child Adolescent Needs and Strengths (CANS) assessment tool	CSOC	External Advisory group, DCF-DCPP and other DCF divisions, CMO, FSO MRSS, CIACC, OOH Providers, Community-based providers (IIC, IIH, etc.)	
Strengthen and expand youth and family peer support	Promote the importance of youth and family peer support - Add Family Support Organization (FSO) activities to the Medicaid platform - Provide a direct connection for youth and families to the DCF-Office of Youth and Family Voice	CSOC	DCF Office of Youth and Family Voice, CMO, FSO MRSS, CIACC, DMAHS (NJ Medicaid)	

| Expand integrated physical health care and BH for youth | Infuse integrated care and wellness activities across the CSOC continuum Expand existing integration models Explore addition of new integration models | CSOC | CMO, MRSS, OOH Providers, Community-based providers (IIC, IIH, etc.), DMAHS (NJ Medicaid), DMHAS | |

Appendix D: Nutrition, Physical Activity, & Chronic Disease Prevention Focus Group Summary

Increasing Access To Healthful Foods And Physical Activity:

Focus Group Summary

In December 2018, the NJ Department of Health conducted three focus groups and six stakeholder interviews to inform the development of an obesity and chronic disease chapter in the State Health Improvement Plan (SHIP).

Focus group participants, residents of Dover (Morris County), Egg Harbor (Atlantic) and Trenton (Mercer) and their respective surrounding areas, shared insights regarding challenges and opportunities related to eating healthy and being physically active, as well as opportunities for the State to better support their efforts.

Stakeholder interview participants included local and statewide leaders in facilitating nutrition and physical activity through initiatives such as Supplemental Nutrition Assistance Program Education (SNAP-Ed), YMCA, the Rutgers Cooperative Extension, the Mayors Wellness Campaign and the Center for Food Action (CFANJ). They described their own work, identified strengths and weaknesses of existing programs and made recommendations to guide future planning.

DOH is deeply grateful to the participants in both focus groups and interviews for sharing their insights. We are especially appreciative of the efforts made by the Zufall Health Center, the Community Food Bank of New Jersey and the Trenton Housing Authority to host the focus groups, and to each area's SNAP-Ed team for recruiting participants and providing them with lunch.

The following summary is divided into three columns: (1) The issue under discussion; (2) Challenges raised by focus group and interview participants related to the issue; and (3) Strengths, opportunities and recommendations for helping to address these challenges.

Please note that this summary does not represent an exhaustive list of the challenges in the State that inhibit healthy eating and physical activity or a list of the only or best solutions. It is a subjective summary based on the notes and impressions of the focus group facilitator/interviewer, in consultation with DOH staff. For any questions, comments or corrections, please reach out to the NJ SHIP Coordinator, Yannai Kranzler, at Yannai.kranzler@doh.nj.gov.

Issue	Challenge	Strengths, Opportunities and Recommendations
Increasing Access to Healthy Food	Urban environments often lack large grocery stores, and transportation is limited for specific populations. Residents often rely on corner stores that sell primarily processed foods. The U.S. Department of Agriculture estimates that 340,000 New Jersey residents are living in food deserts across the state, while The Reinvestment Fund suggests even more alarming numbers with as much as 10 percent of the state's population lacking access to healthy food options[1]. The State has made significant progress making healthy foods available at corner stores, but these efforts are still limited. Corner store owners report that when they sell fresh foods, people do not buy them. They spoil and get wasted. The Healthy Small Food Retailer Act passed without funding attached.	• Increase participation in the Healthy Corner Store Initiative, which currently includes over 150 stores by partnering with state and private organizations such as the Department of Human Services, Department of Agriculture, The Food Trust, The Mayors Wellness Campaign, the American Heart Association/ American Stroke Association, The NJ YMCA State Alliance, and the New Jersey Healthy Communities Network. As of 2017, WIC is open access; there are no longer restrictions on the number of stores that accept WIC. • Align the development plan for The Healthy Small Food Retailer Act with the corner store work of SNAP-Ed and advocate for funding to support implementation • Develop a system for, and partnerships with, participating corner stores to track the purchase of healthy foods • Promote initiatives that support local fresh fruits and vegetable sales and consumption such as the Department of Agriculture's Jersey Fresh and Sustainable New Jersey's Buy Fresh Buy Local programs • Increase the number of nutrition education classes offered at corners stores located in low socio-economic communities
		The Department of Aging provides seniors with rides to supermarkets outside of the city. Public transportation has become more conducive to grocery shopping. In the past in one location, free local public transportation limited passengers to one bag each. This is no longer the case. In one town, rides to grocery were provided through Family Success Center's Time Bank.

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[1] https://communitynews.org/2015/06/19/healthy-small-food-retailer-act-efforts-made-at-nj-state-house-2/

Issue	Challenge	Strengths, Opportunities and Recommendations
	NJ has over 130 Farmers' Markets; currently only 50 are registered SNAP vendors and of the over 10,000 farmers, only 183 are WIC approved vendors. Many farmers markets have too few machines for processing food stamps. This reinforces the stigma of farmers markets as expensive, elitist and out of touch with needs of everyday shoppers.	SNAP-Ed, the Healthy Communities Network and others support farmers markets as critical to the mix of local sites supplying access to local fresh fruits and vegetables. Activities, such as food demonstrations, offer market customers an opportunity to taste seasonal produce and bring home recipes. As of 2019, Farmers Markets will be able to approve "non-traditional farmers," e.g., farms that are less than 5 acres. Participants mentioned the following steps, as well: • Increase SNAP redemption rates at Farmers Markets. • Increase WIC Cash Value Voucher redemption rates. • Increase the number of approved SNAP and WIC farmers/markets located in low socio-economic communities. • Promote initiatives that support local fresh fruits and vegetable sales and consumption such as the Department of Agriculture's Jersey Fresh and Sustainable New Jersey's Buy Fresh Buy Local programs. • Increase the number of SNAP/WIC recipients that participate in nutrition education at Farmers' Markets.
	Food banks are challenged with meeting demands of local food pantries. Local food pantries, like churches, often do not have space or the equipment necessary to offer fresh produce. Non-residents are often ineligible to access food from food pantries. If their local food pantries reduce or cease distribution due to funding challenges or staff/volunteer challenges, they do not become eligible to receive food from a food pantry in a different region. Food pantries have limited hours or limit how many times a person can visit. Often, food made accessible to low income residents is high-calorie/high-fat. Alongside the lack of nutritious value in the present, this reinforces and establishes poor eating habits for people in the future, even if they break out of the cycle of poverty.	NJ has three major food banks that serve hundreds of food pantries across the state. A small percentage of pantries offer consumers the opportunity to select the products they will bring home to their families. This consumer "choice" model is highly desirable and supports best practices to promote and distribute nutritious foods. The Community Food Bank of NJ in Egg Harbor, for example, draws new residents to the area so that they will be eligible to access a "choice" food pantry. • Increase the number of consumer "choice" food pantries that adopt best practices to promote and distribute nutritious foods. • Increase access to healthy food options including fresh fruits and vegetables at food banks and food pantries. • Explore additional funding to support the purchase of shelving and refrigeration units for the display and storage of fresh fruits and vegetables.

Issue	Challenge	Strengths, Opportunities and Recommendations
		• Increase the amount of healthy food options donated to food banks. • Increase the number of nutrition education classes offered at local food pantries to help consumers make informed decisions.
		Mobile food pantries are effective, and many bring produce. North Jersey requires more mobile food banks, especially in areas with poor public transportation. • Increase the number of mobile food pantries offering healthy food options in rural and urban areas.
		Farms in the area partner with food pantries and SNAP-Ed providers. For example, food pantries, local programs and farms will plan summer crops together and coordinate distribution. Specific farms in the State grow produce for the sole purpose of donating it.
		Local programs work with grocery stores that donate unsold perishables to food pantries to increase their supply of healthy foods, as opposed to exclusively providing unsold pastries.
	It can be challenging to enroll in WIC and SNAP (harder to enroll in WIC), which prevents individuals in need from accessing healthy food. SNAP regulatory methodologies often limit the number of individuals eligible to receive benefits or reduce the benefit amounts.	The Governor's Office, led by CFANJ's advocacy, proposed the Hunger-Free Campus Act which would help public college and university students enroll in SNAP and allows them to use their benefits to buy food at campus stores. It will also help colleges establish food pantries. Submitted to the State Legislature before the end of 2018, the Bill is currently advancing through the State Assembly. Another advance ("Heat and Meat") expands access to SNAP by allowing individuals receiving utility benefits to utilize the utility allotment toward calculating SNAP benefits. Similar changes in interpreting existing regulatory frameworks would increase access to food without necessitating legislative action. • Explore opportunities to streamline the enrollment process for various benefit programs including WIC and SNAP. Other states have improved enrollment process; there are best practices for the State to learn from (one interviewee suggested Illinois).

Issue	Challenge	Strengths, Opportunities and Recommendations
	Multiple interviewees raised the concern that undocumented families have decreased their participation in programs like WIC, SNAP and others, for fear of deportation, and suggested that this is likely having implications on their health and the health of their children.	*There were no specific recommendations for how to address this challenge, given the hostility this population is facing nationally. The issue was raised consistently, though, with interviewees urging the State to do more to address the needs of the undocumented population.*
ECE/Schools	The National School Lunch Program, School Breakfast Program, Child and Adult Care Food Program, Summer Food Service Program, Fresh Fruit and Vegetable Program, and Special Milk Program are critical interventions in the fight against hunger and obesity. For many children, they may offer the only full meals they receive daily. Participants raised challenges, though: • Many early care and education programs and schools do not have working kitchens. • Alternatives to "main dishes," some of which some children cannot eat for religious reasons or allergies, tend to be less palatable. • In many districts, salad is not offered as part of the National School Lunch Program. Children that wish to select salad must pay – this is prohibitive. • Participation rates and policies differ base on the district: Some districts, for example, do not offer breakfast. • In higher socio-economic areas, poverty exists in isolated pockets or among families scattered throughout the region. • National school nutrition standards have recently been relaxed allowing for increased sugar and sodium consumption.	According to the Centers for Disease Control and Prevention, student participation in the School Breakfast Program is associated with increased academic grades and standardized test score, reduced absenteeism, and improved cognitive performance. However, according to the Advocates for Children of New Jersey, only 44 percent of low-income children in New Jersey receive breakfast from this program. The "breakfast after the bell" act requires public schools with 70 percent student participation rates develop a "breakfast after the bell program". The school setting also offers a unique opportunity to help address hunger over the summer as well as during the school year. A recently enacted NJ statute requires every school district in which 50 percent or more of the students enrolled in the school district are eligible for free or reduced priced meals under the national School Lunch Program or the School Breakfast program must become a sponsor of the Summer Food Service Program or apply to the NJ Department of Agriculture for a waiver. Alongside lunch and breakfast provision, programs are available to schools to impact children's eating habits and increase physical activity. Interviewees argued that engaging kids in taste-testing and food preparation increases the likelihood that they try and enjoy new/more healthful options. Rutgers Cooperative Extension's "Grow Healthy" program connects garden-work with classroom education, including subjects like math, science and English. • Increase the number of schools offering breakfast after the bell. • Increase participation rates in the Child and Adult Care Food Program.

Issue	Challenge	Strengths, Opportunities and Recommendations
		• Increase participation rates in the School Breakfast program. • Increase participation rates in the Summer Food Service Program. • Explore options for including more fresh fruit and vegetable options to children participating in the National School Lunch Program. • Expand the number of schools that participate in Farm to School activities. • Expand the number of students that participate in nutrition education classes. • Expand the number of schools that incorporate best practices into the Wellness Policy. • Expand the number of schools with gardens. • Link NJ Fresh to elementary schools • Allow students currently receiving "Reduced Price" lunches to receive free lunch. • Expand the number of schools that are sponsors or sites for the Summer Food Service Program.
		• Increase tracking of the implications of hunger on student health and academic performance.
Information and skills	Despite awareness of the importance of healthy eating and physical activity, focus group participants acknowledged a lack of information around what specifically constitutes healthy foods, how to access them year-round, create variety, prepare kid-friendly foods and cook healthier versions of traditional foods. Farms and farmers markets sell produce that residents do not always know how to prepare, such as eggplant and squash. Awareness of programs is often dependent on word of mouth, so specific communities or marginalized individuals get left out. While flyers in central areas like libraries and liquor stores are helpful, some residents do not read or speak the language written in the flyers.	SNAP-Ed, YMCA, Greater Newark Healthcare Coalition, the Rutgers Cooperative Extension and others coordinate and provide food demonstrations and cooking classes at WIC centers, health clinics, farmers markets, mobile food pantries and food banks. There are classes targeted toward teens, seniors and other groups, in multiple languages. Many staff have their own struggles with food security or chronic disease and integrate these into their classes. Participants described these classes as helpful and asked for more. For example, North Jersey could benefit from food demonstrations in mobile clinics. Participants recommended flyers in additional spots, and in multiple languages. Staff should also attempt to gain access to additional social networks, so that classes and services can spread through word of mouth to additional populations in need. MWC provides curricula so community members can lead and adapt classes to local needs.

Issue	Challenge	Strengths, Opportunities and Recommendations
	Participants expressed frustration at not understanding the ingredients in processed foods. Some individuals reported that food labels were unhelpful in explaining what should or should not be eaten. They desire more experience growing foods but were nervous about having fresh foods growing on their property, vulnerable to theft.	Community gardens are prevalent in NJ. Participants appreciated them and expressed hope that they would continue and be expanded.
	Poor childhood eating habits are related to lack of parental information around how to cultivate and sustain healthy eating habits among children. While there are programs for parents, it can be challenging to get busy parents to come out to events and workshops. Grandparents, as well, are often responsible for preparing foods for grandchildren, but many are unaware how to make healthy foods they'll agree to eat in current food environment.	Parenting classes should integrate nutrition and food preparation. Prizes and incentives have been effective at increasing participation in events and workshops. Program staff should continue to engage community members to understand how to increase participation. Participants suggested making more of a concerted effort to involve fathers, who are taking on an increased role in parenting. Groups targeted toward grandparents raising grandchildren would be helpful, as well. Partnerships with health clinics help increase participation in groups. For example, Zufall's dietician refers patients to SNAP-Ed classes and SNAP-Ed participates in Zufall's clinical meetings to inform medical staff of existing programs.
Physical Activity	Transportation is a barrier to physical activity; areas lacking good public transportation limit people's ability to reach gyms/parks. In general, walkability is limited in rural and suburban areas. They lack bike paths; many lack sidewalks.	The State should be more engaged in promoting Complete Streets and Safe Routes to School.
		Health insurance often pays for gym membership. It should cover the transportation to the gym, as well!
	Seniors have time for physical activity, but often cannot get to activities. In absence of healthy recreation, solitude leads to sitting at home, watching TV and eating. It is hard to be alone and sad, and many seniors feel the health impact.	Seniors often live close to each other, either in the same building or complex. Programs for seniors can, therefore, be held in or close by their places of residence, providing both a sense of community, healthy activities and practical information.
	There is a need for access to areas in the winter for physical activity. Gyms are often too expensive or not accessible for people living in remote or rural areas.	Family Success Centers partner with local organizations to enable physical activity. For example, churches host free weekly low impact aerobics classes for seniors.
	NJ has beautiful parks, but many residents feel nervous about being or allowing their kids in parks, especially after dark.	Some neighborhoods will have a community police car stationed next to the park. This, residents say, makes them feel safer.

Issue	Challenge	Strengths, Opportunities and Recommendations
	A lack of free time is consistently mentioned as a barrier to physical activity. Focus group participants who are in caretaking roles expressed this challenge in terms of devoting all their time to others, while not having time for themselves.	Programs like Rutgers Extension Collaborative, MWC and others provide resources for worksite wellness programs. Select workplaces implement initiatives such as installing small fitness centers or providing vouchers to local gyms and offering incentives through which employees can exercise during their work day.
	Program staff that plan worksite wellness programs often don't experience those types of initiatives in their own governmental or non-profit organizations ("We don't practice what we preach!")	The State should recommend and provide solutions and incentives for integrating worksite wellness programs in each of its agencies.
Lack of Community	Participants lamented a lost sense of community. For example, young people resist guidance from older neighbors around how to cultivate health habits among their children. Sharply drawn school districts artificially separate some children from not-too-distant neighbors, and this limits their potential social networks. It takes a village, participants argued, to raise healthy children. This has become difficult.	Participants in Trenton felt that there used to be more programs on building community, strengthening African American identify and developing resilience. Initiatives provided transportation and childcare. In addition to providing parents with information, they fostered community. Bringing them back or learning from them when developing new programs may help build support networks critical to cultivating health and well-being.
	Community members often feel excluded from the process of planning programs. While programs intentionally engage the community, often the same groups of people are involved or attend "community engagement" events. It seems hard to reach new and especially marginalized members of the community.	SNAP-Ed tracks specifically for community engagement. Mayors Wellness Initiative incentives engagement through the "Healthy Town Award." YMCA is making special effort to engage youth voice in health planning. While these are best practices which should be noted in the SHIP, perhaps it is possible to add specific tracking measures for adding groups/people to community engagement. • Engage community representatives to participate on the SNAC.
Partnerships	Understaffing at programs translates into an inability to meet the population's needs for workshops and programs, including limiting outreach to new groups, incorporating additional content areas, engaging communities and making workshops longer.	Partnerships have helped enable programs to expand their reach. Participation in county continuum of care committees, advisory boards, coalitions such as the South's Tri-County Alliance and the North Jersey Health Collaborative enable pooling resources. Staff will attend open community events to seek out new partners. Partnerships with organizations such as the United Way bring in volunteers. Collaboration with supermarket dieticians helps facilitate supermarket tours without necessitating additional

Issue	Challenge	Strengths, Opportunities and Recommendations
		staff. Each program represented in stakeholder interviews had developed strong partnership with local faith-based organizations, community centers and food pantries.
	While interviewees discussed vibrant partnerships at the local level, they also mentioned that territoriality between organizations can limit and disrupt collaboration – at its worst, organizations will draw unofficial boundaries within which they discourage other organizations from providing programs. Programs are largely siloed from each other, with funding streams being very specifically allocated. Many staff still don't have a strong idea of other programs in their area. Tracking tends to be program-specific. Meaning, each program tracks its own progress – number of participants, quantity of food delivered, etc., as opposed to the extent of overall progress experienced by the population. The gap between hyper-specific programmatic process tracking and larger outcome measures, such as the Track Trenton Families study, is too large to understand what is working and what is not, why and when.	Staff of organizations that do not collaborate at the State level have successfully overcome tension over time through sustained collaboration at the local level, "in the field." Partnerships should be incentivized through grant arrangements and tracking measures. Some programs are actively seeking out opportunities to become more intertwined. YMCA-Trenton is a SNAP-Ed grantee. Mayors Wellness Campaign and Sustainable Jersey have created a partnership through which a town that is signed on to MWC will receive Sustainable Jersey "Points." Newark Healthcare Coalition will first refer participants in "faith in prevention" programs to other internal programs, but then help them transition into SNAP-Ed initiatives. • Integrate additional programs such as MWC, the Healthy Communities Network, Regional Health Collaboratives such as Newark Healthcare Initiative and others in the State Nutritional Advisory Council (SNAC). Increase more macro-level tracking of both process and outcomes.
	There is a lack of coordination between government programs such as SNAP-Ed, WIC and the School Lunch Program. This disrupts inter-program referrals, problem-solving and overall tracking of progress.	• Increase coordination through consistent and intentional SNAC meetings.
Reporting Best Practices	There is a lack of reporting best practices or policy advances, which inhibits mutually learning and is genuinely demoralizing. People are doing great work, but not receiving credit for it. That hurts.	Publicize best practices through organizational newsletters, such as DOH News Clips, social media, press releases. Celebrate State initiatives like the Governor's recess program, schools that have innovative health projects, farms that donate food to food pantries, etc.
Managing Chronic Disease	Transportation challenges limit the extent to which individuals with chronic disease can attend self-management programs. In rural areas, for example, programs are spaced far from each other, and only those	There is a need for more and better care coordination for people with chronic disease, as well as more geographically dispersed programs for self-management. Community Health Workers can help bridge these gaps, addressing

Issue	Challenge	Strengths, Opportunities and Recommendations
	with cars and time can follow through with the demands of programs. This inhibits the consistency critical to managing chronic disease and limits the effectiveness of self-management. Participants with chronic diseases such as diabetes described a lack of information related to nutrition and physical activity specific to their condition.	transportation and other logistical challenges, ensuring receipt and tracking of medication, facilitating additional supports, such as coordinated treatment for navigating the cycle between chronic disease and mental illness. The Regional Health Collaboratives, such as Greater Newark Healthcare Coalition, excel at providing chronic disease case management, which includes coaching individuals with chronic disease in maintaining healthy eating habits and physical activity regiments specific to their conditions. MWC provides municipalities with toolkits for improving coordinated care, with a focus on health equity.
Smoking	Smoking remains a central contributor to chronic disease and should not go unmentioned in this chapter.	New Jersey's legislation banning smoking from public parks, beaches, etc., became effective on January 16th. Mention this in the SHIP.

Appendix E: Aligning State and Community Health Improvement Planning Focus Group Summary

In May 2018, the New Jersey Department of Health hosted three regional focus groups with local health representatives to inform the next phase of the State Health Improvement Plan (SHIP), and help the State better align the SHIP with Community Health Improvement Plans (CHIPs) and Community Health Assessments (CHAs).

Participants discussed local assessment and prioritization strategies, as well as the SHIP's six leading health priorities. They addressed resource-related dilemmas and community engagement practices, and made recommendations.

The following summary of their insights is divided into four sections:

1. Addressing CHA/CHIP Challenges
2. Aligning CHA/CHIP with SHA/SHIP
3. In Pursuit of Health in All Policies and Health Equity
4. Local solutions for the SHIP's Leading Health Priorities

Participant feedback is divided into three categories:

- Policy Sphere: A general description of the category under discussion
- Root Cause: A barrier to achieving a desired outcome in the policy sphere
- Assets: Existing or potential resources, policies and programs that currently address the Root Cause/s or did so previously
- Recommendations: Actions participants recommended for addressing Root Causes

DOH is incredibly grateful to the participants for their participation and insights, and to the three MCCs for hosting. Please continue to send feedback, updates and additional recommendations to yannai.kranzler@nj.doh.gov. We are very excited to continue this process together!

Section 1: Addressing CHA/CHIP Challenges			
Policy Sphere	Root Cause	Assets	Recommendations
CHA/CHNA/CHIP Integration	Local Health Departments (LHDs) complete multiple community health assessments that work according to different timelines and divergent geographic zones: Timeline: The State requires counties to submit a Community Health Assessment (CHA) every five years. Hospitals complete Community Health Needs Assessments (CHNA) every three years. Geographic Distribution: Counties have multiple hospital networks, so they are doing multiple CHNAs simultaneously. Hospital networks cut across counties, so multiple counties find themselves working together on the same CHNAs that cover geographic regions that differ from the CHAs. Each assessment is likely to have its own format and emphases. CHNAs are funded. CHAs, largely, are not. CHAs, therefore, lean heavily upon CHNAs. Many participating LHDs reported that they see the CHNA and the CHA as one process; they do not separate between the two or see them as separate entities.	Counties in the North, South and Central regions have formed regional health collaboratives that anchor partnerships, host committees, provide professional support, help avoid duplication and publish data. Partners in the collaboratives include LHDs, hospitals, universities, youth coalitions, faith-based coalitions and others. The North Jersey Health Collaborative recently received 501-3-C status, so they can apply for grants rather than lean exclusively upon LDH contributions.	Participants agreed that establishing a set schedule for assessments would be beneficial for all. Collaboratives would conduct a CHA-CHNA-CHIP process on a consistent multi-year cycle, with DOH supporting the process, publicizing CHAs and CHIPs and advocating for stakeholders to utilize CHAs and CHIPs implement them in their own work. Participants disagreed about the optimum CHA/CHNA cycle. One argued for annual CHAs. Others argued that the hospitals three-year cycle is too short and that the State's current five-year cycle is more appropriate.

	Hospitals are mandated by the IRS to complete their CHNAs. Many hospital networks tell health officers that they do not, ultimately, use their CHNA to drive decision-making (they use market research, instead). They do not feel beholden to the CHIP that resulted from the CHNA. While hospitals are required to publicly post their CHNA, they are not mandated to post their CHIP. As such, CHIPs tend to be less rigorous than CHAs/CHNAs.	Some participants emphasized that they appreciate the hospitals' involvement, as without it, they would not be able to afford to do CHA/CHIP. Atlantic's network, according to participants, has demonstrated both a commitment to and expertise on utilizing the CHNA process as a population health initiative.	The State can coordinate a uniform planning process in collaboration with the NJ Hospital Association, which would establish CHNA priorities, the planning methodology and integration with State-mandated processes like CHA and CHIP. NJHA would then communicate decisions to specific hospitals/networks.
CHA/CHIP Staffing	LHDs hire and manage CHNA's consultants, attend and facilitate meetings and help steer their consultants through complex local policy and practice landscapes. Ultimately, LHDs do much of the work themselves. Consultants produce mixed results. Some have been outstanding. Others	Health Educators have proven to be an extraordinary resource for completing CHAs and CHIPs in the years since CHIP Coordinator funding was cut. Counties have made their RFPs for consultants more specific, which help set expectations.	Health educators should be recognized for their contributions to CHA/CHIP. The State, in partnership with NJSOPHE, could strengthen their efforts, for example, through leadership training and outcomes research training, as well as increased, recognized input into Statewide planning processes.

	seem to struggle with the complexities of the county and local nuances, making conclusions which are either too broad, too generic, or which merely re-state the status quo.	Montclair State and William Paterson Universities helped with the Morris County CHA.	Several participants suggested pursuing collaborations with universities to increase assessment capacity, help set up a more consistent CHA schedule and provide more of a Health Equity/Health in All Policies Approach to CHA.
	LHD staff are all likely taking on double and triple roles. Health Educators now see through many counties' CHAs and CHIPs, but it becomes more complicated to expect this of them when they're positions are funded through specific grants.	LHDs have relied on Emergency Preparedness since Superstorm Sandy to fund local public health action. Of late, though, Emergency Preparedness has become a "catch-all" for public health priorities, and participants agreed that this should not be the case	There should a be strategic process through which people address what priorities emergency preparedness should address and what it should not.
CHA/CHIP Utilization	Regionally-defined health stakeholders, for example, chronic disease coalitions, often work with and according to State priorities, as opposed to the CHA/CHNA/CHIP. They then choose priorities or objectives that differ from those recommended by the CHA/CHIP. It is both deflating for the LHD – why conduct the assessment if it is not going to be used? – and less effective, as the CHA/CHNA data can and should point to more precise entry points for intervention		The State must be a more active, vocal ally for the implementation of CHAs and CHIPs State, for example, by instructing its partners to utilize the CHA/CHNA.

Bio-Medical vs. Population Health Focus	Most hospitals push for a patient/medical focused CHA/CHIP. Because they provide 75-90% of the funding, hospitals drive the content. For the most part, hospitals remain committed more to quality of healthcare services. Participants reflected hospital administrators' own admission regarding the hospital conflict of interest – that they rely on sick patients to drive hospital revenue – and the frustration around how that diverts resources from population health to treatment. In general, the perception is that the State is still treatment-focused, as opposed to population health-focused.	Health Officers have successfully incorporated Population Health recommendations in CHNAs by being actively involved in all stages of the process.	
	In Central NJ, regionalization of hospitals and mergers has led to more distance between hospital and community. In the past, hospital leaders were more connected to their community. They now feel more distanced and less involved.	Some hospital networks have more of an appreciation for population health, due to current incentive structures like DSRIP and the transition to more integrative health care. As previously mentioned, Atlantic, in the North, has supported this approach, and provides their strong data support to produce a more Population Health-focused CHNA.	

Data Collection, Research and Evaluation	Fewer residents are filling out CHA's surveys (one region has seen a 50% drop). Participants attributed this to increased survey fatigue, mistrust of government and a general under-valuing of these kinds of assessments in the community. Data measurement tools with a social determinants emphasis can be personal and interpreted as intrusive, inquiring about details like income and ethnicity. Ironically, in this case the Population Health/social determinants-approach – e.g., trying to link social context to health status and health priorities - can present a barrier to data collection.	LHDs have started to do mobile surveys, which overcome the decrease in land-line usage.	
		Many fill out surveys in the street, meeting people face to face and explaining the importance.	
		LHDs distribute gift cards for participation in data collection.	
		LHDs/CHA data-gatherers go to Soup Kitchens to find people to fill out surveys. Public health nurses are effective at establishing trust and getting surveys filled out.	
		WIC was identified as an effective site for data collection. People are waiting there! In addition, because WIC is identified as a safe zone, it may reduce suspicion around providing information.	
	There are populations that get under-represented in data collection.	LHDs/counties distribute surveys and conduct focus groups in multiple languages, including English, Spanish and Korean.	
		One county mentioned that they oversample for populations that are critical to CHA, but tend to get under-represented during general sampling strategies.	
		One county identified demographic gaps in data, for example, with the local Hispanic population, and then conducted targeted survey recruitment to fill the gaps.	
	Measuring outcomes is challenging. Consultants struggle to design pre-post		Participants expressed a desire for training in outcomes. There

	tests to measure CHA/CHIP outcomes, and local decision-makers request numbers to prove the significance of CHA/CHIP. They end up leaning heavily on "increasing awareness"-type outcomes or objectives, which exclude other health-related outcomes or process measures like increased connections between local organizations/resources and residents		were general trainings long ago; time to do it again.
	Data is still not sufficiently localized. The lack of zip code data makes meaningful data-based conclusions elusive. Counties are diverse, and large municipalities skew data. A county may have a high overall health ranking, but specific municipalities may be doing much worse. Hospitals provide local data based on discharges, but this is not always indicative of illness, but, rather, reason for admission to hospital.	Census Track enables some more local data on social determinants of health, like % of children in the free lunch program or number of kids in poverty. Using the census track data enables counties to apply for grants. Counties have added social determinants to their surveys which they can then stratify by neighborhood/population. For example, they have added violence-related questions (this raises risks, though, listed above, around suspicion of surveys).	
	In general, there is a disparity between data utilization capacity in different counties. Atlantic makes their data resources available for CHA, but other regions do not have this same access. The breadth of data can also be overwhelming, and municipalities with more resources have more access to leveraging existing data for applying to grants, giving them an unfair advantage.	Counties are sharing with each other more than in the past. Participants from the South said that they are now sharing programs and data utilization practices to help each other successfully secure grants. In the past, they acknowledged more competition between LHDs.	

Insurers, like Medication Managed Care Organizations, have access to critical data. Insurers do not provide this data to LHDs, though, as they are in competition with one another/feel that this data belongs to them/are adhering to privacy laws. Few insurers are committed to Population Health, as it is not directly connected to their mandate.	Insurers participate in the North Jersey Health Collaborative, and this has enabled insurers to participate in the process, meet partners and share conclusions based on their data. Multiple participants shared stories of insurers who referred clients to local community health resources. The LHD, in these cases, often acted as the "matchmaker" between the insurer and local resources.	While mandating data-sharing may be too heavy a lift, having representatives from insurers/MCOs/ACOs in all CHA/CHNA/CHIP coalitions would help in developing collaborative mechanisms and sharing of insurers' conclusions based on data. Medicaid is critical to this relationship/collaboration.
There are specific health issues where data is more elusive. Participants cited: ADHD, Prescriptions, Lyme Disease, Cancer Surveillance by zip code.	Counties have used their CHA coalitions to enable access to diverse partners' data sources/data conclusions.	State could provide more direction on this front

Organizational support for CHA	Municipalities and/or Freeholders do not understand why CHA is important, or why so much is invested in building partnerships. CHA/CHIP is often not on the radar even of the local Board of Health. Health officers are accountable to the Freeholders, as well as to the County, and, to a lesser extent, the State. It is a balancing act, and organizational loyalty does not always lead to population health-focused prioritization/resource allocation decisions. LHDs are overwhelmed by inspections, and it can be unclear how CHA/CHIP contributes to this most visible LDH responsibility. There are constant "fires" to put out.	In the past, CHIP Coordinator funding was perceived as a reflection of how important CHA/CHIP was to the State. At the very least, it provided an incentive. Health Educators' greatest asset, participants argued, is that much of their CHA/CHIP work happens under the radar. (This gives them freedom, but no resources).	Turn CHIP/CHA into a mandated deliverable to the State. It is currently an unfunded mandate. State needs to help find a replacement mechanism for the previous CHIP coordinator position/funding. Relying on hospitals is flawed. At the very least, State needs to be more articulate about the importance of the CHA/CHIP and link CHA/CHIP more explicitly with its own goals and objectives
	Municipal staffing can be transient, as some municipal employment arrangements are poor. This results in disrupted CHA/CHIP processes and loss of organizational memory.		Bring back or facilitate new funding for CHIP coordinator, who could also be accreditation coordinator.
	There is no funding or capacity to pursue accreditation. Even when municipalities are on an accreditation track, they do not have the funding or capacity to fulfill accreditation requirements, such as documentation		Facilitate a decision-making process around how to replace Public Health Priority Funding with another mechanism.

	of the process, as well as showing how CHA and CHIP were linked with each other and with SHIP		
Changing grant requirements	Federal and other funding arrangements change terminology and rules without warning. Local representatives assume that the State representative will understand rule changes, but, often, the changes have "come down from above" toward the State, as well, just as much as for the local representatives.	State grant managers try to word grants in ways that fit federal requirements but also meet grantees needs. It's a hard puzzle to piece together, but existing relationships between state grant managers and LHDs make it easier.	Include LHDs in meetings or discussions about possible changes. When this is not possible (the State is often not updated beforehand about federally imposed changes!), update LHDs as soon as information is relayed to the State (often, some said, they only find out when grant applications are distributed).
	Often, county meetings do not include local agencies, including LINKS agencies. Changes then often do not "trickle down" to the local level.		Open some of the county meetings to local departments.
Engaging Partners	Partners are busy! It can be hard to get people to come to various CHA committees. Some areas have lost programming because of reduced participation in community engagement events.

Senior programming in one county lost traction in this way, when senior citizens stopped coming to meetings. ("You can't force people to lead a working group!") | Collaboratives have reduced the number of committees, because people were finding it hard to come and participate.

The North Jersey Health Collaborative has narrowed their committees down to two task forces, Mental health/Substance Use and Nutrition/ Fitness/Obesity. In addition, instead of asking what the local priorities are, they ask partners what they would be willing to lead, and then they align the collaborative's priorities around their responses. | |

Section 2: Aligning CHA/CHIP with SHA/SHIP			
Policy Sphere	Root Cause	Assets	Recommendations
Prioritization Process	The SHA included a formula for checking whether SHIP priorities overlapped with CHAs, but CHA stakeholders did not feel like they contributed to the prioritization processes. LHDs were not directly engaged in determining the State's leading health priorities.		SHIP should ensure that each county has at least one of their CHA-identified priorities addressed by SHIP. SHIP themes – the way the SHIP portrays its health priorities – should be informed by CHA-identified themes.
			The next round of SHA – and the 2030 planning process – should establish, *a priori*, a mechanism for including CHA conclusions and CHA stakeholders in prioritization process. NJACCHO and NJSOPHE are great resources for setting this up.
Ongoing Coordination	CHA/CHIPs and SHA/SHIP have parallel schedules and work plans which do not feed off each other. Neither side is aware of the others' status	There used to be monthly CHIP Coordinator meetings, but these were discontinued when funding was cut. (While participants acknowledged that monthly meetings may be too often, they argued for quarterly, or, at least, monthly meetings with the State).	There should be a yearly or quarterly meeting with State about SHIP/CHIPs.
			LHDs need a SHIP contact person who is available to glean CHA/CHIP conclusions, advise on process and update on SHA/SHIP progress.
			Integrate LHDs in more State health planning processes. Increased municipal, county

			and state collaboration around specific initiatives would strengthen overall CHIP/SHIP integration.
CHA/CHIP and SHA/SHIP Publication	CHAs, CHIPs, SHA and SHIP are published separately, in different places. They can be hard to find. Furthermore, they do not seem part of the same process.		All CHIPs/CHAs and SHIP/SHA should be accessible via one website. The site would also include resources on how to do and use CHIP/CHA/SHIP/SHA, News/upcoming events, evaluations of CHIP/CHA/SHIP/SHA, etc.
			SHIP should include local efforts as examples of action on local priorities
	No uniformity between assessment formats	There are multiple PHAB-accepted methods for CHA and CHIP (MAPP, Healthy Wisconsin, etc.). There are lots of templates to choose from. They are all great. The State just needs to choose one!	State should choose a method and or a template for CHA/CHIP to follow
Section 3: In Pursuit of Health in All Policies and Health Equity			
Policy Sphere	Root Cause	Assets	Recommendations
Intersectoral and Inter-Departmental Collaboration	LHDs encounter resistance when trying to collaborate with other departments/sectors. Successful collaborations are dependent upon individual preferences/dispositions. Health in All Policies-type collaborations occur when there is individual chemistry/openness with people	During the Zika scare, the State provided cross-departmental leadership, which successfully filtered down to the local level.	State can provide leadership, establishing connections with these departments/sectors, and offering direction to local level.

outside of health. Intersectoral collaboration has not yet been institutionalized statewide or locally. Participants identified the Department of Education, Law Enforcement, Housing, Agriculture, Transportation, Restaurants and Sexual Assault as critical but hard-to-reach partners.	In one municipality, when the WIC clinic moved out of the municipality, the State, following action by the local Board of Health, provided a "Certificate of Need" for transportation access to the WIC. There is now On-Demand taxi service, which provides 60 rides round trip per month.	
	On the flipside, there are local collaborations – participants mentioned the Chamber of Commerce, Habitat for Humanity, Faith-Based Organizations, Police and others which can inform/support state-level collaborations.	Local connections can be used to inspire collaborations with State-level representatives of these agencies/organizations. SHIP should cite examples of successful collaborations.
Integrating Health Equity in Planning	Health Equity has not yet been emphasized in CHA/CHIP as much as it could. The State should show leadership in this respect.	State should choose fewer specific "health priorities" and focus more on equity, access and partnerships.
	Defining grants by health priorities as opposed to social determinants favors communities that more explicitly shape their lives around their health status. Lower socio-economic populations may experience struggles that more drastically affect their health, like poverty, racism, etc. "Wellness" initiatives, though, aimed at addressing specific health conditions, may not resonate with them in the same way, leading them to miss out on funding opportunities.	SOPHE has initiated a six-month project with Rutgers Bloustein School and four southern counties. They are bringing planners, engineers and others to be more proactive, before health crises emerge.	DOH leadership on integrating Health Impact Assessment in the State, as well as Health Equity Training, would help both health policy decision-makers and non-health stakeholders understand the importance of collaboration, as well as obtain strategies for collaborating effectively

	Homelessness and housing insecurity exacerbate health disparities. There is a lack of shelter space, and, often, shelters do not offer an acceptable solution to residents in need of housing. Lack of transportation exacerbates impacts of housing insecurity on health.	Local hospitals have become housing advocates and even builders – RWJBarnabas has identified safe housing in proximity to hospital as a cost-saving measure which reduces ER visits. Newark hospitals are hiring local residents, providing employment which positively impacts health. One participant mentioned WeWork's WeCommunity initiative as an example of a private initiative worth learning from or partnering with.	The SHIP should highlight when stakeholders like hospitals take on newer, "beyond medicine" roles. On the flipside, it should emphasize health-promoting initiatives in agencies and sectors not defined as "health." For example, Transportation organizations have "Access to Food" initiatives, and together with local police, coordinate "Walking to School" initiatives.
			Health Commissioner should publicly comment on progressive state projects, like Paid-Family Leave, which promise positive health impacts, even when DOH is not directly responsible.
			Pursue more partnerships with private sector
Section 4: Local Solutions for the SHIP's Leading Health Priorities			
Policy Sphere	Root Cause	Assets	Recommendations
Obesity/Chronic Disease	There's a lack of access to healthy food and grocery stores. One out of seven children in NJ go hungry (1 out of 9 adults). In Jersey City, for example, there are two supermarkets, both of which are inaccessible without a car.	Healthy Vineland, a CDC-funded nutrition/physical activity initiative based in part on CHA data, has been adopted in/localized by other municipalities in the South. (Funding, though, was cut in its final year due to federal cuts, and there is no next round of funding).	State support of the Healthy Corner Store Bill, which mandates corner stores to sell, at the very least, canned or frozen produce, would be helpful to representatives at the local level.

		They have evidence of success, including documented effectiveness of their Healthy Corner Stores initiative.	
	Community gardeners are concerned about the possibility of lead in community gardens.	NJ farms are located in proximity to many regions with high levels of food insecurity.	Education for community gardeners about how to identify lead in gardens, as well as State-sponsored resources for testing soil
	Agricultural waste. It is cheaper for farmers to destroy/dispose of leftover produce than to deliver it.		Incentivize more farm-to-table/farmers markets that connect NJ farm produce to people
	LHDs are sometimes left out of local health promotion initiatives, like the Mayors Wellness Campaign, which goes through the Mayor's Office and often does not "trickle down" to the Health Department.	Mayors Wellness Campaign enables great work and local energy around promoting nutrition and physical activity, among other health priorities.	State should help strengthen the connection between LHDs and the Mayors Wellness Campaign.
	There are impending federal cuts to SNAP-Ed. This would be devastating to food insecurity in the State.	Through the Food Trust, local food pantries provide diabetes screenings, as the hungry population is both more likely to suffer chronic disease and have less access to health care. The Food Trust launched a pilot of integrating once a month education, screenings and provision of food. They have also piloted a successful "Diabetes Box." Passaic County has established a Food Policy Council in collaboration with the United Way.	DOH can be an advocate for preserving SNAP-Ed funding, and help Food Trust and local food pantries identify alternative sources of funding in the case that cuts go through
		North Jersey Health Collaborative developed a resource guide for where to find soup kitchens, food pantries and other critical services	

Hunger among college-aged students is now prevalent. This affects academic performance, as well.	Rutgers has launched campus food pantries.	
Funding arrangements often increase competition, or, at the very least, do not increase integration. Chronic Disease Coalitions, for example, lead to splitting apart funding at the local level and disrupt collaboration. Chronic Disease Coalitions' transition to a regional approach was "devastating" for LHDs, many of whom could no longer apply for funding.	Municipalities/regional coalitions have learned to ask the chronic disease coalitions for specific resources, like sunscreen, which they provide on a less selective basis.	State should hold Chronic Disease Coalitions accountable for defining objectives according to the CHA/CHNA
Lack of access to physical activity	Many municipalities have outdoor exercise equipment – some have even placed them next to playgrounds, so adults can exercise while children play. Some municipalities have placed explanatory signs next to the equipment to instruct users. Others hold free tours to walk residents through equipment.	Free trainings on site of outdoor exercise equipment
Collaborations can raise new barriers: For example, counties that have pursued collaboration with schools to get children outside during recess must address the fact that some schools do not have safe outdoor places to play, and that sun safety has emerged as an additional health concern around playing outside		DOH-DOE collaboration on establishing policies and protocols for safe access for schools to outdoor play areas would help counties and communities negotiate solutions locally.

	People are so busy!	Burlington's Tuesday's with Turrey uses social media to deliver short, informative videos on active living.	
Birth Outcomes	At the policy level, LHDs are not always engaged with the Improving Pregnancy Outcomes (IPO) program. Some counties collaborate with IPO's Community Health Workers, but participants expressed a desire for more contact and systematic involvement in the process		Partnership between DOH's Family Health Services and the Office of Local Public Health could help establish a more systematic relationship between LHDs and IPO
	Participants discussed the need to focus more on smoking cessation and other preventative measures		
Immunization	Schools are reluctant to remove under-vaccinated children. Daycares are hardest! Letters from schools to parents are not effective. LHDs conduct school audits, and when schools do not comply, in some cases, LHDs end up taking Daycare Centers to court, which, of course, they wish they would not have to do. They expressed a desire for more state support and direction.		Stronger State policies around how schools notify parents of unvaccinated children and how they relate to them if their children remain unvaccinated. DOH-DOE collaboration
	Misinformation still reaches parents, especially in specific geographic regions. Even among parents that are not viciously anti-vaccine, there is reliance on the herd immunity which leads parents to question how critical it is to adhere to the vaccination schedule.	Camden created an immunization display, and the education had an impact and helped increase vaccination rates. Other counties created immunization toolkits, as well.	
		Vaccination for Children (VFC) walk-in clinics make vaccinations accessible	

		LDHs have provided successful trainings at daycare centers.	
	It has been challenging to promote HPV vaccination in politically conservative regions. LHDs cannot always utilize materials developed elsewhere, because they focus on risks regarded by local populations or politicians taboo. Burlington Freeholders have objected in the past, for example, to using APHA materials. The connection between HPV and sex creates a stigma around HPV vaccination and leads some parents to avoid it		
	There is less awareness about importance of boys being vaccinated against HPV		
	Immunization often does not emerge from quantitative local health assessments as a local health priority, because it is not something that the local population directly or visibly suffers from en masse. Local immunization coverage data can be elusive, as well	Counties have become more informed about immunization coverage challenges through qualitative consultations with local health professionals or others.	

Mental Health and Substance Use	There is a lack of geographically well-distributed mental health resources, which complicates finding a provider in some counties/areas, leads to long waiting lists and presents cost barriers. Culturally appropriate and/or bi-lingual services are even more elusive, especially for undocumented and/or homeless residents. Need is particularly pronounced for children, with a lack of child psychiatrists statewide, and an extreme lack of child psychiatrists in rural areas. Wait times for an ADHD test can be six months; there are consequences when children with mental health struggles must wait to receive services and support.	Mental Health First Aid has been promising – organizations like YMCA are giving trainings locally.	Increase Mental Health First Aid trainings.
			Invest radically in mental health workforce development.
		Faith-based organizations, like Cherry Hill's Muslim Community Center, offers free mental health services for the whole community, not just faith members.	Help reduce stigma around utilizing local health services, as well as suspicion around non-affiliated individuals' use of faith-based organizations' free mental health services
			Incorporate Trauma-Informed Care across the medical treatment spectrum
	It's a challenge to access EMS and HIPA data.	The CHIP planning process helped build collaborations with stakeholders with access to data.	
	The integration of DMHAS into DOH caused a lot of confusion and disruption of services at the local level. The process is still far from being complete.	Partnerships and other stakeholders are learning to adapt	The State needs to support and hasten the transition.

	Prevention is critical, and Municipal Alliances are great local prevention resources, but they are often lacking sufficient funds to fulfill their mission.		
	Mental health is emerging as a critical issue on college campuses. Many students are still unaware of the services that exist on campus (or there is stigma around using those services). On the flipside, students are often pushed, when they do turn to services, to seek mental health treatment off campus, which is likely not to be covered by insurance.	Campuses currently offer some treatment services to students suffering mental health challenges.	Colleges/Universities should include a mandatory course on mental health for all students, which could include Mental Health First Aid and guidance on how to seek out help for oneself or a peer/family member, both on campus and off.
	Stigma is still a major challenge, especially for specific populations.

It has been challenging to get people to participate in mental health working groups for CHA/CHIP due to stigma. | Some groups have started to use different language around programming, advertising parenting groups for how to care for "over-extended child" as opposed to "children who suffer from anxiety." | |
| | There are significant, unmet mental health treatment needs in prisons | Mercer County has created a partnership with prisons, treating people while incarcerated or in halfway houses. | |