



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
New Jersey**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and certifications are available and maintained on file in the Office of the Assistant Commissioner of the Division of Family Health Services.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

To include public input into the annual development of the MCH Block Grant Application and Annual Report, a public hearing is scheduled annually in May. A draft of the application narrative is posted on the Department's website four weeks prior to the public hearing. Notice of the public hearing is published in local newspapers throughout the State. Notification of the public hearing and availability of the draft application is posted on the Department's website and is mailed to over 300 individuals on the Division of Family Health Services mailing and e-mail lists.

Although only one individual signed up to present verbal testimony and the public hearing was cancelled, eight written letters of support were received. Written letters of testimony were all supportive of the application narrative and needs assessment. Issues in common in several written letters of testimony included: the need to improve access to quality care for children with special health care needs, the need to provide health insurance to all children through NJ FamilyCare, and continued support for several MCH programs including: Access to Prenatal Care Initiative, Perinatal Addictions, Postpartum Depression, Fetal-Infant and Maternal Mortality Review, the Newborn Screening Program, and Coordinated School Health Program.

Input into Title V activities is encouraged throughout the year through involvement of individuals and families in the many advisory groups and task forces as described in Section III.E

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

This is a brief summary of the five year Needs Assessment submitted with this year's application. There have not been any recent priority changes for the MCH population in New Jersey. There have been a number of new activities to address existing priorities which are described in the Needs Assessment and Narrative. These new activities include implementation of the Access to Prenatal Care Initiative, expansion of the Newborn Biochemical Screening Program, activities of the Governor's Council for Medical Research and Treatment of Autism, and the expansion of the Office of Nutrition and Fitness.

The selection of the New Jersey's eight priority needs is a product of FHS's continuous needs assessment. Influenced by the departmental budget process, the MCH Block Grants needs assessment process and the collaborative process with other MCH partners, FHS has selected the following eight priorities (see Section IV.B. State Priorities): SP #1 Increasing Healthy Births, SP #2 Improving Nutrition and Physical Activity, SP #3 Reducing Black Infant Mortality, SP #4 Reduction of Adolescent Risk Taking Behaviors, SP #5 Improving Access to Quality Care for CYSHCN, SP #6 Reducing Teen Pregnancy, SP #7 Decrease Asthma Hospitalizations, SP #8 Improving and Integrating Information Systems.

Some of these priorities have been longstanding priorities (SP #3 Decreasing Black Infant Mortality, SP #6 Decreasing Teen Pregnancy, SP #8 Improving and Integrating Information Systems, and SP #5 Improving Access to Quality Care for CSHCN). Others are priorities that broadly address several issues (SP #4 Decrease Adolescent Risk Taking Behaviors and SP #1 Increase Healthy Births). The remaining two priorities focus attention on more recent public health issues (SP #2 Improving Nutrition and Physical Fitness, and SP #7 Decreasing Asthma Hospitalizations).

State Performance Measures (SPM) have been changed through the new needs assessment process. Two existing SPM will be kept, five new SPM are being added, six old SPM are being deleted. The 2 existing SPM which will be continued are: Black non-Hispanic preterm infants in NJ, and children with elevated blood lead levels. The 5 new SPM are: Regional MCH Consortia conducting community-based FIMR Teams and implementing recommendations through a Community Action Team; children and adolescents who are overweight or obese; newborns who are discharged from NJ hospitals, reside in New Jersey, did not pass their newborn hearing screening and who have outpatient audiologic follow-up documented; live children registered with the BDARS who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services; and the average age of diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

The 6 old SPM to be deleted are: Regional MCH Consortia implementing community-based FIMR Teams; repeat pregnancies among adolescents 15 - 19 years of age; State supported initiatives implemented for improving the nutrition and physical activity of children and adolescents; children with birth defects who are appropriately reported to the NJ Birth Defects Registry; children reported to the NJ Birth Defects Registry by three months of age; and HIV exposed newborns receiving appropriate antiviral treatment to reduce the perinatal transmission of HIV.

Attached to Section IV. A. Background and Overview are ten MCH Indicator Trend Charts including:

- Chart 1 Births by Race/Ethnicity
- Chart 2 1st Trimester Prenatal Care Initiation
- Chart 3 No Prenatal Care
- Chart 4 Teen Births 15-17 Years of Age
- Chart 5 Low Birthweight
- Chart 6 Very Low Birthweight
- Chart 7 Infant Mortality by Race/Ethnicity
- Chart 8 Neonatal and Postneonatal Mortality
- Chart 9 Breastfeeding by Race/Ethnicity
- Chart 10 Multiple Births

III. State Overview

A. Overview

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

A brief overview of New Jersey demographics is included to provide a background for the maternal and child health needs of the State. While New Jersey is the most urbanized and densely populated state in the nation with 8.7 million residents, it has no single very large city. Only six municipalities have more than 100,000 residents.

New Jersey is one of the most racially and ethnically diverse states in the country. According to the 2010 New Jersey Population Estimates, 68.6% of the population was white, 13.7% was black, 8.3% was Asian, 0.3% was American Indian and Alaska Native, and 2.7% reported two or more races. In terms of ethnicity, 17.7% of the population was Hispanic. The racial and ethnic mix for New Jersey mothers, infants, and children is more diverse than the overall population composition. In 2010, 26.9% of mothers delivering infants in New Jersey were Hispanic, 45.5% were white non-Hispanic, 15.2% were black non-Hispanic, and 10.3% were Asian or Pacific Islanders non-Hispanic. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

Maternal and child health priorities continue to be a focus for the NJDHSS. The Division of FHS, the Title V agency in New Jersey, has identified 1) improving access to health services, 2) reducing disparities in health outcomes and 3) increasing cultural competency of services as three priority goals for the MCH population. Specific attention has been placed on improving birth outcomes, obesity prevention, early access to prenatal care, black infant mortality reduction, reduction of risk taking behaviors among adolescents, newborn biochemical screening, autism, and improving access to quality care for children and youth with special health care needs (CYSHCN). These goals are consistent with the Life Course Perspective which proposes that an inter-related web of social, economic, environmental, and physiological factors contribute in varying degrees through the course of a person's life and across generations, to good health and well-being.

Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all New Jersey's families. Title V will continue to maintain a safety net of direct services, especially for children with special health care needs. During a period of economic hardship and federal funding uncertainty, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services.

To improve New Jersey's commitment to early prenatal care and healthy births, a Commissioner's Prenatal Care Task Force Report in 2008 issued recommendations to increase public awareness of preconception health; ensure the availability of ongoing early prenatal care services for women in areas affected by hospital closures or reduction in obstetric services; and promote equity in birth outcomes. Following the recommendations from the Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Goals of the Access to Prenatal Care Initiative are

to increase public awareness of preconception health; ensure the availability of ongoing early prenatal care services for women in areas affected by hospital closures or reduction in obstetric services; and promote equity in birth outcomes. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care. Nine projects were funded within the Access to Prenatal Care Initiative representing a variety of best practice models.

To improve access to health services, the State has provided reimbursement for uninsured primary medical and dental health encounters through the designated Federally Qualified Health Centers (FQHCs) since 1992. In SFY 2012, reimbursement for uninsured care remained at \$46.4 million.

An emerging MCH issue in NJ and nationally has been the growing obesity epidemic. In May 2008 the NJDHSS was awarded a 5 year cooperative agreement by the Centers for Disease Control and Prevention (CDC) to the Office of Nutrition and Fitness (ONF) to provide state leadership and coordination of nutrition, physical activity and obesity (NPAO) strategies. Through this cooperative agreement ONF has taken the lead in building a robust infrastructure by creating a statewide partnership of over 200 organizations and individuals, called ShapingNJ, to collaborate, build capacity and develop a comprehensive and coordinated system to halt further increases in obesity and other chronic diseases.

CDC recognizes six target behaviors for intervention to prevent or control obesity including: 1) increase breast feeding initiation, duration and exclusivity; 2) increase physical activity; 3) increase fruit and vegetable consumption; 4) decrease TV viewing; 5) decrease the consumption of sugar sweetened beverages; and 6) reduce consumption of high energy dense foods. Additionally, CDC recommends five settings for the prevention and treatment of obesity including medical/ healthcare, community, schools, childcare and the worksite. CDC requires that strategies are targeted to populations that are at risk for health disparities as indicated by data.

Priorities for the NPAO State Plan include to: 1) increase number, reach, and quality of targeted policies and standards to support a healthy lifestyle; 2) increase access to and use of environments that support healthful eating and physical activity; 3) increase the number, reach and quality of social and behavioral approaches that complement policy and environmental strategies; 4) identify data sources and monitor outcomes; 5) engage strategic public/private partnerships at the state & local level; and, 6) prioritize use of evidence-based strategies/best available evidence.

Federal American Recovery and Reinvestment Act funding for New Jersey has focused on three NPAO components including: 1) promote the initiation and duration of exclusive breastfeeding among NJ mothers; 2) improve nutrition, physical activity and decrease TV viewing for children in licensed child care centers and registered family day care homes; and 3) build capacity among local health departments to implement policy and environmental change at the community level to impact obesity.

Additionally, a 5 year cooperative agreement was awarded by the CDC to the Department of Education (DOE) to collaborate with the DHSS on a Coordinated School Health Program to address nutrition, physical activity and tobacco. Three grants, each located in one of three New Jersey regions (North, Central and South), have been awarded funds to be used for the implementation of CDC's model in at least eight public middle- and/or high- schools of public school districts.

In the area of children and youth with special health care needs (CYSHCN), the Newborn Screening and Genetic Services Program helps to ensure that all newborns and families affected by an abnormal screening result will receive timely and appropriate follow-up services. All newborns receive mandated screening for 54 disorders. New Jersey is among the top 5-10

states in offering the most screenings for newborns. Follow-up services include notification and communication with parents, primary care physicians, pediatric specialists and others to ensure the baby has immediate access to confirmatory testing and treatment. In Fiscal Year 2011, significant improvements in laboratory testing were made to decrease false positive results; 102,315 newborns received initial screens and 5,590 infants had abnormal results.

The Program meets and communicates regularly with several advisory panels composed of parents, physicians, specialists and others to ensure New Jersey's program is state-of-the-art in terms of screening technologies, operations and is responsive to any current concerns regarding newborn screening.

According to the Centers for Disease Control and Prevention's (CDC) 2008 prevalence figures published in the Morbidity and Mortality Weekly Report (MMWR) on March 30, 2012, one of every 49 eight year olds in Union County, New Jersey had autism. Thus New Jersey continues to have one of the highest rates of autism in the United States.

The State's proposed rule for the implementation of the Autism Registry was formally adopted in September 2009. The registry includes a record of all reported cases of autism with other information deemed relevant and appropriate to (a) improve current knowledge and understanding of autism, (b) conduct thorough and complete epidemiologic surveys of autism, (c) enable analysis of this problem and (d) plan for and provide services to children with autism and their families. Reporting to the Autism Registry is done through the existing process of reporting to the Birth Defects Registry. To accommodate Autism, the BDR was expanded and is now available as the web-based Birth Defects & Autism Reporting System.

The Governor's Council for Medical Research and Treatment of Autism (the Council) has been transferred to the Office of the Commissioner at NJDHSS. The Governor's Council for Medical Research and Treatment of Autism is a 14 member, legislatively mandated Council that is charged with creating a Center of Excellence for Autism in the State where basic science and clinical research studies, as well as clinical diagnosis and treatment initiatives can take place. The Council currently has two major grant initiatives (a \$5 million dollar Biomedical Research Grant program and an \$8.55 million dollar Clinical Enhancement Center Grant program). The Clinical Enhancement Center Grant Program will end in June 2011; a new request for applications is currently being developed.

The Department released the Early Identification of Autism Spectrum Disorders: Guidelines for Healthcare Professionals in New Jersey in April 2009. These guidelines have been disseminated to health care professionals and members of the public to assist in evaluating infants and toddlers living in the State for autism, to ensure timely referral to appropriate services, and to provide information on the medical care of individuals with autism.

Maintaining ongoing Title V supports and services for children and youth with special health care needs (CYSHCN) and improving access to quality care for NJ CYSHCN is enhanced by collaboration with community partners. To that end, Special Child Health and Early Intervention Services (SCHEIS) will work with the Statewide Parent Advocacy Network (SPAN), the NJ Academy of Pediatrics, Pediatric Council on Research and Education (PCORE), Special Child Health Services (SCHS) Case Management Units (CMUs), pediatric specialty providers and other community-based organizations on SPAN's HRSA funded State Implementation Grant for Integrated Community Systems (Integrated Systems Grant or ISG 1). The ISG 1 is providing resources and manpower to address capacity in the identification of need, coordination of care and access to information across multiple systems, data sharing, collaborating with community partners and evaluating success. In addition, NJ has been very successful in linking children registered with the Birth Defects and Autism Reporting System (BDARS) with services offered through the SCHS CMUs; Child Evaluation Centers including the Fetal Alcohol Syndrome and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers; Cleft Lip/Palate Craniofacial Centers; Tertiary Care Centers; and Family WRAP (Wisdom, Resources and Parent

to Parent). With CDC Surveillance grant funding, the system is undergoing enhancements to support tracking of CYSHCN referred to SCHS CM, monitoring of services offered and/or provided to determine client outcomes. Information garnered from both the ISG 1 and CDC Surveillance initiatives is anticipated to support and enhance NJ's efforts to improve the six core MCHB outcomes for CYSHCN.

Title V CYSHCN shares an active collaborative partnership with SPAN and AAP, New Jersey Chapter, which was featured at two "Knowledge Café" sessions at this year's Association of Maternal and Child Health Program's annual conference. Title V CYSHCN, SPAN, and AAP communicate regularly via monthly scheduled conference calls in addition to meetings and other activities to strengthen this relationship. Title V, SPAN, and AAP, as well as over 100 other local, county, and state organizations and diverse family leaders also all share in a partnership working together to better serve children and families with special health care needs. This partnership and its accomplishments was recognized at the Community of Care Consortium Statewide Summit in April 2012.

On July 1, 2009, the Early Identification and Monitoring (EIM) Program implemented the Birth Defects and Autism Reporting System (BDARS). This new electronic reporting system updated and replaced the Birth Defects, Autism, and Special Needs Registry, which has been an invaluable tool for surveillance, needs assessment, service planning, research, and most importantly is a mechanism to link families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking registered children to health services. Since 1985, NJ has maintained a population-based BDR of children with all defects. Starting in 2003, the SCHS Registry received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses and the Registry was renamed the Birth Defects & Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects to age 6, and added severe hyperbilirubinemia as a reportable condition. The BDARS, at present, refers all living children and their families to our SCHS Case Management Units, but does not monitor the progression into the service stream. On July 1, 2009, the first case was entered into the new web-based BDARS. EIM staff spent most of the second half of 2009 training reporting facilities on the use of the new BDARS. In 2010, over 9,700 children were newly registered with the BDARS.

New Jersey has been very successful in linking children registered with the BDARS (formerly known as the Special Child Health Services Registry) with services offered through our county based Special Child Health Services Case Management Units (SCHS CMUs). However, the System did not further track children and families to determine if and what services were offered to any of the registered children. To address this weakness, a second module is being added to the Birth Defects and Autism Reporting System (BDARS). This module will be used by the SCHS CMUs to track and monitor services provided to the children and their families. It will electronically notify a CMU when a child living within their jurisdiction has been registered. Also included in the module is the ability to create and modify an Individualized Family Service Plan, track services and service providers for each child, create a record of each contact with the child and child's family, create standardized quarterly reports and other reports, and register previously unregistered children.

The Case Management module went online in August 2011 in one county. Mercer County had volunteered to be the early adopter in order to test the functionality of the system in a live environment. The module was successfully adopted by all 21 counties by January 2012.

In fall 2009, the New Jersey Early Hearing Detection and Intervention Program (EHDI) began a new collaboration with several Federally Qualified Health Centers (FQHCs), with supplemental grant funding received from the Health Resources and Services Administration (HRSA). Three

FQHCs were selected for funding that would allow them to purchase equipment and train staff to allow them to conduct outpatient rescreening for infants who did not pass their initial screening. The FQHCs will provide this service at no charge to the families, to reduce the fiscal barriers to lack of newborn hearing screening follow-up. Three FQHC's purchased hearing screening equipment in 2010 and were trained on screening infants. In early 2011, two additional FQHCs were awarded funding to purchase screening equipment. Once the equipment is delivered, the EHDI audiologist will train the FQHC staff on proper screening techniques.

Another collaboration made possible by the supplemental HRSA funding was the implementation of follow-up phone calls to parents and physicians of children in need of follow-up. While EHDI rules give hospitals the primary responsibility for ensuring children receive appropriate follow-up after discharge, the level of effort put into this by each hospital varies widely. Thus this program provides supplemental contacts to compliment the hospital's outreach efforts. This outreach is being done through funding provided to the Mercer County Case Management Unit. In 2010, over 1,700 families were contacted through this initiative. This project will continue in 2012.

The NJ Pediatric Hearing Healthcare Directory was updated in 2010. Annually, audiologists and hearing aid dispensers in NJ are asked to verify their current listing and new facilities are added. The 2010 update included a new section listing pediatric otolaryngologists, made possible with the partnership of the New Jersey Hearing Evaluation Council. There were 33 pediatric otolaryngologist offices who wished to be included in the Directory. This resource enables physicians and families to locate facilities in their area that have the required diagnostic services. In April 2011, the NJ Pediatric Hearing Health Care Directory was improved as a searchable on-line directory with the ability to map facility locations and obtain driving directions. This update was made possible through partnership with the DHSS Office of Information Technology Web Team.

Legislation mandating newborn pulse oximetry screening to detect Critical Congenital Heart Disease took effect on August 31, 2011. Since then, NJDHSS has developed a mechanism to collect data on all infants screened by having birthing facilities submit quarterly aggregate data reports. In addition, information on all infants with failed screens is reported by each birthing facility to the Birth Defects Registry. In the first quarter of screening, at least two infants with previously unsuspected critical congenital heart disease were detected through the screening program. NJDHSS continues to provide technical assistance to the birthing facilities and is also working to develop educational materials for parents and health care providers.

The Birth Defects and Autism Reporting System (BDARS) was utilized to track all infants who failed their Pulse Oximetry screen. At present, a reporting template has been copied into a note field to capture relevant information. Currently a complete Pulse Oximetry Module is being programmed for use in the BDARS. This is anticipated to be implemented by June 2012.

The following MCH Block Grant Application/Annual Report provides a detailed overview of public health programs designed to address the MCH needs in New Jersey consistent with the MCH Bureau's growing recognition for the need to target upstream determinants of health and support for a Life Course Perspective. FHS is looking to address health risks earlier in the life span, during developmentally sensitive periods, when prevention, early intervention and health promotion can yield the greatest benefits.

B. Agency Capacity

This section describes Family Health Service's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN). The MCHS and SCHEIS Programs ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health

services with other services at the community level.

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

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

Other statutes exist to provide regulatory authority for Title V related services such as: services for children with Sickle Cell Anemia (N.J.S.A. 9:14B); the Newborn Screening Program services (N.J.S.A. 26:2-110, 26:2-111 and 26:2-111.1); genetic testing, counseling and treatment services (N.J.S.A. 26:5B-1 et. seq.); services for children with hemophilia (N.J.S.A. 26:2-90); the birth defects registry (N.J.S.A. 26:8-40.2); the Catastrophic Illness in Children Relief Fund (P.L. 1987, C370); the childhood lead poisoning prevention program (Title 26:2-130-137); and the Sudden Infant Death Syndrome (SIDS) Resource Center (Title 26:5d1-4). Recent updates to Title V related statutes are mentioned in their relevant sections.

The following is a description of New Jersey's Title V capacity to provide preventive and primary care services for pregnant women, mothers and infants, preventive and primary care services for children, and services for CYSHCN.

III. B. 1. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal and Child Health Services (MCHS) within FHS is to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low income and special populations. Prenatal care, family planning, perinatal risk reduction services for women and their partners, post partum depression, mortality review, child care, early childhood systems development, lead poisoning prevention, immunization, oral health, nutrition and physical fitness and teen pregnancy prevention are all part of the MCHS effort.

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

/2012/ The Department has made the commitment to decrease the number of MCHC from 6 to 3 by the end of 2011. The MCHC have been directed to move forward with consolidation in an effort to decrease costs to both the hospitals and the public sector. As of July 1, 2011 there are 5 consortia.//2012//

/2013/ As of July 1, 2012 there are 3 consortia. DOH grant funding saved by the

consolidation will be redirected to direct services for clients.//2013//

The Commissioner's Prenatal Care Task Force was convened by former Commissioner Heather Howard in February 2008 to improve access to early prenatal care and improve healthy birth outcomes. The Task Force's charge was to make recommendations to improve access to first trimester prenatal care in NJ and ultimately to increase the number of women seeking and receiving care within the first trimester of their pregnancy. One recommendation of the Task Force was to redirect current funding to an Access to Prenatal Care Initiative. Further information about the Access to Prenatal Care Initiative to improve access to early prenatal care and improve birth outcomes, is provided in the Section on National Performance Measure #18.

To promote healthy births, MCHS has embraced the Fetal Infant Mortality Review (FIMR) Program as a mechanism for quality improvement. FIMR is one of the original American College of Obstetricians and Gynecologists (ACOG) Partnership projects. The overall goal of New Jersey FIMR is to establish a statewide system of fetal-infant mortality review by implementing or expanding FIMR projects with each of the MCH consortia. New Jersey follows guidelines for planning and implementing community fetal and infant mortality review developed by the National Fetal-Infant Mortality Review Program (NFIMR). The projects use standardized data collection, entry and reporting methods to ensure consistency of the review process throughout the State. This includes using data abstraction and case review summary forms developed by NFIMR and modified by NJ FIMR.

The major goals of the Perinatal Addictions Prevention Project (PAPP) include providing professional and public education, encouraging all prenatal providers to screen all of their pregnant patients for substance use/abuse and developing a network of available resources to aid pregnant substance using/abusing women. Risk-reduction coordinators working with this project provide ongoing regional professional training, individual on-site training, technical assistance and monitoring, grand rounds training, networking, and a link between regional and local services relating to prenatal substance use/abuse.

Multiple studies demonstrate the benefits to both mother and infant with use of screening, assessment, and referral. NJ has adopted the 4P's Plus, designed specifically for prenatal care settings, as the screening tool that will be used. Developed by Dr. Ira Chasnoff, the questions are broadly based, highly sensitive and require only 'yes' or 'no' response. When the provider asks just a few questions, it results in quick identification of patients in need of in-depth assessment or follow-up monitoring. The obstetric providers' participation in this screening project is voluntary. They screen pregnant women during their first prenatal visit and then again during their 28 week visit. The screening information is collected on a statewide basis.

/2013/ Approximately 30% of the pregnant women were screened for substance use during the past year. The majority of these patients were seen at public clinics. Referral information is given to those women who are smoking, using drugs and/or alcohol and those who have possible domestic violence issues. Last year there were 153 education programs held for over 2527 professionals. There were 425 programs held to educate the general public and approximately 23,429 people participated.//2013//

/2012/ NJ successfully applied for the 2010 Maternal, Infant and Early Childhood Home Visiting Program (MIEC HV) Formula Grant to the Health Resources and Services Administration. The goal of the NJ MIEC HV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the grant project will be carried out in collaboration with the Department of Children and Families (DCF). Currently DCF provides funding and administrative oversight to 35 evidence-based home visitation (EBHV) programs in NJ.

A comprehensive needs assessment for home visiting services was submitted as part of the

MEIC HV grant application. The needs assessment included: 1) identification of the at-risk municipalities where evidence-based home visiting (EBHV) services will be provided; 2) a detailed assessment of the particular needs of the identified municipalities in terms of risk factors, community strengths, and existing services; 3) identification of home visiting services to be implemented to meet identified needs in the identified municipalities; 4) a description of the State and local infrastructure available to support the program; 5) specification of any additional infrastructure support necessary to achieve program success; and 6) a plan for collecting benchmark data, conducting continuous quality improvement and performing required program evaluation.

NJ also applied for the 2011 MIEC HV Competitive and Formula Grants to further expand home visiting services. //2012//

/2013/ The notice of grant award was received for the competitive MIEC HV application. Discussions and negotiations with partners to implement the expansion project began in April 2012.//2013//

Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. Hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. NJDHSS offers a PPD helpline (1-800-328-3838) that operates 24 hours per day, seven days a week to provide resources and information to women and their families and friends. In addition, a dedicated Web site (www.njspeakup.gov) provides educational materials such as brochures, videos, books, support groups, FAQs, and other helpful Web sites on postpartum depression and other perinatal mood disorders.

//2012/ Funding for Post Partum Depression Education was used to support the PPD initiative via public service announcements and production of materials for community distribution was eliminated. The MCHC serve as a resource and continue to provide technical assistance via health service grants to the member hospitals and other health care providers/facilities in implementing the law.//2012//

/2013/ Due to the consolidation of the MCHC, a portion of the PPD funding has been redirected from infrastructure to direct client services beginning July 1, 2012 including developing mechanisms for follow up of women with positive screens.//2013//

//2012/ The elimination of \$7.5 million of State dollars in July 2010 to the family planning delivery system required the RPHS Program to restructure the services to maximize the ability to locate at least one family planning clinical health care site in each of the 21 counties. In cooperation with the NJ Family Planning League, services are provided in each of the 21 counties.//2012//

/2013/ Family planning services continue to be provided in each of the 21 counties.//2013//

III. B. 2. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program, within MCHS, focuses on primary prevention strategies. The emphasis in Child Health is to prevent lead poisoning among children under six years of age through the collaborative, prevention-oriented outreach and education of to parents, and property owners, and the education of health care providers.

The Childhood Lead Poisoning Prevention (CLPP) Project uses is a home visiting model to provide program providing case management and environmental interventions for children six years of age or younger with confirmed elevated blood lead levels. Twelve sites throughout the State receive funding to assess blood lead levels, immunization status, nutritional status, growth and developmental milestones, and parental-child interaction, in addition to identifying and then provide education, supportive guidance, and assisting property owners in the remediation of lead

hazards.

The goal of the CLPP Project is to promote a coordinated support system for lead-burdened children and their families through the development of stronger linkages with Special Child Health Services, Medicaid Managed Care Organizations (MCOs), DCF, DOE, DCA, and community-based agencies that provide early childhood services. Services provided this year include a healthy homes assessment tool so that health and safety issues in the home can be identified and remediated so that homes are free of disease-causing agents and sources of preventable injuries. DHSS has established a partnership with DCF home visitation programs that provide services for pregnant women, infants, young children, in addition to resource family homes that provide a safe residential environment for children who are in the foster care system.

/2013/ In September 2011, the CLPP project was awarded funding to integrate a healthy homes approach into the current CLPP service delivery system. This included the integration of a healthy homes assessment tool so that health and safety issues in the home can be identified and remediated.//2013//

Adolescent Health funds through June 2010 the Community Partnership for Healthy Adolescents (CPHA) initiative that addresses injury and violence (including bullying and gangs), risk behavior reduction through positive youth development approaches, and school health. Beginning July 2010, the focus of Adolescent Health will be to expand and enhance the Department of Education's (DOE) cooperative agreement with the CDC to implement the CDC Coordinated School Health (CSH) model. Successful CSH applicants, selected through a competitive application process, will be responsible for the administrative oversight, training, technical assistance and resource support for the implementation of CSH in at least eight (8) middle- and/or high schools of public school districts geographically located one each, in three NJ regions: Northern, Central or Southern. School districts are a required partner for this application.

School Health (SH) Specialists, hired by the successful applicants will collaborate with a School Health (SH) Coordinator identified by the school district partner. The SH Coordinator will ensure the implementation of required school health activities and assure that the activities, funded by this grant, align with State goals and project objectives. As a result of participation, the school district partner is expected to progressively expand the implementation of CSH district-wide. Collaboratively, the DHSS with its three successful applicants and their school district partners will join the Department of Education's (DOE) NJ CSH Demonstration Project in serving as the proactive leaders to mobilize NJ's expansion of CSH statewide.

The goals for this pilot project are to increase the number of schools that are using CDC's CSH model to: 1) address the physical, emotional and social well-being of their students, 2) create opportunities for healthier choices by students and school staff through environmental or policy change strategies, and 3) strengthen and sustain state and school district capacity to support a coordinated school health system through effective leadership, strategic partnerships, youth engagement, funding development and the use of data-driven and best practices or evidence-based programs.

/2012/ Three regional grantees - the Center for Prevention and Counseling (North), Empower Somerset (central) and Atlanticare (south) - were approved for funding and on July 1, 2010 initiated activities for the implementation of CDC's CSH model. Three areas to be addressed on a statewide basis are: 1) sustainability; 2) youth involvement and 3) project recognition.

Workgroups are anticipated to be formed during the spring of 2011 and a goal statement and objective(s) identified by August 2011. DHSS/DOE CSH is a co-lead with Rutgers University for the implementation of school-based strategies developed by the CDC NPAO Shaping NJ Partnership to meet the CDC-approved State Plan objectives.//2012//

/2013/ The CAHS Program successfully applied for two new federal grants to prevent teen pregnancy. The NJ Abstinence Education Program (NJ-AEP) funds will provide services to youth populations that are at high-risk for teen pregnancy, STDs/STIs, teen births. The

purpose of NJ-AEP will be to promote abstinence from sexual activity and, where appropriate, provide options that may include mentoring, counseling and/or adult supervision. The NJ Personal Responsibility Education Program (NJ PREP) will enable New Jersey to replicate evidence-based programs that have proven effectiveness in changing behaviors to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth.//2013//

Promoting healthy and safe early childhood programs is a priority for NJDHSS and its partners. In September 2005, NJ was awarded an Early Childhood Comprehensive Systems (ECCS) implementation grant. The ECCS Team continues to work with a myriad of public and private agencies. Collaborative state partners have included the DHS, DCF, DOE, DEP, Department of Agriculture, Department of Labor & Workforce Development, Department of Treasury, and the DCA. Community partners include parent support, child advocacy and early education professional development organizations, infant/child health, mental health, and special child service providers, and early education, child care and child welfare professionals.

The priority and focus of the ECCS Grant during 2009 was development of a statewide Early Childhood Health, Development and Early Learning Website, a state of the art web-based resource for consumers and professionals. The website's breakout categories have been designed to fulfill the federal ECCS grant's twelve designated key requirements for early childhood system building and provide the necessary framework for interdepartmental systems building and collaboration. The 12 key requirements include: access to care, mental and social /emotional health, early care and education/child care, parent education, family support, financing, governance, family leadership development, provider/practitioner support, communication, standards, monitoring and accountability.

/2012/ The priority and focus of the ECCS Grant during 2010 was launching in June 2010 and promoting the website - "NJ Parent Link, New Jersey's Early Childhood, Parenting and Professional Resource Center". //2012//

The website has been designed to function as the IT gateway for all State based services and resources, for parents and caregivers of young children, and will include direct links to all 15 executive departments, the Governor's office, the legislative and judicial branches and provide interactive parent-to-parent forums, E-serve services and professional collaborative portal features. The Website is expected to go live to the public May 30, 2010.

/2012/ Community building website features include: interactive consumer content sections; tailored subscription services; a community calendar of events; continuing education/leadership postings; a children's art gallery; an easy to navigate En Espanol feature and a translation service for over 50 languages. Numerous data collection and quality assurance markers are weaved throughout the website's features to maximize assessment capabilities and real time opportunities for collaboration and coordination of shared goals and resources within the early childhood community. The Website launched on June 1, 2010. //2012//

//2013/ Total number of NJ Parent Link website hits from 6/1/2010 to 6/1/2012 are 1,073,363. The average percent of visitors who use the website more than once each month is 22%. In May 2012, 7,001 unique visitors accessed information from the NJ Parent Link website. //2013//

The NJDHSS established the NJ Children's Oral Health Program in 1981. The Program provides a variety of oral health education activities for children in grades pre-K through 12. The Program is regionally implemented in all 21 counties of the State with each region having an Oral Health Coordinator and other program personnel that implement program activities. Educational activities are age-appropriate and cover a variety of oral health issues including, but not limited to, good oral hygiene, fluoride as a preventive measure for tooth decay, dental sealants, healthy food choices, periodontal disease, tobacco cessation, and the prevention of oral trauma. Classroom presentations include discussion, audio-visual materials, and extensive student participation. All

Children's Oral Health Program activities can be adapted for an audience of children with special needs. Educational presentations are also provided to parents and pregnant women. Furthermore, the program staff provides in-service or workshop programs to non-dental professionals, including school nurses, public health nurses, teachers, WIC Coordinators, and social workers.

/2013/ During the 2010-2011 school years, over 74,000 individuals participated in formal oral health education programs provided by the Regional Oral Health Coordinators and dental hygienist staff. //2013//

III. B. 3. Preventive and Primary Care for Children with Special Health Care Needs

Special Child Health and Early Intervention Services (SCHEIS) ensures that all persons with special health needs have access to comprehensive, community-based, culturally competent and family-centered care. NJ administers programs and services through the Family Centered Care Services (FCCS) Unit that ensure access to comprehensive, family-centered, culturally competent, community-based care for children age birth to 21 years of age with special health care needs. These programs partially support 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, 11 Child Evaluation Centers (CECs) of which six house Fetal Alcohol Syndrome Disorder Centers, and five Cleft Lip/Palate Craniofacial Anomalies Centers of which three also provide newborn hearing screening follow-up and three Tertiary Care Centers.

/2012/ A limited fee-for-service program is administered by FCCS to ensure eligible CYSHCN's access to medically necessary services, hearing aids, braces, orthotics, prostheses, and medications to treat asthma and cystic fibrosis.//2012//

/2013/ Despite the implementation of Grace's Law, access to health insurance through NJ FamilyCare and Medicaid a need remains for assistance to services provided through the Fee-for-Service (FFS) program for the underinsured. In addition, ineligible FFS applicants were assisted to optimally use their insurance benefits and their employers were educated when Grace's Law applied.//2013//

Seven Ryan White Part D (RWPD) Family Centered HIV Care Network Centers are also administered through FCCS and serve clients across the age span. They are funded by the HIV/AIDS Bureau, collaborate across programs and link with Title V programs and services, as needed.

/2013/CYSHCN with HIV/AIDS are referred to these Centers by Title V agencies as appropriate and case management of AIDS Community Care Alternative Program clients is coordinated across systems.//2013//

A priority for SCHEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. Historically, SCHEIS has addressed the early identification, outreach to and the support of that special needs population through follow-up of CYSHCN by the SCHS CMUs. Typically, CYSHCN age birth -- 21 years of age are identified to the SCHS CMUs in the county in which the CYSHCN resides through the BDARS and the Catastrophic Illness in Children Relief Fund; by community, family and self-referrals; and through the Social Security Administration (SSA).

A recent change in the process by which SCHEIS has streamlined SSA referrals to the SCHS CMUs is facilitating timely access to comprehensive care. The SSA referral system has moved from paper to electronic transmission. The DHSS uploads monthly county specific reports which are then viewable by the SCHS CMUs through the DHSS' secured web access. The SCHS CMUs outreach to all CYSHCN referred by SSA to offer information and referral; development of an individualized service plan; case management services as needed; linkage with community-based primary and pediatric specialty care, transition to adulthood, family support and social service supports across local, State, and federal programs. This electronic referral system

eliminates the need and cost to mail SSA reports, leaving only a minimum number of paper reports received from Disability Determinations needing to be mailed to the SCHS CMUs for follow-up. With electronic access to their county specific reports, the SCHS CMUs manage their workflow. In addition, receiving the data electronically has enabled SCHEIS to more accurately track the numbers of CYSHCN referred and served. In 2009, 13,810 CYSHCN were referred versus 7,700 in 2008 (44% increase in total unduplicated referrals); and 7,348 CYSCN served in 2009 versus 4,600 in 2008, (60% increase in unduplicated served). In 2009, 22% (2,350) of the 10,500 active children with Individual Service Plans served statewide through the County Case Management Units were identified as Supplemental Security Income (SSI) beneficiaries. /2012/ In 2010, the number of SSA referrals received by the SCHS CMU's remained nearly level at 13,649. A quality assurance initiative was implemented to assess follow-up on SSA referrals subsequent to the change from paper to electronic referrals. Overall, the SCHS CMU's chart reviews indicated a timely and comprehensive follow-up on referrals received via the revised system. An update on follow up of SSA referrals follows in Health System Capacity Indicator 08.//2012//

/2013/ The web based SSA referral continues to be an effective referral tool and affords State Title V staffs the additional efficiency of preselecting charts in preparation for site visits. In addition, SCHS CMUs indicated that the format is easier to use and State staffs observed an improvement in reporting. See Health System Capacity Indicator 08. //2013//

SCHEIS partially supports hospital-based out-patient rehabilitative services for CYSHCN including blind and disabled CYSHCN under the age of 16 receiving benefits under Title XVI.

The Specialized Pediatric Services providers include Child Evaluation Centers, Tertiary Centers and Cleft Lip/Cleft Palate Craniofacial Anomalies Centers. Over 11,000 encounters of specialty and/or subspecialty services were reported statewide. In review of 2009 program data on client encounters by units of service, the majority of encounters (34%) were with a cardiologist, followed by neurologist (33%), gastroenterologist (32%), immunologist/allergist (32%), pulmonologist (23%), nephrologist (14%) and urologist (10%). The Centers provide evaluation and/or treatment for CYSHCN, and ensure access to care regardless of ability to pay. These health service grantees are expected to make a reasonable effort to collect payment for services rendered, however no CYSHCN is denied care because of inability to pay. The Centers are noted as Centers of Excellence by NJ Medicaid. They accept NJ Medicaid, Medicaid Managed Care, NJ Advantage, commercial insurance and/or payment on a sliding-fee commensurate with the SCHEIS Fee-for-Service/NJ Charity Care guidelines.

/2013// Although a slight decrease in pediatric specialty/subspecialty provider encounters was noted in 2011 (150,000) vs. 2010 (156,000), demand for access to these services remained strong. Encounters with a physician (26%), physical therapist (24%) and speech therapist (23%) were most frequently cited by the Comprehensive Evaluation Centers (CEC's). Attention Deficit Hyperactivity Disorder (24%), Autism (14%) and speech disorders (12%) were the most frequently cited diagnostic categories for children served by the CEC's. Gastroenterology (14%), oncology (11%) and cardiology (11%) continue to be specialty services in highest demand by the Tertiary providers.//2013//

To ensure family participation and address cultural competency, the Centers provide written informed consent guidelines for all aspects of the evaluation, diagnostic and/or treatment services. The confidentiality of records is protected, written procedures regarding access to records is made available to all staff, and the sharing of records is determined by the parents of CYSHCN. Each Center maintains written procedures for parental consent for release of records. The Centers must comply with the Americans with Disability Act (ADA) requirements. Limited English proficiency needs are addressed through access to foreign language interpreters and/or interpreters for the deaf. The Centers cannot discriminate through admission policies, hiring practices, or promotional opportunities on the basis of race, religion, ethnic origin, sex or handicapping conditions. CYSHCN with ongoing needs that warrant care coordination are linked

with the SCHS CMU located in their county of residence.

Upon receipt of referral the SCHS CMUs conduct outreach to determine CYSHCN's needs and with parent input develop an Individual Service Plan (ISP). The ISP addresses medical, dental, developmental, rehabilitative, social, emotional, and economic needs of the CYSHCN and/or the family as related to the child's needs. Periodic monitoring of needs and progress toward attaining services are also conducted.

In 2009, nearly 9,000 hard copy BDARS referrals were received by the SCHS CMUs. Likewise, the SCHS CMUs report new or revised data to the BDARS on a paper form. In an effort to improve efficiency, the BDARS is collaborating with the State SCHS Case Management program to develop a web based reporting and tracking system. This mechanization is eagerly anticipated to improve accuracy in reporting and tracking.

/2012/ In 2010, over 9,100 hard copy BDARS referrals were received by the SCHS CMUs for follow up. In addition nearly 14,000 referrals from the Social Security Administration, more than 400 referrals from the Catastrophic Illness in Children Relief Fund, as well as community-based referrals are all screened for registration compliance. State Case Management and BDARS staffs continue to collaborate with Case Management grantees and Rutgers University staff to develop the Case Management component of the electronic reporting and follow-up module. Screen shots have been developed, the system is being finalized and training needs are being explored for implementation in 2011. This system is anticipated to streamline registration, follow-up and tracking.//2012//

/2013/ A pilot of the BDARS' Case Management module occurred during August 2011. By January 2012, the BDARS was implemented in all 21 Case Management units. //2013//

/2013/ A slight increase in the number of BDARS referrals into SCHS CM was noted in 2011 (9180) vs. 2010 (9100). A slight increase was also noted in the number of SSI referrals from the State Data Exchange, 2011 (15,324) vs. 2010 (14,000). Overall, the CMUs assisted with nearly the same number of Catastrophic Illness in Children Relief Fund (CICRF) applications, 2010 (500) vs. 2011 (522), however an increasing trend in the source of origin for those applications was observed. In 2011, more CICRF applications originated with the assistance of an SCHS CM rather than independently by a parent and submitted directly to the State CICRF office about 50% of the time; 348 originated from the SCHS CMU and 174 had been directly submitted to the State. In addition, progress continues in the collaboration between the BDARS, SCHS CM and Rutgers University in development of the electronic case management referral system (CMRS).//2013//

The system went live in August 2011 with several pilot counties and is described in more detail in State Performance Measure 05.

Funded by the HIV/AIDS Bureau Ryan White Part D and housed in FCCS, the NJ Statewide Family Centered HIV Care Network provides a full range of high quality, culturally sensitive and coordinated HIV/AIDS medical and social support services to women, infants, children, and adolescents infected with or affected by HIV disease. The Network's vision of family health builds on an innovative integration of clinical, research, and educational services to provide the best family care possible. For over 22 years, Network physicians and staff have been at the forefront of HIV care and are committed to improving the quality of life for people living with HIV disease.

The target population served by the Family Centered HIV Care Network includes women, infants, children, and youth, and their affected family members. In 2009, 3,601 clients were served. African Americans account for 68% of the clients served, and Latinos account for 22% of the clients served. New Jersey's experience in serving children and youth indicates that the number of HIV infected newborns and children has steadily decreased in the past five years, while the number of HIV infected adolescents has steadily increased over the same time period. In addition to collaboration with Title V MCCH and SCHEIS services and programs, the NJ Ryan

White Part D program has the lead responsibility for implementing the federal HRSA Ryan White Quality Management Cross-Part Collaboration Project. Development and implementation of the plan from collaborating with the cross title NJ team and providing technical assistance on data collection has been ongoing to the Ryan White grantee agencies statewide.

/2012/ The NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to women, infants, children, youth and families infected and affected by HIV disease in the State. In 2010, 3,600 clients were served by the Network. Since 2006, the number of clients aged 2-12 years has decreased from 229 to 91 in 2010. During the same timeframe, the number of clients aged 13-24 years has increased annually from 428 to 513, representing a 21% increase. This is due to the number of perinatally infected children who have aged into the adolescent program as well as new adolescent cases being identified.//2012//

/2012/ Collaboration among RWPD providers, families, SCHS Case Managers and DHS Office of Home Care staff continues to ensure a safety net of community-based care as well as to facilitate monitoring and transition of CYSHCN enrolled in the AIDS Community Care Alternative Program (ACCAP) Waiver program.//2012//

/2013/ The NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to women, infants, children, youth and families infected and affected by HIV disease in the State. In 2011, 3,414 clients were served by the Network. Through diligent efforts to treat and educate HIV infected pregnant women the perinatal transmission rate in NJ remains very low. Intensive case management coupled with appropriate antiretroviral therapy, enables children with HIV to survive into and successfully transition into adulthood. Most recent data indicates that we are now seeing a shift to an older HIV positive population. The number of women 45 years of age and older receiving medical care at a NJ Ryan White Part D Network agency has risen from 551 in 2005 to 829 in 2011.//2013//

For approximately 20 years, SCHEIS has worked with parent groups, specialty providers and a statewide network of SCHS CMs to provide family-centered, community-based, coordinated care for Children and Youth with Special Health Care Needs (CYSHCN) and facilitate the development of community-based services for such children and their families. The Statewide Parent Advocacy Network (SPAN) funded through SCHEIS provides parent support through a three-pronged approach titled Family WRAP (Wisdom, Resources, Advocacy and Parent-to-Parent). Specific Family WRAP programs include Project Care, Parent-to-Parent and Family Voices New Jersey.

SPAN and SCHEIS have continued to collaborate to identify resources to expand the number of Resources Specialists (trained support specialists) on site at the SCHS Case Management Units particularly in the southern New Jersey counties. Through the federal Parent Training Information Center (PTI) funding, the additional five Parent Resource Specialists continue to be housed in Cape May, Cumberland, Burlington, Salem and Gloucester Counties. This collaborative initiative maintains the total of case management units with part-time onsite family support to 15 counties and additional telephone support to the remaining 6 county units. Funding is being sought to further expand on-site parent support at the remaining counties through a 2009 HRSA sponsored State Implementation Grant, and notice remains pending on that application.

/2012/ Through collaboration with SPAN on the PTI grant as well as with intergovernmental and community-based partners on the HRSA funded Integrated Systems Grant (ISG), 20 part-time Family Resource Specialists are co-located and/or housed at SCHS Case Management Units statewide.//2012//

In an effort to enhance family support capacity, the SCHEIS collaborated with SPAN, the NJ Academy of Pediatrics Pediatric Council on Education and Research (PCORE), and other community partners to develop grant applications for supplemental funding. Recent successful

collaborations with SPAN include the HRSA State Implementation Grant for Integrated Community Systems (Integrated Systems Grant or ISG 1), and the Administration on Developmental Disabilities' Military 360 initiative for military families at the combined Fort Dix McGuire Air Force Base and Lakehurst Naval Air Station mega-base.

/2012/ The ISG 1 collaborative application was approved and funded for \$300,000. A subsequent HRSA sponsored Autism collaborative grant application was developed to extend the ISG 1 activities to address CYSHCN with autism. This subsequent grant is referred to as the Autism Integrated System Grant or ISG 2. Both the ISG 1 and ISG 2 grants provide funding to enhance capacity for additional SPAN Resource Parents to be housed at and/or support families served by SCHS Case Management Units and Autism Clinical Enhancement Centers.//2012//

/2013/ The ISG 1 and ASG 2 partnerships of intergovernmental agency representatives, community-based organizations, youth with special health care needs and their families collaborated to promote activities that addressed the six Core Outcomes and strengthen NJ's community-based system of services mandated for CYSCHN. The activities are integrated into SPM 02-06. Quarterly meetings of the full Consortium of Care provided opportunities to discuss strategies and incorporate autism into the ISG model, and monthly conference calls among the core team members, SPAN, NJ Academy of Pediatrics Pediatric Council on Research and Education (NJ PCORE), and Title V, facilitated project implementation.//2013//

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

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

/2012/ Gloria Rodriguez accepted the position of Assistant Commissioner for Family Health Services in December 2010 when Celeste Andriot Wood retired. Gloria Rodriguez was the former Director of SCHEIS.//2012//

See attachment to Section B. Agency Capacity for an organizational chart for the NJDHSS Division of Family Health Services.

See attachment to this Section C. Organizational Structure, for an organizational chart for the NJ Department of Health & Senior Services.

See attachment to Section D. Other MCH for an organizational chart for the Maternal and Child Health Services in the Division of Family Health Services.

See attachment to Section E. State Agency Coordination for an organizational chart for the Special Child Health Early Intervention Unit in the Division of Family Health Services.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The following section describes the number and location of staff that work on Title V programs.

Maternal and Child Health Services (MCHS) Unit

Maternal and Child Health Services (MCHS) is comprised of three program managers, 24 professionals, and 14 support staff. All staff members are housed in the central office. Dr. Lakota Kruse is the Service Director for MCHS. Dr. Kruse is a Pediatrician and an MCH

Epidemiologist who has been with the NJDHSS since 1993. Among the professional staff are individuals with nursing, social science, environmental, nutrition, statistical, epidemiology, and other public health backgrounds.

Reproductive and Perinatal Health Services is staffed by 10 professionals and 3 support personnel and a Program Manager, Sandra Schwarz, RNC,MS. The program is responsible for the regional MCH Consortia, Healthy Mothers, Healthy Babies Coalitions, Certificate of Need rules and MCH Consortia regulations, morbidity and mortality reviews, Healthy Start projects, Family Planning, the Black Infant Mortality Reduction Initiative, perinatal addictions and fetal alcohol syndrome prevention projects, post partum mood disorders initiative, Access to Prenatal Care Initiative, and preconceptional health. Resources for staff have been from Federal MCH Block, Federal Title X, Preventive Health and Health Services Block, and Healthy Start Grants.

/2013/ Reproductive and Perinatal Health Services is staffed by seven professionals and three support personnel and a Program Manager, One nursing professional was added to the program to assist with the MEIC HV grant. Several professional staff members participate in the various subcommittees of the Home Visiting Work Group. The Healthy Mothers, Healthy Babies Coalitions and Black Infant Mortality Reduction Initiative were rolled into the Access to Prenatal Care Initiative. //2013//

Child and Adolescent Health Services is comprised of a staff of 7 professionals, 5 support personnel, 1 paraprofessional and a Program Manager, Cynthia Collins. Resources include: State MCH funds, Federal MCH, and Preventive Health and Health Services Block Grants, Centers for Disease Control and Prevention cooperative agreements for Lead and School Health, an Early Childhood Comprehensive Systems (ECCS) Implementation grant from HRSA, MCHB and State Lead funds. All staff members are housed in the central office. Child and Adolescent Health has oversight by a Program Manager with responsibilities that address childhood lead poisoning and prevention and adolescent health in middle and high schools. Childhood lead poisoning and prevention has one Primary and Preventive Health Services Coordinator, four professionals and 1 paraprofessional. The Health Resources and Services Administration (HRSA) funds New Jersey's Early Childhood Comprehensive System grant and its activities are coordinated by one professional staff position. Adolescent health currently includes the Community Partnership for Healthy Adolescents initiative and the Centers for Disease Control's Coordinated School Health model and is staffed by two professional positions. Child and Adolescent Health staff has varied professional backgrounds including nursing, nutrition, health education, research and data analysis.

/2012/ The Child and Adolescent Health Program is comprised of a staff of 9 professionals (6 of which work in childhood lead poisoning and prevention, 4 support personnel, 1 paraprofessional and a Program Manager, Cynthia Collins. One new professional staff person brings a legal background to the Program; the other is a MSN, RN.//2012//

/2012/ Two additional funding resources were applied for and approved from DHHS, ACF for the Title V Abstinence Education Program and the Personal Responsibility Education Program (PREP). The Community Partnership for Healthy Adolescents initiative ended June 30, 2010. //2012//

/2013/ The Child and Adolescent Health Program is comprised of 6 professional staff (4 in Healthy Homes/Childhood Lead Poisoning and Prevention unit, 2 administrative support staff, 1 paraprofessional and a Program Manager, Cynthia Collins, MS, CPM. One professional retired, one transferred and one accepted a promotion in WIC Services. DHSS was awarded the CDC Healthy Homes 3 year cooperative agreement September 1, 2011. Unfortunately, grant funding will end August 31, 2012 due to federal funding cuts. //2013//

To build state and local capacity for addressing the health and development needs of children and adolescents through coordinated school programs the NJ Department of Education

(NJDOE), in partnership with the NJDHSS, applied for and was awarded a five-year cooperative agreement in March 2008 by the Centers for Disease Control and Prevention (CDC.) A portion of the CDC funding is allocated to NJDHSS, through a Memorandum of Agreement, for one full-time equivalent professional position that functions as the DHSS School Health Coordinator.

Adolescent Health released in February 2010 a competitive Request for Applications for organizations interested in applying for "Building a Coordinated School Health (CSH) System in New Jersey". Three grants, each located in one of three New Jersey regions (North, Central and South), will be awarded funds to be used for the implementation of CDC's model in at least eight public middle- and/or high- schools of public school districts, for a total of at least 24 schools. It is the intent of this grant to provide funds for a three year pilot project period; however, budgets will be annually submitted and approved.

In May 2008, two months after the award of the CDC cooperative agreement with the NJ Department of Education (NJDOE), the NJDHSS was awarded a 5 year CDC cooperative agreement to the Office of Nutrition and Fitness (ONF) for state leadership and coordination of nutrition, physical activity and obesity strategies (NPAO). Through this cooperative agreement, DHSS will collaborate with the existing infrastructure, which includes NJDOE, the Department of Agriculture, the Department of Transportation (DOT) and the Department of Children and Families (DCF) for the implementation of state determined strategies focused in the school venue to prevent obesity.

/2012/ The evidenced based school strategies include:

- 1) Advocating for an increased school meal subsidy to enable schools to offer a variety of healthy foods and beverages and to prepare appealing school meals.
- 2) Creating/ensuring adequate school infrastructure to prepare a variety of healthy, appealing, kid-friendly fruits and vegetables or provide schools with adequate access to resources to purchase such foods.
- 3) Working to enhance the minimum standards in the state school wellness policy around nutrition, physical activity and TV viewing. The policy will also encourage local districts to locate schools where students can safely and easily walk and bike to school.
- 4) Promoting and support active school-based wellness councils that implement school wellness policies; councils will include community and school representatives.
- 5) Ensuring that all students are actively engaged in their Physical Education class.
- 6) Providing students with diverse and developmentally appropriate activities to meet individual needs and interests.
- 7) Providing facilities that are conducive to learning (with respect to class size, equitable space, sufficient equipment and technology and safe and clean facilities).
- 8) Working to ensure that schools provide a variety of quality activities during the school day to encourage students to be physically active (such as recess, activity breaks, energizers and before- and after-school physical activity programs)./2012//

/2013/ In June 2012, the School Strategy Workgroup disseminated a Tool Kit to assist ShapingNJ partner organizations with implementation of school nutrition strategies./2013//

The next steps for the NPAO project is establishing comprehensive work groups per each strategy. These groups will identify the federal, state and local policy barriers and opportunities specific to implementation of work. The strategy workgroups will identify specific tasks for their strategy. The ultimate goal for all school workgroups is to empower the full partnership to advocate for policies that will support implementation.

The Children's Oral Health Education Program comprised of 1 professional and 1 support staff who reports to the Office of the Director. Dr. Beverly Kupiec-Sce coordinates the program which provides age appropriate oral health education to school age children.

/2012/ Classroom-based education is targeted to the high-need/high-risk areas while a system of

Oral/Dental Health teaching kits are available through a loaner system. In addition, the Program administrates a voluntary fluoride mouth rinse program, "Save Our Smiles" to schools in areas where the water is not optimally fluorinated. The Program also develops and distributes the NJ Dental Clinic Directory, "Dial A Smile" which is a central source of information for public dental clinic services. The annual school newsletter, "Miles of Smiles" is distributed to school nurses, teachers, and public health nurses Statewide. //2012//

The mission of the Maternal and Child Health Epidemiology Program (MCH Epi) is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects. The MCH Epi Program promotes the central collection, integration and analysis of MCH data. MCH Epi is comprised of three research professionals, and two support staff. All research staff members possess extensive experience in statistics, research, evaluation, demography and public health. Additionally, professional staff members have extensive experience with data linking, record matching and epidemiological research. One professional staff position is supported entirely by resources from the MCH Bureau's State Systems Development Initiative (SSDI) grant. The Pregnancy Risk Assessment Monitoring System (PRAMS) survey is coordinated by the MCH Epi Program. Ingrid Morton is the Program Manager for MCH Epi. The MCH Epi program was integrated into the MCHS Unit in April 2010.

The Office on Nutrition and Fitness (ONF) within FHS consists of a Director, Peri Nearon, with 7 professional staff and 1 secretarial support staff. Funding sources include: a Centers for Disease Control and Prevention cooperative agreement for Nutrition, Physical Activity and Obesity (NPAO) and state MCH funds. All staff members are housed in the Division of Family Health Services. In addition to the CDC cooperative agreement for NPAO, the Office also includes the Healthy Community Development Leaders' Academy and mini grants. ONF is responsible for addressing obesity prevention throughout the lifecycle. ONF staff have varied professional backgrounds including nutrition, public health, environmental studies, research and data analysis.

/2012/ Staffing within ONF consists of a Director, Peri L. Nearon, 8 FTE professional staff and 1 FTE secretarial support staff. Current financial support includes a CDC cooperative agreement for NPAO (2008 - 2013); supplemental funding from CDC for Communities Putting Prevention to Work - State & Territorial Initiatives (CPPW - STI) (Jan 1, 2010 - Dec 31, 2011) for Healthy Communities, Child Care Initiative & Breastfeeding initiatives; state MCH funds and Preventive Block funds. Funds have been leveraged within the state to secure funding from The Robert Wood Johnson Foundation and the Partners for Health Foundation (Mountainside Hospital) to offer grants to additional communities. The ONF also includes the Healthy Community Development Leaders' Academy held bi-annually and distribution of mini grants. Efforts of the ONF are aimed at obesity prevention throughout the life cycle through policy & environmental change with a focus on disparate populations that carry the burden of chronic disease. The goal is to make healthy choices easier for NJ residents.//2012//

/2013/ The Office on Nutrition and Fitness (ONF) within FHS consists of a Director, Peri Nearon, with 7 professional staff and 1 administrative support staff. Funding sources include: a Centers for Disease Control and Prevention cooperative agreement for Nutrition, Physical Activity and Obesity (NPAO) and state MCH funds. All staff members are housed in the Division of Family Health Services. In addition to the CDC cooperative agreement for NPAO, the Office also includes the Healthy Community Development Leaders' Academy and mini grants. ONF is responsible for addressing obesity prevention throughout the life cycle. ONF staff have varied professional backgrounds including nutrition, public health, public administration, environmental studies, research and data analysis.//2013//

Special Child Health and Early Intervention Services (SCHEIS)

Special Child Health and Early Intervention Services (SCHEIS) consist of the following programs and services: Early Identification and Monitoring, Newborn Screening and Genetic Services Program, Family Centered Care Services, and the Early Intervention System.

/2012/ Dr. Marilyn Gorney-Daley is the Director of SCHEIS. Dr. Gorney-Daley was named Director of SCHEIS in December 2010, when Dr. Gloria Rodriguez, former Director of SCHEIS, accepted the position of Assistant Commissioner in Family Health Services. Dr. Gorney-Daley is board certified in General Preventive Medicine and Public Health; she has worked in DHSS since 1995 and had served as Medical Director for SCHEIS previously. All SCHEIS staff members are housed in the central office.//2012//

The Early Identification and Monitoring (EIM) Program is responsible for the reporting and monitoring of children with birth defects and special needs (the Special Child Health Services Registry), and Autism, and the Early Hearing Detection and Intervention Program. The EIM Program is comprised of a staff of ten professionals, seven support staff, and a Program Manager, Leslie Beres-Sochka, who holds a Master of Science in biostatistics and has over 20 years experience in research, statistical analysis, and database design and management. Resources for staff come from the MCH Block Grant, a HRSA grant for universal newborn hearing screening, and two Centers for Disease Control and Prevention cooperative agreements (EHDI and Birth Defects Surveillance), and the Autism Medical Research and Treatment Fund.

/2013/ The EIM program now has nine professionals as one of their professional staff retired. The program will request an exemption to the hiring freeze in order to back-fill the position.//2013//

The Newborn Screening and Genetic Services Program is responsible for the follow-up of newborns with out-of-range screening results. This program also provides partial support through its grants to specialty care centers and facilities for metabolic and genetic services, pediatric endocrine services, pediatric hematologic services, pediatric pulmonary services and specialized confirmatory and diagnostic laboratory services. The Newborn Screening and Genetic Services Program is currently comprised of a staff of 7 professionals and three support staff and a Program Medical Director, Lorraine Freed Garg, MD, MPH.

The Family Centered Care Program (FCCP) is responsible for funding, monitoring, and evaluating services provided by the 21 Title V funded case management units, Family WRAP family support services, 11 child evaluation centers which include 6 FAS Diagnostic Centers, 5 cleft lip/cleft palate centers, 3 tertiary care centers, two organ donor and tissue sharing donor awareness education programs, and the 7 Ryan White Part D funded Statewide Family Centered HIV Care Network sites. Resources for staff come from the MCH Block Grant and from the HRSA AIDS Bureau under Ryan White Part D. This program is comprised of a staff of seven professionals, three support staff, and a Program Manager, Mrs. Pauline Lisciotta, RN, MSN. The Coordinator of Special Child Health Services, Case Management is Mrs. Bonnie Teman, RN, MSN. Ms. JoAnn Ayres, RN, M.Ed., and Ms. Suzanne Canuso, RN, MSN, recently joined FCCP to coordinate Specialized Pediatric Services and staff Case Management.

/2012/ Ms. Felicia Walton, BA, joined SCHS Case Management to assist with program monitoring and training related to the roll out of the electronic BDARS, however 2 Public Health Nursing vacancies remain.//2012//

The Early Intervention System is headed by Terry Harrison, Part C Coordinator. This System provides services to infants and toddlers with disabilities or developmental delays and their families in accordance with Part C of the Individuals with Disabilities Education Act.

All programs within SCHEIS have staff with varied professional backgrounds including nursing, medicine, physical therapy, epidemiology, speech pathology, public health, research, statistics, family counseling, education, and genetic counseling. Both senior level and support staff

includes parents of children with special health care needs such as developmental delay, seizure disorder, specific genetic syndromes, and asthma.

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

This sections describes relevant organizational relationships between FHS and the State Human Services agencies (mental health, social services/child welfare, education, corrections, Medicaid, SCHIP, Social Security Administration, Vocational Rehabilitation, disability determination unit, alcohol and substance abuse, rehabilitation services); the relationship of State and local public health agencies (including MCH Consortia) and federally qualified health centers; primary care associations; tertiary care facilities; and available technical resources which enhance the capacity of the Title V program.

This section also describes the plan for coordination of the Title V program with (1) the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), (2) other federal grant programs (including WIC, related education programs, and other health, developmental disability, and family planning programs), and (3) providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for services.

New Jersey has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The consortia are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs.

/2013/ In an effort to better leverage public and private funds and to reduce infrastructure costs, the DHSS made the commitment to reduce the number of MCHC to 3.//2013//

Promoting healthy and safe early childhood programs is a priority for NJDHSS and its partners. In September 2005, NJ was one of 18 states that were awarded an Early Childhood Comprehensive Systems (ECCS) implementation grant. The focus of the ECCS Grant was development of a statewide Early Childhood Health, Development and Early Learning Website, a state of the art web-based resource for consumers and professionals. The goal of the website and portal will be to improve the accessibility, coordination and delivery of information and services to children and their families, and to improve the communication capabilities for ongoing service collaborations and policy development. Following completion in June 2010 of the website and portal, early childhood systems building efforts will continue with the rebuilding and expansion of the NJ ECCS Team.

School health collaboration and coordination is accomplished through a school health liaison position within the Adolescent Health section. The Departments of Education and DHSS staff have developed joint statements and a Strategic Plan for School Age Health signed by both Commissioners. The strategic plan affirms both departments' support for comprehensive school health programs, with a particular focus on the 31 special needs school districts.

To address school health and adolescent risk taking behavior, DOE formalized a partnership with DHSS, through the use of a MOA, for implementation of CDC's Coordinated School Health (CSH) model. In addition to DOE and DHSS, there is state department representation from: Agriculture (NJDA); Children and Families (DCF) School Based Youth Services Program, Environmental Protection (DEP), the Juvenile Justice Commission (JJC) and Transportation's (DOT) Safe Routes to School.

/2013/ Through a competitive application process, Ms. Collins, Program Manager was

selected to participate in the 2012-13 MCH PHLI Cohort and complete the project proposal: A Comprehensive Public/Private State Plan for School Health.

The ShapingNJ Partnership - the state partnership for nutrition, physical activity and obesity prevention currently has 180 plus partners, from agencies and organizations across the State, committed to policy and environmental changes that will make the healthy choice the easy choice.//2013//

Coordination between the State's Primary Care Office and FQHCs continues. The Coordinator of Primary Care works out of the Office of Primary Care. The Federal Primary Care Cooperative Agreement is administered by this office. The Office of Primary Care has provided cost-base reimbursement to qualified FQHCs for eligible visits by uninsured and underinsured individuals since 1991. Funds to compensate the centers for uninsured visits are derived from the Health Care Subsidy Fund, which is financed by an assessment on hospital operating revenues.

//2013/ The portion of the annual assessment that is allocated to the FQHCs is \$45 million in SFY 2011 and \$46.4 million in SFY 2012.//2013//

//2012/ The 20 FQHCs have a combined 94 licensed satellite sites throughout the State. In 2010, almost 178,775 uninsured persons were services and over 500,000 uninsured visits reimbursed. Overall, there were almost 400,000 patients and over 1.2 million visits provided by the state's network of FQHCs. The average FQHC site is operational 54 hours per week.//2012//

//2013/ The FQHCs operate in 20 of NJ's 20 counties. The 20 FQHCs have a combined 96 licensed satellite sites throughout the State. As a consequence of expansion and capacity building initiatives overall growth in the number of uninsured visits reimbursed has been exponential. In SFY 2011, almost 195,000 uninsured persons were services and over 440,000 uninsured visits reimbursed. Overall, there were almost 425,000 patients and over 1.3 million visits provided by the state's network of FQHCs.//2013//

The NJ Title V CYSHCN program collaborates with programs and services across State government to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. The Department of Human Service (DHS) is the largest department in NJ State government, and although Title V collaborates with many of its health programs and support services, those directly addressing medical, dental, developmental, rehabilitative, mental health, and social service are essential. Title XIX and Title XX services are administered by DHS, and provide critical supports for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children's Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need.

//2012/ SCHS Case Management collaborates with intergovernmental partners in the DHS' Office of Home Care and the DHS' Office of Developmental Disabilities, and DHSS' Long Term Care in the development of standardized case management waiver training. Standardized training of SCHS CMU's using the mandatory training module was conducted statewide. In addition, as core partners in the ISG, the Title V CYSHCN program collaborates with SPAN, the NJ Academy of Pediatrics Pediatric Council on Research and Education, DHS, the Department of Children and Families, as well as other intergovernmental and community-based partners to plan and implement interventions to address the six core outcomes for CYSHCN.//2012//

//2013/ In the Spring 2011, the NJ DHS introduced its Medicaid Waiver concept paper proposing structural consolidation and reform of NJ's Medicaid program. Public input was sought and NJ's Comprehensive Waiver application was submitted to CMS. Key elements of the Comprehensive Waiver (pending CMS approval) will close NJ FamilyCare to new parents, eliminate prior quarter coverage for new enrollees-excluding those eligible for nursing home placement, and enhance premium assistance programs to maximize

third party coverage to ensure Medicaid remains payer of last resort. Proposed benefits to families of CYSHCN include consolidation of waiver programs, integration of behavioral health for those not currently covered by the Children's Behavioral Health System, expansion of home and community-based services and supports for people with developmental disabilities consistent with the Affordable Care Act, expansion of home and community-based services and draw down of additional federal matching funds, and strengthening of HMO contract language to place more responsibilities on HMOs for reporting fraud and abuse. By the close of 2011, Medicaid mandated enrollment into managed care, including waiver clients. Title V facilitated the identification of children whose families needed to self-select an HMO that best met their child's needs. Moving forward, DHS proposes to move services for children with developmental disabilities to DCF, as well as reconfigure and rename some programs currently serving children at risk for abuse and neglect. Title V's input in this process is ongoing, and updates are shared with community-based organizations and families to facilitate their participation in the process.//2013//

On the local level, the SCHEIS programs, SCHS CMUs, SPS, and RWPD, screen all referrals for insurance and potential eligibility for Medicaid programs, counsel referrals on how to access Medicaid, NJ FamilyCare, Advantage, and waiver programs, and link families with their county based Boards of Social Services and Medicaid Assistance Customer Care Centers. They collect and report program data including insurance status. That report is compared with Medicaid data in determining CYSHCN need. Referrals are made to Boards of Social Services, NJ Family Care, Advantage, Charity Care, Department of Banking and Insurance, and Disability Rights NJ for supports/advocacy.

/2012/ Updates on the roll out of federal healthcare reform and its benefits for NJ families of CYSHCN are shared with SCHEIS programs by DOBI through presentations at meetings and updates on the Department of Banking and Insurance website.//2012//

/2013/ The Family Centered Care Services' health service grantees continue to screen CYSHCN for insurance status and referral to resources to facilitate access to Medicaid and/or insurance. Likewise, the SCHS CMUs, Specialized Pediatric Services providers and the Ryan White Family Centered HIV Care Network assist families to navigate Medicaid managed care and/or coordinate access to care through third party providers. //2013//

FHS maintains a memorandum of agreement with the DHS Medicaid to facilitate operation of the SCHEIS Fee-for-Service program. It ensures access to medications for the treatment of children with asthma and cystic fibrosis through NJ Medicaid participating pharmacies. Children birth to 21 years of age referred for this program are linked with the SCHS CMU in their county of residence for intake, information and referral, individualized service plan development, intermittent monitoring of needs, and registration with the BDARS. Likewise, State DHS staff that administer Medicaid durable medical equipment services and SCHEIS Fee for Service staff collaborate on technology and resource trends related to hearing aids, braces and orthotics.

/2012/ For example, collaboration among DHS Medicaid, SCHS Case Management, the State audiologist, and hearing aid dispensers resulted in clarification of billing codes for bone conduction hearing aids and related services./2012//

The State SCHEIS office collaborates with DHS offices and programs to develop and implement policy that will ensure that children referred into the SCHS CMUs and their families are screened appropriately for healthcare service entitlements and waived services. 100% of CYSHCN served through SCHS are screened for insurance status and/or referred for Medicaid/NJ FamilyCare or waiver programs, as applicable.

In 2010, major changes are occurring in NJ Medicaid Managed Care, with two of the Medicaid health maintenance organizations acquiring two other currently existing plans and a new HMO being awarded. Over a 6 month period, 100,000 Medicaid managed care enrollees are targeted

to change health plans. To facilitate this process SCHEIS is collaborating with the Office of Medicaid Managed Care Quality Assurance to provide outreach and support to families and specialty providers.

/2012/ As a result of in-reach to families of CYSHCN by SCHEIS provider agencies enrolled in Medicaid Managed Care and affected by HMO restructuring, families were assisted through the transition. This included redirecting families to Medicaid's hotline, technical assistance on access to specialty providers and promoting awareness about Medicaid Managed Care, Care Coordination. A proposal in the State 2012 budget mandates the enrollment of Fee-for-Service Medicaid recipients into Medicaid managed care.//2012//

/2013/ Subsequent to implementation of mandatory MMC, a need to clarify the coordination of third party liability and Medicaid benefits was noted. To that end, the DHS Office of MMC developed a guide to understanding health coverage in NJ.//2013//

The DHS, Division for the Deaf and Hard of Hearing (DDHH), partners in planning access to care and service delivery for CYSHCN with impaired hearing. SCHEIS staff and DDHH staff cross refer CYSHCN and their families for services and supports. Advocacy, employment and vocational opportunities, sign language interpreter services and assistance with social, legal, medical, educational, and recreational issues are examples of services that SCHS CM and the Specialized Pediatric Services providers refer CYSCHN to DDHH.

The Early Identification and Monitoring (EIM) Program has multiple collaborations with the DDHH, in the NJ DHS. The EIM Program Manager is the DHSS representative on their Advisory Council. DHSS has partnered with DDHH on numerous outreach programs for consumers, and printed brochures.

/2013/ The Early Hearing Detection and Intervention program (EHDI) collaborated with the Department of Children and Families (DCF), Division of Youth and Family Services (DYFS), to allow nurses responsible for health outcomes of children under DYFS supervision to have read-only access to hearing screening modules that are in the New Jersey Immunization Information System. Continued partnership with five of the Federally Qualified Health Centers (FQHCs) has allowed for hearing re-screening for uninsured families at these locations.//2013//

Collaboration between SCHEIS staff, SCHS CM and/or Specialized Pediatric Services providers and the DHS, Division of Family Development (DFD) is essential in coordinating access to care and social services for many of NJ's most vulnerable CYSHCN and their families. The primary tasks of DFD include directing NJ's welfare program, Workfirst NJ (WFNJ), and providing funding, information management services, and administrative support to the county and/or municipal welfare departments that implement the federally funded Food Stamps food assistance program. The DFD also oversees child care licensing, Kinship supports for families, and child support. The federal SSI benefit program for aged, blind or disabled individuals is also supplemented by DFD. WFNJ recipients who may be eligible for federal SSI benefits can now get free legal help. The DFD has established an agreement with Legal Services of NJ (LSNJ) to assist recipients in either filing for SSI benefits or appealing a denial of benefits.

The DHS Division of Disabilities Services (DDS) and SCHEIS collaborate to promote and facilitate independence and participation for people with disabilities in all aspects of community life. Through its system of Information and Referral (I&R), the DDS supports active information exchange regarding community services and fosters coordination and cooperation among government and community-based agencies. The I&R Specialists commonly refer families of CYSCHN to the SCHEIS CECs, Tertiary Care Centers and Cleft Lip/Palate and Craniofacial Anomalies Centers; SCHS CM and family supports. In addition, SCHEIS refers families to the Traumatic Brain Injury (TBI) Fund, TBI Waiver and Personal Preference: NJ Cash and Counseling Program; and the Medicaid Personal Care Assistant (PCA) services. The SCHEIS regularly uses these DDS resources to assist families of CYSHCN to find health and transition to

adulthood supports. In addition, the SCHS CMUs are the contracted case management vendors for the AIDS Community Care Alternatives Program (ACCAP) waiver; and Community Resources for People with Disabilities (CRPD) waiver.

/2012/ The DDS produces a valuable directory of State, federal, and disability specific resources annually. SCHEIS contributes updates on programs and services and widely distributes "Resources" at consumer and provider trainings. In addition, the State Case Management staffs meet with State DDS waiver staff to ensure access to waived services. State and local Case Management staffs participated in the development and implementation of waiver trainings in 2010.//2012//

/2013/ The DHS DDS Office of Home Care, Title V and SCHS CMU staffs communicate regularly on waiver procedure. Waiver training was conducted on a statewide Waiver CM format as well as through participation at the SCHS CMU Coordinator meetings. In addition, a revised DDS waiver training manual is in development. A formal statewide Medicaid Comprehensive Waiver training was conducted in 2011, attended by SCHS CMUs and Title V staffs, and reinforced communication across systems.//2013//

Statewide mental health services for CYSHCN with serious and persistent mental illnesses are coordinated by the DHS Division of Mental Health Services (DMHS) and the Division of Addiction Services (DAS). Supporting CYSHCN with emotional/behavioral co-morbidities and their families is a challenge. The SCHEIS' CECs, FASD's, and Tertiary Care Centers serve as a vital community-based asset for families and mental health providers to consult for comprehensive evaluations and treatment of CYSHCN. Likewise, the SCHS CMU's link CYSHCN with emotional behavioral needs to the mental health and specialized pediatric providers to coordinate access to care across those systems.

In operation for over 20 years, the Catastrophic Illness in Children Relief Fund (CICRF) Commission administers a financial assistance program for NJ families whose children have an illness or condition otherwise not fully covered by insurance, State or Federal programs, or other source. By legislative mandate, the FHS sits on the CICRF Commission. The FHS maintains a memorandum of agreement (MOA) with the CICRF program to formally refer children birth to 21 years of age whose families have accumulated medical debt for the care and treatment of their children's medical condition. All applications received by the State CICRF program are forwarded to the SCHS CMU in the CYSHCN's county of residence for intake, information and referral, individualized service plan development, intermittent monitoring of needs, and registration with the BDARS.

/2012/ As the SCHS CMU staff conduct intake on new referrals and/or monitoring of active clients' needs, insurance status and outstanding medical debt are queried. In 2010, the SCHS CMU's assisted families to process 525 applications statewide with 318 awards totaling \$ 7.1 M.//2012//

/2013/ In compliance with CICRF's intergovernmental MOA, the Title V State staffs conduct outreach through the State BDARS mailings and by the SCHS CMU follow-up on new referrals, as well as through public speaking engagements, webinars and community events. Cross-referral of clients identified to CICRF and SCHS CM occurs regularly, for those both eligible and ineligible for CICRF. In 2011, the CICRF application was posted online, and CICRF is developing functions to enable electronic submission. State Title V staffs are meeting with CICRF to establish protocol to support transmission of referrals to the SCHS CMUs for more rapid linkage to community supports. A nearly 10% increase in the number of applications for assistance generated by the SCHS CMUs was noted in 2011 (382) as compared to 2010 (348).//2013//

The NJ Council on Developmental Disabilities (NJ CDD) functions in accordance with the federal Developmental Disabilities Assistance and Bill of Rights Act, and in NJ State government by N.J.S.A. 30:1AA 1.2 and is codified in Title 10 of the State Administrative Codes. According to State statute the Title V agency has a seat on the NJ CDD. The purpose of the NJ CDD is to

engage in advocacy, capacity building, and systemic change that contribute to a coordinated, consumer and family-centered, consumer and family-directed comprehensive system that includes needed community services, individualized supports, and other forms of assistance that promote self determination for individuals with developmental disabilities and their families.

//2013/ Collaboration in referral to families served by Title V to participation in PIP continues, and State staffs participated in the leadership training program.//2013//

The Medical Assistance Advisory Committee (MAAC) operates pursuant to 42:CFR446.10 of the Social Security Act. The 15 member Committee is comprised of governmental, advocacy, and family representatives and is responsible for analyzing and developing programs of medical care and coordination. State SCHEIS staffs participate at MAAC meetings and share information on access to care through Medicaid managed care with Committee members as well as with SCHEIS programs. Likewise, information shared by the MAAC is incorporated into SCHEIS program planning to better assure coordination of resources, services, and supports for CYSHCN across systems.

//2012/ Updates in Medicaid programs and services (i.e. change in transportation provider agency) are shared through MAAC meetings and disseminated to SCHEIS provider grantees. This communication is helpful in assisting consumers to access community-based services in a timely manner.//2012//

//2013/ State staffs' participation at quarterly MAAC meetings served as a forum for discussion, information sharing and public input for development of the Comprehensive Waiver.//2013//

In order to ensure access to health insurance and benefits to enrolled CYSHCN, SCHEIS collaborates with the Department of Banking and Insurance (DOBI), Division of Insurance colleagues in the development of policy and procedure; i.e., Grace's Law, EIS, and Autism. Likewise, DOBI partners participate with SCHEIS in provider and consumer education and advocacy and regularly provide technical assistance and training at the SCHS quarterly meetings. State SCHEIS staffs are dialoguing with DOBI staff in planning for NJ implementation of the Patient Protection and Affordable Care Act (PPACA).

The Department of Children and Families (DCF) is focused on strengthening families and achieving safety, well-being, and permanency for all NJ's children. Current priorities focus on child welfare, safety, health, family strengthening, and the establishment of foster homes. DCF is also engaged in reengineering child abuse prevention, building capacity in the child behavioral health system, and improving the system of health care for children in the State's care. Collaboration between State SCHEIS, local agencies implementing CYSHCN health and related support services, and the statewide DCF system are ongoing to ensure access to health and related services to the most vulnerable CYSHCN.

//2013/ In addition to routine dialogue to ensure access to supports as needed for CYSHCN with behavioral needs, Specialized Pediatrics staff organized a structured meeting with DCF. Key staffs from both Departments explored resources and linkages to better support clients through the DHSS' Child Evaluation Centers, Fetal Alcohol Spectrum and Alcohol-Related Neurodevelopmental Disorder and Autism Clinical Enhancement Centers, and DCF's Children's System of Care Initiative. The shortage of pediatric psychiatrists and improved access to psychology, counseling and family supports remain challenges in NJ, particularly in some of the more rural areas with limited transportation. //2013//

//2013/ Title V CYSHCN is a partner with SPAN and AAP in SPAN's recent grant awards from the Healthcare Foundation of NJ and the Partners for Health Foundation, to connect primary care providers with child and adolescent psychiatrists, through the Essex County Primary Care-Child Psychiatrist Consultation Pilot Project.//2013//

Linkages with the DCF's Division of Prevention and Community Partnerships, Division of Community Services, and Office of Education ensures access to behavioral health providers, emergency response providers, the DCF child health nurses, and local child protection services offices. These linkages are essential for SCHS Case Managers, Specialized Pediatric Services (SPS) provider agencies, Ryan White Part D (RWPD) providers, EIS, and other DHSS programs to maintain capacity to serve the State's most vulnerable children.

Collaboration with the Department of Labor and Workforce Development ensures access to programs such as Vocational Rehabilitation, Social Security Disability Determination, Temporary Disability Insurance, and Workers Compensation. The Division of Vocational Rehabilitation (DVR) Services is responsible for training and placement of persons of employable age with disabilities. As SCHEIS counsels families on transition to adulthood planning options, programs regularly refer to DVR. Likewise, DVR staffs collaborate with SCHEIS programs on family and provider training, individual service plan, and individualized education plan development.

Medically fragile children from birth-6 years of age in need of day care services are typically referred by SCHS CMUs, SCHEIS specialty providers, EIS, primary care providers, and/or self referred to pediatric medical daycare providers. Community level collaboration is encouraged between pediatric medical daycares and SCHEIS to ensure that children are linked to health services and support services beyond childcare. Likewise, the State SCHEIS and DHSS Division of Support Services for the Aged and Disabled collaborate on ensuring access to pediatric medical daycare through technical assistance and training of community-based providers and rule making.

//2013/ Family Centered Care Services (FCCS) health services grantees continue to refer children to pediatric and/or adult medical day services and assist families as needed. In 2011, the DHSS and DHS announced significant revisions to the process of eligibility determination for medical day services. Some functions formerly conducted by DHSS staff have been restructured and the Medicaid HMOs have a more prominent role in the eligibility and plan approval process. Title V and DHS Medicaid disseminated information to FCCS grantees to facilitate these changes.//2013//

Childcare is a need for CYSHCN and SCHEIS collaborates with MAPS to Inclusive Child Care Training and Technical Assistance Project, Healthy Start programs, as well as the MCCH Adolescent Health unit. The goals of the project are to increase the quality of early care and education for children with special needs; increase the number of child care providers that offer inclusive child care; increase awareness among parents, child care providers, and child care resource and referral agencies of the services available for children with special needs; and improve the delivery of services for children with special needs through collaboration among providers of child care services and special needs services.

Linkage with access to primary care is coordinated with NJ's Office of Primary Health and the local Centers for Primary Health Care. These Centers refer CYSCHN to the SCHS Specialized Pediatric Service providers as well as to the SCHS CMUs for assistance in coordination.
An attachment is included in this section. III E - State Agency Coordination

F. Health Systems Capacity Indicators

Health Systems Capacity Indicators are presented individually with multi-year data.

See From 17.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

Since 1999 Maternal Child Health Bureau (MCHB) has included performance plans and performance information in its budget submission. MCHB must submit annual reports to Congress on the actual performance achieved compared to that proposed in the performance plan. This section describes the performance reporting requirements of the Federal-State partnership. Figure 3, "Title V Block Grant Performance Measurement System" on page 45 of the federal guidance, presents a schematic of a system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. After each State establishes a set of priority needs from the five-year statewide needs assessment, programs are designed, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH "pyramid" -- direct health care, enabling, population-based, and infrastructure building services. Program activities, as measured by 18 National performance measures and State performance measures should have a collective contributory effect to positively impact a set of 6 national outcome measures for the Title V population.

Attached to this section, IV. A. Background and Overview, are ten MCH Indicator Trend Charts including:

Chart 1	Births by Race/Ethnicity
Chart 2	1st Trimester Prenatal Care Initiation
Chart 3	No Prenatal Care
Chart 4	Teen Births 15-17 Years of Age
Chart 5	Low Birthweight
Chart 6	Very Low Birthweight
Chart 7	Infant Mortality by Race/Ethnicity
Chart 8	Neonatal and Postneonatal Mortality
Chart 9	Breastfeeding by Race/Ethnicity
Chart 10	Multiple Births

An attachment is included in this section. IVA - Background and Overview

B. State Priorities

This section describes the relationship of the priority needs, the National and State performance measures, and the capacity and resource capacity of the State Title V program.

SP #1. Increasing Healthy Births

Increasing Healthy Births is a state priority that encompasses reducing low birth weight, preterm births, infant mortality, and increasing first trimester prenatal care and adequate prenatal care (NPM #8, 15, 17, 18). Several initiatives address healthy births including Healthy Start outreach activities, Community Action Team projects based on FIMR findings, and most recently the Access to Prenatal Care Initiative. The Perinatal Addictions Prevention projects seek to educate professionals and consumers of the risks involved with substance use and abuse in the perinatal period. Preconceptual health projects seek to have a healthy mother prior to conception.

The Family Planning projects provide a broad range of acceptable and effective family planning methods and related preventive health services that include natural family planning methods, infertility services and services for adolescents. Clinics have effective contraceptive methods, breast and cervical cancer screening, nutrition and prevention services that correspond with nationally recognized standards of care, sexually transmitted infections (STIs) and HIV prevention education, testing and referral, adolescent abstinence counseling, and other preventive health services. Aimed at schools and community groups, educational activities focus on primary pregnancy prevention, the program integrates assessment of adolescent risk behavior within routine family planning services.

The Family Planning Program hosts an annual Adolescent Health Institute to bring together adolescent stakeholders from throughout NJ to foster networking and collaboration and to provide an opportunity to focus on new information and resources as they pertain to the many issues facing adolescents.

/2013/ The Healthy Mothers, Healthy Babies Coalitions and Black Infant Mortality Reduction Initiative were rolled into the Access to Prenatal Care Initiative. Beginning with the SFY2013, RPHS is restructuring Access to Prenatal Care Grants to include preconception/interconception counseling incorporating the Life course model into the projects. This component would emphasize the health of reproductive age women including linkages with healthy lifestyles and medical home. All projects will promote cultural competence.//2013//

SP #2. Improving Nutrition and Physical Activity

Improving Nutrition and Physical Activity is a state priority related to SPM # 4 and NPM #14 and the growing obesity epidemic in NJ and nationally. NJ has one of the highest obesity rates among low-income children 2 to 5 years of age at nearly 18 percent in 2008. The obesity epidemic is taking a toll on the future health of our children by contributing to the rise in related chronic diseases and disabilities, and adding billions of additional dollars in health care costs. Children who are obese are at grave risk of lifelong, chronic health problems like heart disease, asthma, arthritis and cancer.

In May 2008 DHSS was awarded a 5-year cooperative agreement by the CDC to the Office of Nutrition and Fitness (ONF) to provide state leadership and coordination of nutrition, physical activity and obesity (NPAO) strategies. Through this cooperative agreement ONF has taken the lead in building a robust infrastructure by creating a statewide partnership of organizations and individuals, called ShapingNJ, to collaborate, build capacity and develop a comprehensive and coordinated system to halt further increases in obesity and other chronic diseases. Activities of the ONF and the ShapingNJ partnership are discussed in detail in the section on NPM #14 and SPM #4.

/2012/ The ShapingNJ Partnership is comprised of more than 100 organization members who have signed a partner agreement with Shaping NJ to collaborate on addressing nutrition, physical activity and obesity (NPAO) prevention strategies in five (5) settings: schools, communities, child care centers, worksites and healthcare facilities.//2012//

/2013/ NJ has one of the highest obesity rates among low-income children 2 to 5 years of age at 17.3 percent in 2010. ShapingNJ is the statewide partnership of 200 organizations.

In 2011-2012, the DOE CSH provided technical assistance and developed a Student Focus Group Toolkit. This toolkit enabled wellness team leaders to conduct focus groups to gain insight into student eating and activity behaviors before and after school. The focus group data resulted in more student participation in planning of school events. The Student Focus Group Toolkit was also provided to DHSS CSH grantees. In addition, DOE conducted Fitnessgram and SHI trainings to DHSS CSH to assure alignment between the

departments.//2013//

SP #3. Reducing Black Infant Mortality

Maternal and Child Health Services (MCHS) has a long history of interest in perinatal health disparities with special emphasis in 1985 when the Infant Mortality Reduction Initiative was initiated. Subsequently, MCHS submitted an application for the initial round of Healthy Start projects. In 1996, the Department established the Blue Ribbon Panel on Black Infant Mortality Reduction. Following release of the report from the panel, an Advisory Panel on Black Infant Mortality was created to implement recommendations from the report including a public awareness campaign and community-based projects to provide outreach and education services in high need communities.

Following recommendations from Commissioner Heather Howard's Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

Nine health service grants were awarded for the Access to Prenatal Care Initiative providing statewide representation. The agencies and their activities are described for SPM #1.

/2013/ The Access to Prenatal Care initiative addresses eliminating disparities in all of its activities. The grantees target the areas that have had the poorest birth outcomes and lowest rates of first trimester prenatal care.//2013//

SP #4. Reduction of Adolescent Risk Taking Behaviors

Creating a Coordinated School Health (CSH) System in NJ to reduce adolescent risk taking behaviors relates to NPM #8, 10, 13, 16 and SPM #5 &, 6 & 10. The anticipated start date of this project is July 1, 2010. The current DHSS Community Partnerships for Healthy Adolescents (CPHA) initiative, will end with the start-up of the three regional CSH grants. The CPHA initiative conducted a total of 220 activities impacting 51,624 adolescents and addressed these issues: violence prevention including bullying and gangs, improving healthy food choices, increasing physical activity and decreasing TV and other screen time; access to youth-serving health and social services; alcohol, tobacco and other drugs (ATOD), sexuality and prevention of sexually transmitted infections (STIs) including HIV/AIDS, life skill development and heart health.

/2012/ The CPHA initiative ended June 30, 2010. The CSH System in NJ began on schedule on July 1, 2010.//2012//

/2013/ CSH grantees and their school partners are implementing activities to create a culture of health and wellness through the use of school health wellness teams, improvements to strengthen local school health policies (mainly through physical activity, nutrition and tobacco (PANT) strategies and by assessing school climate through participation in Rutgers University's Improving School Climate for Academic Success (ISCALS) survey. In September 2011, schools were required to implement the Anti-Bullying Bill of Rights. This law, touted to be the toughest in the country, set new rules and strict time frames for schools to address alleged harassment, intimidation and bullying (HIB) and required schools to designate an anti-bullying specialist and create a school climate team. In March 2012, the legislature approved a \$1M appropriation to fund the changes required by the law.//2013//

In 2009 a 5 year cooperative agreement was awarded by the CDC to the Department of Education (DOE) to collaborate with the DHSS on a Coordinated School Health Program to address nutrition, physical activity and tobacco. Three grants, each located in one of three NJ regions (North, Central and South), will be awarded funds to be used for the implementation of CDC's Coordinated School Health model in at least eight public middle- and/or high- schools of public school districts.

/2012/ Three regional grantees and one individual grantee were awarded funds to work with a total of 28 school partners in 1/3 (7 counties) of New Jersey.//2012//

SP #5. Improving Access to Quality Care for CYSHCN

NJ will continue to improve access to quality care for CYSHCN through collaboration and partnership building, targeting resources and efforts to maintain capacity and to comprehensively address the six MCHB core outcomes for CYSHCN and State Performance Measures (#6, 7, and 8) in order to achieve its State Priority # 5 of Improving Access to Quality Care for CYSHCN.

The network of specialty providers, linkages with enabling services provided by Special Child Health Services Case Management Units (CMUs), collaboration with intergovernmental agencies and community-based organizations (refer to stakeholder list), and leadership from the State agency strengthens the safety net of access to care for NJ's CYSHCN. Although many of NJ's CYSHCN have access to primary care, the coordination of care for medically fragile children is often managed through their specialty providers; Child Evaluation Centers (CECs), Fetal Alcohol Syndrome/and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers, Cleft Lip/Palate Craniofacial Anomalies Centers, Tertiary Care Centers and Ryan White Part D HIV Care Network, and NJ is attempting to reverse that trend. Through the NJ Academy of Pediatrics' Pediatric Council on Research and Education's (PCORE) efforts to promote medical home and the Statewide Parent Advocacy Network's (SPAN's) statewide Systems Integration Grant (SIG) /2012/ State Implementation Grant for Integrated Community Systems (Integrated Systems Grant or ISG 1) activities, medical home initiatives are being developed to promote collaboration between pediatric subspecialists and primary care providers. NJ is working toward all CYSHCN receiving high quality, comprehensive care through a medical home that assures timely access to necessary pediatric specialty and subspecialty care, community supports, and transition to adult care when appropriate. //2012//

/2013/ Title V efforts to improve quality of care included continued collaboration on ISG 1 and ISG 2 addressing the six core outcomes for CYSHCN through parent-professional medical home initiatives. Using a multi-county approach, outreach was conducted to pediatric and family practices, and federally qualified health centers throughout the southern and central regions of the State. The SCHS CMUs provided lists of providers that routinely served CYSHCN in their case loads, and SPAN and PCORE invited practices to "Kick Off" events providing an overview of the medical home/ISG initiative. Title V provided consultation on specialized pediatric services and case management, presented at medical home learning collaborative meetings and care coordination webinars, and provided resources to practices. Additional outreach to the northern and western regions of NJ are scheduled into 2012.//2013//

NJ continues to work toward ensuring that a sufficient number of pediatric subspecialists are available statewide to provide high quality tertiary care to CYSHCN and endorses the interdisciplinary team approach to comprehensive care. In addition to autism care being provided by the CECs, 6 Clinical Autism Centers have been partially funded by the Governor's Council for Medical Research and Treatment of Autism/DHSS to enhance their autism diagnostic and treatment services.

Access to appliances including hearing aids, braces, orthotics; and medications for the treatment of asthma/cystic fibrosis is facilitated through the SCHEIS Fee for Service program.

Training and technical assistance for SCHS CMUs, Pediatric Specialty Providers, families and community-based partners on NJ's rapidly evolving health insurance landscape is critical in 2010 and for the near future. In 2008, the NJ Healthcare Reform Act expanded NJ FamilyCare, established a mandate for health care coverage of children, and reformed individual and small employer insurance markets. In addition, recently passed legislation requires State regulated insurance plans to cover certain treatments for autism and other developmental disabilities, including those treatments based on Applied Behavior Analysis. Full and equitable financing by NJ third party payers and State Medicaid remains a challenge but we embrace that challenge to achieve the early identification and management of chronic conditions, comprehensive preventive care, and collaborative practice between primary and subspecialty pediatric care. The landmark federal Patient Protection and Affordable Care Act contains some provisions that have already existed in the NJ individual and small employer markets. However, some provisions that affect children are to be implemented as of July 1, 2010, including plans may not exclude coverage for children under age 19 due to pre-existing conditions and plans may not establish lifetime limits on the dollar value of essential benefits, as well as other significant changes that affect access to care. Dialogue with colleagues in the NJ Department of Banking and Insurance, the SCHS CMUs, Pediatric Specialty Care providers, SPAN's ISG 1 Consortia of Care, PCORE and other stakeholders described earlier will be important to maintain access to care in this changing environment, and community-based trainings on how these changes benefit CYSHCN will be addressed.

/2012/ In 2010, periodic training and updates on NJ's implementation of the federal Patient Protection and Affordable Care Act has been provided to the SCHS CMUs by the NJ Department of Banking and Insurance (DOBI). Likewise, DOBI regularly updates its website to provide consumers with access to healthcare changes. For example, in July 2010 NJ unveiled a new health insurance option for uninsured persons with pre-existing medical conditions. Coverage through NJ Protect will generally cost less than comparable individual health insurance. Because the program is federally subsidized, treatment for pre-existing medical conditions is covered as of the day a policy goes into effect, and preventive care will be covered at no out-of-pocket cost to the policyholder. The introduction of this new insurance product, in addition to existing programs such as NJ Medicaid, NJ FamilyCare, and NJ Advantage provides the uninsured with additional options to access affordable healthcare. However, families of CYSHCN report that challenges remain particularly in the private insurance sector, i.e., affordability of rising costs for co-payments and premiums; non-covered services such as private duty nursing and durable medical equipment; gaps in coverage of hearing aids for youth over age 15 years. Likewise, it remains a challenge for families and service providers to understand the rapidly evolving health insurance arena.//2012//

/2013/ A statewide teleconference featuring Ms. Tricia Brooks, senior fellow at the Center for Children and Families and an assistant research professor at the Georgetown University Health Policy Institute was conducted to educate State Title V staffs and FCCS grantees on anticipated changes in health care reform for 2014. The presentation format provided an opportunity to dialogue with a national expert on policy and implementation issues affecting coverage for children and families with a focus on children who are eligible but not enrolled in Medicaid and SCHIP.//2013//

Given the high rate of overweight and obesity in CYSHCN, SCHEIS, by joining Shaping NJ and collaborating with other stakeholders, is currently working to draw attention to the obesity prevention needs of CYSHCN.

SP #6. Reducing Teen Pregnancy

Teen pregnancy prevention is a state priority for NJ and relates to NPM #8 & SPM #4. Teenage childbearing can have long-term negative effects on both the teenage mother and the infant. Infants born to teen mothers are at higher risk of being low birthweight and preterm. They are

also far more likely to be born into families with limited educational and economic resources. Several inter-agency initiatives have been developed to address this priority.

Title X, NJ Family planning agencies with 58 clinical sites continue to provide comprehensive reproductive health services to adolescents provided free of charge or at a nominal fee. They assure on-going high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families.

/2012/ MCHS applied for and was approved for funding from DHHS, ACF: 1) Title V New Jersey Abstinence Education Project (AEP); and, 2) Personal Responsibility Education Program (PREP). A competitive AEP RFA was released in February 2011. Grant funding is expected to begin July 1, 2011. A competitive RFA for PREP was released in July 2011. Grant funding is expected to begin October 1, 2011.//2012//

/2013/ Grant funds for Title V AEP was awarded to four grantees, two in the northern region, one in central and the fourth in the southern region. The AEP has implemented activities since October 2011. PREP funds were awarded to seven grantees serving at least 50% youth in the 30 high-risk New Jersey municipalities. Implementation of PREP is planned for fall of 2012.

/2013/ Title X NJ Family Planning agencies provide services in all 21 counties through 49 sites.//2013//

SP #7. Decrease Asthma Hospitalizations

Asthma is the most common chronic disease reported in children. It is a leading cause of hospital stays and school absences and poses significant limitations on quality of life for many children and families. Asthma has increased in NJ and worldwide in recent years.

The DHSS Asthma Awareness and Education Program (AAEP) funds the American Lung Association of MidAtlantic (ALAMid), to support the infrastructure of the Pediatric/Adult Asthma Coalition of NJ. The PACNJ implements strategies and initiatives to address the asthma burden, and assist the Department in implementing the State Asthma Strategic Plan. With over 70 members on six task forces, PACNJ works with schools, child care providers, health care providers, health insurers, community groups and environmental agencies to reach all individuals in NJ with the most effective methods for managing their asthma.

Significant accomplishments in the last year are detailed in the section for HSCI #1 (rate of children hospitalized for asthma).

SP #8. Improving and Integrating Information Systems

The MCH Epidemiology Program, Family Health Services and the NJDHSS are all involved in efforts to improve and integrate public health information systems. Activities are related to NPM #1, 9, 12 & HSCI #5, 9A, 9B, & 9C. Examples of improving access to and integration of public health information are discussed in sections specific to the performance measures and health systems capacity indicators.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	112406	6061	5825	5655	5421
Denominator	112406	6061	5825	5655	5421
Data Source		Newborn Screening Program	Newborn Screening Program	Newborn Screening Program	Newborn Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

Source: Newborn Biochemical Screening Program as reported by the state's Inborn Errors of Metabolism laboratory.

Number of unique screen-positive newborns per calendar year who received timely follow-up. See attached Table - Newborn Screening Disorders FY 2011 Data

Notes - 2010

Source: Newborn Biochemical Screening Program as reported by the state's Inborn Errors of Metabolism laboratory.

Number of unique screen-positive newborns per calendar year who received timely follow-up. See attached Table - Newborn Screening Disorders FY 2010 Data

Notes - 2009

Source: Newborn Biochemical Screening Program as reported by the state's Inborn Errors of Metabolism laboratory.

Number of unique screen-positive newborns per calendar year who received timely follow-up.

a. Last Year's Accomplishments

Newborn Screening continues to be an essential, preventive public health program for early identification of disorders that can lead to catastrophic health problems. The Newborn Screening and Genetic Services Program (NSGSP), which houses the follow-up component of newborn biochemical screening, ensures that affected newborns and their families receive prompt intervention by contacting primary care providers, physician specialists and parents to ensure evaluation, confirmatory testing, and a final diagnosis. All newborns with confirmed disorders received appropriate follow-up services -- see attached chart.

In 2011, New Jersey's Newborn Screening Program continued to meet with the Newborn Screening Advisory Review Committee (NSARC) to develop recommendations concerning the

management of residual dried blood spots. Recommendations are currently pending Commissioner Review. The Program continues to be in the forefront nationally in terms of the number of disorders for which screening is provided to newborns. Babies receive blood spot screening for 54 disorders in New Jersey. In 2010, Kathleen Sebelius, Secretary of Health and Human Services, endorsed the recommendation by the Advisory Committee for Heritable Disorders in Newborns and Children, to add newborn screening for severe combined immunodeficiency (SCID) to the Recommended uniform Screening Panel. In April, 2011, NSARC also voted to recommend adding SCID to New Jersey's newborn screening panel. This recommendation is currently under review by the Commissioner of Health. In 2012, legislation was passed mandating screening for 5 lysosomal storage disorders. This legislation does not go into effect until certain conditions, such as the existence of FDA approved reagents, are met. In the meantime, NSARC is continuing its review of lysosomal storage disorders.

Newborn screening was instituted in New Jersey in 1964 with the implementation of statewide screening for phenylketonuria (PKU). Screening expanded to include congenital hypothyroidism in 1978, galactosemia in 1982, and the hemoglobinopathies, including sickle cell disease in 1990. With advances in screening technologies and public advocacy for expanded newborn screening, in 2000, the New Jersey Department of Health and Senior Services (DHSS) convened an advisory panel of metabolic and genetic experts, parents, nurses, pediatricians and other health care professionals to closely examine New Jersey's program. Statewide public hearings were also held to enable interested parents, advocates and other concerned individuals the chance to voice their experience and concerns with newborn screening. In 2001, a significant expansion of the program was implemented with the addition of 4 more disorders: Maple Syrup Urine Disease, Cystic Fibrosis, Congenital Adrenal Hyperplasia and Biotinidase Deficiency. In 2002, screening continued to expand in New Jersey with the acquiring of tandem mass spectrometry technology. By the end of 2003, 12 more metabolic disorders were added to the panel. The last major expansion was completed in 2009 with the additional screening for 34 disorders.

Appropriate educational materials are also provided to hospitals, parents, physicians, and specialists. Educational materials have been prepared for parents and health care professionals. Pediatric specialty consultant groups agreed on using HRSA ACT sheets as a resource for physician information to replace the current physician information sheets at the time of expansion. In order to improve parent informational material, the program adopted new brochures, developed as a result of extensive HRSA and AAP funded studies. The brochures, entitled "These Tests Could Save Your Baby's Life," are available in English and Spanish and have been distributed to all New Jersey birthing facilities.

The DHSS recognizes that screening is only the first step in a state-mandated newborn screening program: successful programs require additional resources and funding to ensure immediate access to confirmatory testing, appropriate treatment and follow-up of each affected infant and family. Due to the nature of some of these disorders, a delay in confirmatory testing and/or treatment can be life threatening. Sub-specialists who can provide these essential services have been identified for the various disorders and funding has been committed to provide a statewide safety net of specialized diagnostic and treatment services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expanded screenings to include 54 newborn biochemical disorders.			X	
2. Tandem mass spectrometry technology has been implemented in the Newborn Screening Laboratory.			X	
3. Regional specialty care centers have been established and supported for affected newborns and their families.	X			X

4. Ongoing collaboration with specialists and pediatric primary care providers.				X
5. FHS and The Newborn Screening Laboratory, Division of Public Health Infrastructure Laboratories and Emergency Preparedness staff regularly meet with established specialty consultants.			X	X
6. Newborn Screening Annual Review Committee (NSARC) reconvened to advise Newborn Biochemical Screening Program.				X
7. Improvements in generic NBS parent pamphlets.		X		
8. Follow-up protocols, new parent and physician fact sheets for expanded NBS.		X		
9.				
10.				

b. Current Activities

The NSGSP currently collaborates with the Newborn Screening Laboratory, several specialty consultant groups, and the NSARC to continue to refine a best practice model for newborn screening services and follow-up. NSARC has recommended the addition of severe combined immunodeficiency (SCID) to the newborn screening panel and continues to discuss whether or not to recommend the addition of lysosomal storage disorders, ahead of the effective date of the recent legislation, to the screening panel.

SCHEIS continues to provide partial support for the provision of specialty services in the areas of genetics/metabolic disorders, pediatric pulmonary and endocrine disorders, hemoglobinopathies, and specialty laboratory services.

For each of the newborn biochemical disorders, semi-annual meetings continue to be held with the respective consultant groups to ensure that testing and follow-up procedures used by the State are reflective of best medical and laboratory practices. Additionally, the medical consultants represent the concerns of families with affected newborns, including such diverse issues as insurance reimbursement, obtaining referrals for appropriate medical care and treatment and identification of other unmet needs.

In 2011, Governor Christie signed legislation making NJ the first state in the nation to mandate pulse oximetry screening of newborns. NJDHSS worked with an expert consultant group to develop a recommended screening protocol for the hospitals.

c. Plan for the Coming Year

The Newborn Screening and Genetic Services Program will continue to work with its many partners and consultants including the NSARC in 2012.

The Program will continue to meet regularly with specialty consultant groups in hematology, endocrinology, pulmonology, and genetic and metabolic medicine to determine appropriate cut-offs for screening tests, as well as follow-up procedures and general program operations.

The Program will continue to be represented and participate in local and national association meetings and activities which are designed to advance newborn screening practice. These include working with the New Jersey Human Genetics Association, the New York Mid-Atlantic Consortium for Genetic and Newborn Screening Services, and the American Association for Public Health Laboratories. The Program will also continue to provide data and respond to surveys as requested by the National Newborn Screening Information System, which is housed in The National Newborn Screening and Genetics Resource Center (NNSGRC). The NNSGRC is a cooperative agreement between the Maternal and Child Health Bureau (MCHB), Genetic Services Branch and the University of Texas Health Science Center at San Antonio (UTHSCSA), Department of Pediatrics.

In 2012, the Program will continue to work on having a module for newborn biochemical screening in the new electronic birth certificate. This module would help ensure that all newborns born in New Jersey receive newborn screening and enable easier tracking of affected newborns for follow-up. Web-based updates regarding newborn screening activities, policies and services will be made in accordance with any changes.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	101692					
Reporting Year:	2011					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	101692	100.0	20	1	1	100.0
Congenital Hypothyroidism (Classical)	101692	100.0	1582	85	85	100.0
Galactosemia (Classical)	101692	100.0	76	17	17	100.0
Sickle Cell Disease	101692	100.0	93	80	80	100.0
Biotinidase Deficiency	101692	100.0	172	2	2	100.0
Cystic Fibrosis	101692	100.0	123	13	13	100.0
Homocystinuria	101692	100.0	9	0	0	
Maple Syrup Urine Disease	101692	100.0	0	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	101692	100.0	6	3	3	100.0
Argininosuccinic Acidemia	101692	100.0	1	1	1	100.0
Citrullinemia	101692	100.0	5	0	0	
Isovaleric Acidemia	101692	100.0	10	1	1	100.0
Propionic Acidemia	101692	100.0	10	0	0	
3-Methylcrotonyl-	101692	100.0	38	2	2	100.0

CoA Carboxylase Deficiency						
Methylmalonic acidemia (Cbl A,B)	101692	100.0	10	0	0	
Glutaric Acidemia Type I	101692	100.0	18	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	101692	100.0	12	4	4	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	101692	100.0	0	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	62	56	57	58	59
Annual Indicator	55.4	55.4	55.4	55.4	69.2
Numerator					
Denominator					
Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	70	70	70	72	72

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, a numerator and denominator is not available.

a. Last Year's Accomplishments

Annual audits of each of the 50 health service grantees was conducted by State staffs using standardized monitoring tools which included report of family involvement in program evaluation; i.e., family satisfaction surveys, focus groups patient interview and parent forums using standardized tools with open ended questions. State audit of clinical grantees included observation of parent-provider interaction during clinics, client chart review, and review and discussion of individualized service plan development with providers. Site visits afforded some observation of grantees' in-service training and team meetings. Examples of efforts by grantees' to ensure parent input included anonymous patient satisfaction and Press Ganey surveys, parent attendance and participation at team meetings, and family satisfaction surveys that had been completed anonymously by parents. Parent responses were reviewed by the local project Coordinator and shared with staffs to revised practice and incorporate family input into the delivery of services; i.e., revisited scheduling and office practices, language translation supports. Title V consultation and technical assistance was provided on an as needed basis.

Through a collaborative effort with the State Early Hearing Detection and Intervention (EHDI) program and using one time funding, 5 focus groups were conducted by the FCCS family support grantee, SPAN's Project Family WRAP, to gather family input on satisfaction with hearing screening, diagnostic and educational and family supports. Twenty-eight parents participated and represented English speaking, non-English speaking, bilingual and hearing impaired parents of biological and adopted children with hearing loss. Parent responses demonstrated that most of the families were linked to care and resources and were satisfied with those services. However, they remarked about feeling isolated, wanting to meet other parents of children with hearing impairment and needing more support at points of transition.

Progress was made by the State SCHS CM, State BDARS, Rutgers University and the county SCHS CMUs in implementing the CDC Surveillance project. Both the electronic transmission of Registration data, and the Case Management Reporting System (CMRS) module went live in 2011, and 100% of the CMUs are now online. Historically, State SCHS CM staffs needed to view hard copy records of a child's BDR and individualized service plan (ISP) to conduct audits. The electronic record is anticipated to allow State staffs more access to client's records and consequently more opportunity to validate family partnering in ISP development and satisfaction with services.

To ensure family partnership and satisfaction, the SCHEIS ensures access to SCHS case management family support and specialized pediatric services for CYSHCN and their families. This is being conducted formally through annual State SCHEIS monitoring and technical assistance of the 50 health services grants, as well as through discussion of those agency's findings gathered from family satisfaction surveys, focus groups and quality assurance initiatives. Consultation and collaboration is provided by State staffs to ensure that findings noted on individualized service plans and progress notes incorporate family driven needs identified by CYSHCN and their families. Likewise, consultation and technical assistance is provided on an as needed basis in developing resources in response to family satisfaction surveys, focus groups and quality assurance initiatives. In addition, SCHEIS collaborates with community- based

partners including SPAN, other Consortium Care members and families to assess family satisfaction and engage parents and CYSHCN in decision making.

On the programmatic level, annual audits of each of the 50 health service grantees are conducted by State staff using standardized monitoring tools which include report of family involvement in program evaluation: i.e., family satisfaction surveys, focus groups, patient interviews, and parent forums using standardized tools with open ended questions. Family feedback is reviewed by State and local staffs and considered in program planning.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SPAN		X		X
2. Parent-to-Parent Network		X		X
3. Statewide Family Voices chapter		X		X
4. Family satisfaction surveys, focus groups and/or additional methods of evaluation to be conducted periodically by SCHS CM, Specialized Pediatric Services, Family WRAP providers to measure family satisfaction.		X		X
5. SCHS CMU CDC Surveillance Project		X		
6. Statewide Integrated Systems grant in collaboration with SPAN and Consortium of Care partners		X		
7. NJ Council on Developmental Disabilities		X		X
8. Quality assurance project on access to hearing aids through Fee-for-Service program		X		X
9.				
10.				

b. Current Activities

Fifty health service grants partially support Title V services through the FCCS programs. To ensure family partnership and satisfaction, the SCHEIS ensures access to SCHS case management, family support and specialized pediatric services for CYSHCN and their families. This is being conducted formally through annual State SCHEIS monitoring and technical assistance of the 50 health services grants, as well as through discussion of those agency's findings gathered from family satisfaction surveys, focus groups and quality assurance initiatives. Consultation and collaboration is provided by State staffs to ensure that findings noted on individualized service plans and progress notes incorporate family driven needs identified by CYSHCN and their families. Likewise, consultation and technical assistance is provided on an as needed basis in developing resources in response to family satisfaction surveys, focus groups and quality assurance initiatives. In addition, SCHEIS collaborates with community-based partners including SPAN, other Consortium of Care members and families to assess family satisfaction and engage parents and CYSHCN in decision making.

State staffs are continuing with training and technical assistance of SCHS CMUs, and technical assistance with BDARS and Rutgers staffs to implement electronic records through CMRS. This system will facilitate access to SCHS CMU client records, and allow for more flexibility in monitoring of individual service plans.

c. Plan for the Coming Year

SCHEIS will maintain its network of providers to ensure access to culturally competent community-based care for CYSHCN, and its partnership with SPAN and PCORE in the ISG Consortium of Care. Contractual language will remain to encourage grantees to collect family input data through surveys, interviews and focus groups, and to integrate that feedback to

improve service delivery in a culturally competent manner. Continued CMRS training and technical assistance for State and county based SCHS CMU is ongoing. State staffs will revise training documents as revisions of the system are released. State staffs plan to pilot an online chart review and assess ISPs for parent input.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	57	42	43	44	45
Annual Indicator	40.8	40.8	40.8	40.8	38.3
Numerator					
Denominator					
Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	39	39	39	41	41

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

a. Last Year's Accomplishments

Title V programs and services continue to ensure statewide access for NJ's CYSCHN to primary care and SCHEIS subsidized direct specialty and subspecialty care. Eleven comprehensive Child Evaluation Centers (CECs), 5 Cleft Lip/Palate Centers, and 3 Tertiary Care Centers continue to provide access to comprehensive multidisciplinary team based-evaluation and/or treatment, regardless of the client's ability to pay. The provision of coordinated, ongoing, comprehensive care, including assistance with care coordination and linkage with a primary care provider/pediatrician supports appropriate care in the child's medical home. Although, the medical fragility/rare conditions of some CYSCHN presents challenges in accessing primary care through a community-based provider and the pediatric specialist serves dual roles; specialist and primary.

The Centers are recognized by NJ DHS's Medicaid managed care system as Centers of Excellence, are commonly referred clients by community-based providers including pediatricians, child study teams, DCF Child Behavioral Health and other community-based providers. Services are provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach. Additionally, a special insurance program is available for those individuals with Hemophilia A or B who do not have access to any of the traditional insurance programs.

Monthly Core Team ISG meetings with SPAN, PCORE, Title V and the Department of Children and Families (DCF) were conducted to discuss strategies and progress in addressing CYSCHN's access to medical home. The Team continued to collaborate on and implement the ISG 1 statewide plan including integration of ISG 2 autism content, to meet with pediatricians, family practitioners and federally qualified health centers and promote access to a medical home for CYSCHN. Lessons learned from the Monmouth county pilot project; i.e., practices to self-identify needs to develop their AIM/PDSA statements; support practices to define and identify CYSCHN in their individual practices; engage parent partners as members of the Medical Home QI team, etc., were applied. State Title V and county based SCHS CMUs contributed consultation and lists of primary care providers to initiate the ISG expansion into the southern (Camden, Gloucester and Salem counties), central (Middlesex county) and northern (Essex county) areas of NJ.

Regional medical home kick-off events and learning sessions were replicated in each region. Title V provided overviews of the role of Title V in ensuring access to care for CYSCHN, and linkage with primary and specialty pediatric services. Conference calls and webinars provided additional technical assistance to practices, including a co-teleconference by State SCHS CM and State Autism program; Title V and You, Access to Care for CYSCHN.

Preliminary results for the southern medical home initiative (10 practices) indicated improvement in practice familiarity with Medical Home and Family-Centered Care concepts. Family Feedback Surveys (200) regarding their practice suggested confidence that they could get the health care that their child needs (78.4%), their healthcare provider listened to their concerns and questions (82.6%). Interestingly, parents also reported their top 3 out-of-pocket expenses; payment co-pays, out of network care, and treatment/therapies not covered by their insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Case Management Services		X		
2. NJ AAP/PCORE Medical Home Projects		X		
3. Medicaid Managed Care Alliances				X
4. Subsidized Direct Specialty and Subspecialty Services	X	X		
5. Participation in Medical Assistance Advisory Council		X		
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Referral to and coordination with in-State specialty care providers was a component of technical assistance provided through the ISG medical home project. To that end, in collaboration with the Arc of NJ's Mainstreaming Medical Care initiative, Title V State staffs in collaboration with two regionalized comprehensive CECs experts authored and published an article in Arc's fall 2011 Healthy Times Newsletter. Broadly distributed to families and providers, and available on the Arc's website, the article describes services, eligibility, and cost for an evaluation at the CEC's and the CEC Fetal Alcohol Syndrome Disorder programs.

c. Plan for the Coming Year

The Title V SCHS CMUs and pediatric specialty providers will continue to provide a safety net for families of CYSCHN throughout 2013. State programmatic monitoring to ensure that clients have and/or are referred to community-based providers will remain ongoing; audit visits to assess clinic days and provide consultation as well as follow-up telephone support will continue. Continued collaboration with the DHS Office of Medicaid Managed Care and the ISG medical home initiative are anticipated. The ISG initiative will expand into northwest (Sussex, Warren and Morris counties), winter 2012. Title V will continue to collaborate, link providers and families of CYSCHN to care coordination and pediatric specialty care services in that region of NJ.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	64	61	62	63	64
Annual Indicator	59.9	59.9	59.9	59.9	54.9
Numerator					
Denominator					
Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	55	55	55	57	57

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and

the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

a. Last Year's Accomplishments

Understanding, integrating and supporting families through major health insurance and health services systems shifts was a big focus in 2011, and it is anticipated to continue into 2012. The Medicaid Comprehensive Waiver, mandatory Medicaid Managed Care (MMC), federal healthcare reform, coordination of care integrating third party liability, as well as the challenges of being underinsured and uninsured presented a dynamic environment of change for Title V programs/service providers, CYSHCN and their families. Likewise, the reorganization of some State agencies contributed to relearning about services and systems by State and local agencies and families of CYSHCN. In spring 2011, NJ released a Medicaid concept paper outlining significant changes to its Medicaid system, followed by public input and submission of a formal Comprehensive Waiver application that remains pending at this time. Mandatory enrollment of all Medicaid clients into MMC including SSI and waiver clients was implemented in fall 2011. Title V SCHS CM State, SCHS CMUs and Specialized Pediatric Services (SPS) providers worked quickly to identify CYSHCN in their caseloads potentially affected by these changes, facilitated HMO enrollment, advocated with State and MMC HMOs and supported families through their transition. The DHS' Office of Home and Community Services collaborates regularly with the MMC HMOs, Title V and the SCHS CMUs on ensuring access to waived services. State Title V staffs met quarterly with the Office of MMC, DHSS Senior Services, DHS Office of Home Care and the MMC HMOs to facilitate dialogue about systems issues.

At point of referral and periodic monitoring, families of CYSCHN were screened for the following: health insurance status; comprehensiveness of their plans to meet their special needs; NJ FamilyCare; NJ Advantage; private insurance; Charity Care/sliding fee scale; charitable foundations; and the need for assistance with outstanding medical debt through the Catastrophic Illness in Children Relief Fund (CICRF). No one is turned away from Title V services due to the inability to pay. 100% of applicants to the CICRF were referred to the SCHS CMU in their county of residence for assistance with care coordination and screening for additional socioeconomic supports as well as health and related services.

The SCHS CMUs and the SPS providers demonstrated that they remain knowledgeable about Charity Care, community-based charities and/or foundations in their regions that may assist to defray medical and related expenses and keep a family home. For example, a 16 year old CYSCHN diagnosed with cerebral palsy and quadriplegia was referred to an SCHS CMU by the SSA referral system. Upon outreach it was determined that although the child had a motorized wheelchair, there was no access to the home or van. The family could not afford to move or to build a handicapped ramp. The SCHS CM collaborated with multiple public and private agencies to mobilize support for the family to build a ramp; i.e., County Office of Disability, Healing the Children, Habitat for Humanity, a local real estate and construction company, local high school students and a men's church group. The ramp is anticipated to be built in spring 2012.

Participation in ISG activities provided opportunities to educate participating providers about Title V services and linkages with DHS Medicaid, presumptive eligibility, waivers, NJ FamilyCare, CICRF, SPS providers and other agencies and supports for CYSHCN that remain uninsured or underinsured. Preliminary ISG family survey data from the south Jersey medical home initiative suggested that of 200 baseline Family Feedback Survey's returned from participating practices, parents of CYSHCN identified 3 top out-of-pocket expenses; payment of co-pays, out of network care, and treatment/therapies not covered by their insurance. Title V shared with ISG participating agencies that strengths in referring clients to the SCHS CMU in their county of residence include potential assistance in developing a CICRF application, referral to charitable assistance and/or financial counseling if out-of-pocket expenses for care and treatment were more than they could afford.

Adequate authorization and payment for specialized infant and pediatric formula for CYSCHN with metabolic disorders was addressed with the DHS, Office of MMC. The DHS hosted a meeting with Title V and the DHS MMC HMO providers to explore challenges in access.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. County Case Management		X		
2. Subsidized Direct Specialty and Subspecialty Services	X	X		
3. Collaborate with the Catastrophic Illness in Children Relief Fund			X	
4. Collaborate with NJ Department of Banking and Insurance		X		
5. Medical Assistance Advisory Council		X		
6. NJ Hospital Association Health Research & Educational Trust CHIPRA Coalition		X		
7. ARC of NJ		X		
8. SPAN ISG 1 and ISG 2		X		
9. Collaborate with NJ DCF			X	
10. Collaborate with NJ DHS, Medicaid			X	

b. Current Activities

The Title V State office and programs collaborate with SPAN, PCORE and other Community of Care Consortium (COC) members to promote access to adequate and comprehensive insurance coverage for CYSCHN including underserved minority and/or limited English proficiency through the Adequate Insurance Workgroup.

State staffs collaborated with the BDARS, Rutgers University and the SCHS CMUs on implementation of the CDC Case Management and Reporting System (CMRS). State staffs conducted statewide training of the SCHS CMUs to facilitate implementation of electronic reporting and receipt of BDRs. 100% of the SCHS CMUs are live. This exciting innovation is anticipated to provide electronic access to BDARS data as well as information included on the CYSCHN's individualized service plan, including insurance status and other health and social service needs. Technical assistance is ongoing to facilitate policy development, problem solve and plan for system modifications.

State staffs collaborated with Medicaid and the SCHS CMUs to facilitate mandatory MMC enrollment for all current Medicaid clients. In addition they provide technical assistance and guidance to grantees and families, as well as, participate at MAAC meetings.

c. Plan for the Coming Year

State staffs will continue to collaborate with the BDARS, Rutgers University and the SCHS CMUs on implementing and refining the Centers for Disease Control (CDC), Case Management Reporting System (CMRS).

It is anticipated that there will be additional reorganization of DHS services as proposed in the Medicaid Comprehensive Waiver. Components of the DHS' Division of Disability Services addressing children and youth is expected to be reorganized into the DCF. Likewise, some programmatic reorganization within both the DHS and the DCF are anticipated. As a follow-up to previous meetings, Title V will revisit the proposed reorganization of those Departments services to dialogue about access to services and supports for CYSHCN warranting medical, developmental and behavioral services; access to care and adequate payment.

Title V will continue to collaborate with intergovernmental and community-based partners described above to promote awareness about changes in NJ's public and private health insurance landscape through trainings and participation on the ISG 1 and ISG 2 projects.

SCHS CMU and SPSP providers will continue to screen CYSHCN for insurance status, refer clients to the Department of Banking and Insurance, Boards of Social Services, and NJ FamilyCare Outreach programs, as needed to facilitate access to comprehensive coverage. Likewise, they will continue to document and track CYSHCN's insurance status. State staffs will continue to monitor grantees' insurance status data and provide technical assistance and guidance to providers and consumers in their efforts to assist families to navigate access to care.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	80	88	90	90	91
Annual Indicator	88	88	88	88	62.3
Numerator					
Denominator					
Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	63	63	63	70	70

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001

CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

a. Last Year's Accomplishments

Title V maintained an organized system of Special Child Health and Early Intervention Services (SCHEIS) to ensure the early identification and reporting to BDARS of CYSHCN, follow-up, linkage to care and family support. The system of early identification through newborn screening, reporting to the BDARS, follow up by the SCHS CMU's, support from Family Resource Specialists and referral to the Specialized Pediatric Services providers, other community-based programs and services enabled a structure to identify CYSHCN and link them with care. SCHEIS collaborated with the County Boards of Chosen Freeholders to maintain the network of 21 county-based SCHS CMU's and linked over 12,000 CYSHCN with community-based services. In collaboration with SPAN, 20 SRS were housed in and/or linked with SCHS CMU's to enable SRS to reach out to families to provide family support.

Likewise, SCHEIS partnered with community-based hospitals to maintain regionalized Specialized Pediatric Services including Child Evaluation Centers, Cleft Lip/Palate Centers (CEC), Tertiary Care Centers and the Ryan White Family Centered HIV Care Network to ensure access to care, afford collaboration on developing support systems with families and linkage to community-based resources. These systems of care are deliberately organized to provide opportunities for consultation with and cross referral on needs for CYSHCN's and their families and specialty providers. Co-locating some of the SCHS CMUs with specialty providers continued to facilitate access.

A letter of agreement with the Catastrophic Illness in Children Relief Fund enabled cross referral between our systems to screen families with CYSHCN experiencing medical debt related to their child's care and linkage with SCHS CMU's and family support. Collaboration with State, federal and local partners enabled coordination across systems and access to related medical, developmental, educational, rehabilitative and social, emotional and economic supports. Examples of collaborative partners includes the DHS Medicaid, waiver and NJ FamilyCare and Division of Developmental Disabilities programs (DDD); Department of Education Office of Special Education; DCF's Children's Behavioral Health Services and Family Support; Department of Labor's Disability Determinations and Vocational Rehabilitation; SPAN's ISG Consortium of Care (COC) and Family WRAP; Arc of NJ and other disability specific organizations; and charities.

The SCHEIS State office and community-based providers, SPAN's ISG 1 and 2 and Family WRAP activities, NJ PCORE's medical home initiatives and families provided input on the accessibility of community-based services for CYSHCN and their families. The NJ PCORE Monmouth county medical home project initiated two years ago with one-time Title V support was

partially supported by ISG funding. This financial support extended medical home projects into southern, central and northern NJ. A key construct of the project has been the participation of practice based Parent Partners as a mechanism to support parents of CYSHCN, measure and incorporate their input into the practice model, thereby enriching the "medical homeness" of service delivery. The ISG partners in each region including SCHS CMUs, specialty providers and disability specific organizations contributed to community mapping of county, regional, State and national healthcare resources. These resources were provided to practice-based care coordinators, Parent Partners and providers to more readily identify service systems to support CYSHCN in their communities. In addition, each of the ISG participating practices recruited Parent Partners and SPAN provided telephonic support and face to face trainings for those families. Topics such as care plans for a CYSCHN, community road maps and individual health plans were discussed at a one day Parent Partner training, followed by an onsite orientation visit. Resources provided by ISG Core Team members were also supplied to the practice and Parent Partners.

Enhanced capacity through SPAN's ISG 1 and 2, and Parent Training Institute grants partially supported the SPAN Family WRAP initiative. Five additional SPAN Resource Specialists had been trained and are being housed at SCHS CMUs; Cape May, Cumberland, Burlington, Salem and Gloucester. This collaborative initiative brings the total number of SCHS CMUs with either onsite part-time family support or SPAN designated parent support to 17 counties.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide Parents Advocacy Network			X	
2. Parent-to-Parent Network			X	
3. Family Voices parent group			X	
4. PCORE			X	
5. SCHS CMUs			X	
6. Child Evaluation Centers				X
7. Autism Clinical Enhancement Centers				X
8. SPAN ISG 1 and ISG 2			X	
9. CDC Surveillance project			X	
10.				

b. Current Activities

Subsequent to NJ's Comprehensive Waiver application, Title V has engaged in enhanced collaboration with the DHS Office of Medicaid Managed Care, Office of Home and Community Based Services, Medicaid managed care organizations, DHSS' Global Options staff, NJ's MAAC and other State, local and advocacy organizations and providers. This collaboration has presented opportunities to train and/or retrain those entities on the role of Title V and facilitate case finding.

The State SCHEIS program networks with partners in the disability community to outreach to underserved populations. Title V State staff presented an overview of SCHEIS services at the Bogg's Centers program; Arab American Communities and Disabilities Conference: Getting to Know You, Getting to Know Us.

Continued participation in ISG 1 & ISG 2 medical home initiatives affords opportunities for parent champions at participating medical practices to outreach to parents whose children are receiving medical care through a pediatric/family practice and link them with additional family support and/or education services.

The State SCHEIS staffs and SCHS CMU's, SPAN Resource Specialists and SPS providers conduct outreach efforts to assist families of CYSHCN to identify community-based services and supports by partnering with State and community-based agencies.

c. Plan for the Coming Year

State SCHEIS staffs and SCHS CMUs and SPS agencies will continue to engage in the ISG initiative with SPAN and PCORE. This collaboration will maintain the availability of SPAN Resource Specialists in each county, serving as a cross referral and family support. Likewise, the ISG affords opportunities for providers and Parent Partners to link families of CYSHCN with county and State Title V supports. The northwest region of NJ is targeted for the next ISG medical home intervention.

Continued collaboration between SPAN, SCHEIS and other community-based partners will continue to enhance the provision of accessible family-centered care. SPAN Resource Parents will provide technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues through Project Care. SCHEIS will continue to collaborate and partially support a Family Voices chapter. Likewise, SCHEIS will continue to provide intra/intergovernmental and community-based technical assistance to facilitate access to care for CYSHCN.

Following the Beta testing of the BDARS CDC Surveillance project implementing electronic referral of registrations to the SCHS CMUs in July 2011, all 21 county based SCHS CMUs are now receiving and submitting BDARS with the State office. Training on the BDARS and the CMRS system was provided by State staffs in multiple formats; live on-site, off-site and remotely. State SCHS and SCHS CMU staffs are collaborating on implementation of the system; debugging, policy and procedure development, technical assistance. Lessons learned from the SCHS CMUs and State staffs are shared among the CMUs by the State office regularly through a Helpful Tips worksheet. As records become populated within the system, State and CMU coordinators will become more proficient in using the system and the database is anticipated to provide information such as trends in community access to care and supports.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	12	40	41	40	42
Annual Indicator	37.9	37.9	37.9	37.9	41.8
Numerator					
Denominator					
Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	42	42	42	45	45

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

a. Last Year's Accomplishments

Although the majority of CYSNCN served across the FCCS provider agencies were under aged 14, youth (14-21 years of age) comprised 10-14% of the population services. The coordination of access to transition supports and planning for those clients was initiated on or about age 14. In collaboration with SPAN, SCHS CMUs, parents of CYSHCN and other community-based partners, transition to adulthood packets provided by SCHS CMUs to transitioning youth and their families were updated. The packets included current resources such as local vocational rehabilitation and DHS Division of Developmental Disabilities contacts, guardianship, individual health plan development, Section 504 planning and Americans with Disabilities Act, Social Security and basic rights in transition. As the SCHS CMUs contact active clients approximately 14 years of age for monitoring and/or individualized service plan updates, families are encouraged to develop a goal for their CYSHCN to work toward transition to adulthood. Community-based resources are provided, including information on available transition to adulthood workshops through SPAN, local school districts, Department of Labor Division of Vocational Rehabilitation, as well as the transition to adulthood resource packet. These resources are revisited at subsequent monitoring.

Through the ISG activities, over 20 youth with a diverse range of SHCN from 11 counties have been recruited to serve on a Statewide Youth Advisory Council (SYAC). The SYAC is working to develop strategies to (a) provide YSHCN with the skills and opportunity to participate in decisions affecting their own transition to adulthood, (b) strengthen the voice of YSHCN in planning, implementation, and evaluation of integrated, community-based systems of care, and (c) build capacity of parent and professionals to work with YSHCN to facilitate effective transitions. Examples of these two activities included participation in webinars, teleconferences and meetings to learn about transition resources and to share their experiences.

In addition, through Family WRAP with SPAN, numerous transition teleconferences were conducted and archived onto SPAN's website, accessible 7 days/week, 24 hours/day for youth, parents and providers as well as downloadable resources. Span Resource Specialists (parents of CYSHCN trained through Family WRAP to support other parents) in collaboration with the SCHS CMUs provided presentations at family support group meetings.

The Specialized Pediatric Services (SPS) providers conducted evaluations and developed service plans with adolescent CYSCHN and their families. In addition, SPS providers reported providing youth with transition to adulthood resources regarding genetics, family medicine and other medical related needs.

Transition to adulthood services and supports training was provided by the DHS, Division of Developmental Disabilities (DDD) staffs to the SCHS CMUs. Program updates were provided, resources were shared and questions were clarified. In addition, DDD staffs explained their role in transition planning for youth with DD and the DDD Priority Waiting List, eligibility for the Community Care Waiver, options for self-direction through the Real Life Choices program, and guardianship.

Collaboration with SPAN's ISG 1 and 2 continued with planning and implementation transition to adulthood activities with the SYAC and with pediatric providers through medical home activities. Strategies were explored to support medical home Parent Partners in educating and supporting parents of CYSHCN and practice providers to facilitate transition to adulthood. Resources to support families and youth through the transition process were provided to the practices.

State Title V staffs continue to collaborate with the SSA and NJ Department of Labor Disability Determinations Unit staffs to ensure communication to community-based providers and SCHS Case Management Units are informed of changes in SSA eligibility, services and supports. During the Fall, 2011, Title V State staffs and SCHS CM staffs participated in training conducted by the Bar Association on federal health care reform, and anticipated changes to Medicaid and Medicare for persons with disabilities. The spring quarterly SCHS CMU meeting will focus on the SSI eligibility criteria, assisting a client with how to submit an application and follow-up. State DOL Disabilities Determinations and SSA colleagues will present at the statewide meeting.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition to adulthood needs assessment		X		
2. Transition planning for CYSHCN in SCHS Case Management		X		
3. SPAN/ISG 1		X		
4. ARC of NJ		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through the SCHS CMUs statewide is ongoing. Transition packets as noted above are shared with families and linkage with community-based supports is provided. State staffs monitor the SCHS CMU's efforts to inreach and outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' individualized service plans.

The ISG 1 and 2 transition to adulthood activities include dissemination of transition to adulthood materials to medical practices, youth and families of CYSCHN, including transition in archived teleconferences and engaging the Youth Advisory Council (YAC) in review and dissemination of materials. Community-based partners continue to identify a resources and linkages are being made through SPAN's transition to adulthood project and community-based organizations that support CYSCHN.

Collaboration with community partners remain an essential strategy in supporting CYSCHN to prepare and experience transition. Some examples of supports being provided to CYSCHN include home visits to assist with applications to DDD services and SSI applications; telephone family support to assist with linkage to guardianship; resources; and collaboration between the CYSCHN, parents, SCHS CM and SPAN Resource Specialist to problem solve family concerns prior to a high school EIP meeting to prioritize wants and needs for the youth's career planning.

c. Plan for the Coming Year

Identification and monitoring of transition to adulthood needs for CYSCHN and their families served through the SCHS CMUs statewide is ongoing. Transition packets as noted above will continue to be shared with families and linkage with community-based supports is provided. State staffs will monitor the SCHS CMUs efforts to inreach and outreach to CYSCHN regarding transition, and documentation of goals related to transition on adolescents' individualized service plans.

The SCHS CMUs will continue to facilitate transition to adulthood with youth by ensuring a transition to adulthood goal on the individual service plan. Likewise, exploring youth and their parents' needs to facilitate transition; insurance, education, employment, housing, and linking them to community-based partners.

SCHS CMUs and pediatric specialty providers will refer youth and/or their parents to NJ CDD for participation in Partners in Policymaking self advocacy training as well as continue to assist youth and their families to advocate for transitional supports through their individualized education plans and community-based supports.

The SPAN ISG 1 initiative is planning to move forward in development of a Youth Advisory Council (YAC). The YAC is intended to provide a forum for empowering approximately 15 youth to develop leadership and self/group advocacy skills. It is anticipated that the YAC will link with other YSHCN that are currently informally meeting and participating in self advocacy, to develop a statewide resource and a voice for YSHCN in access to health care, social supports, employment, housing and other needs to establish successful transition to adulthood.

Through ISG 1 & ISG 2, Consortium of Care partners look forward to continued participation of YAC members in conducting school and community based outreach and workshops to support other youth in developing transition to adulthood plans.

Under health care reform, Medicaid will expand in 2014 to cover additional beneficiaries. As this population is intended to include a significant percentage of childless adults with incomes below 133 percent of FPL it is anticipated that CYSCHN transitioning to adulthood will have expanded opportunity to access health coverage through Medicaid, the insurance exchange, and coverage through their parents' insurance through age 26 (or in certain circumstance till age 31) and/or . In addition, it is also possible that some youth/young adults with special needs on Medicaid may experience a shift in eligibility to an insurance exchange. Title V will continue to participate in the discussion of NJ Medicaid, Department of Banking and Insurance regarding insurance benefits to support CYSCHN's transition to adult health care and related services.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	83	83	84	74	74
Annual Indicator	82.3	72.8	70.2	66.2	67
Numerator					
Denominator					
Data Source		NIS, CDC	NIS, CDC	NIS, CDC	NIS, CDC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	68	69	70	71	72

Notes - 2011

Data is from the National Immunization Survey Q1/2010-Q4/2010 at the CDC, The data is reported as 67.0% ± 6.7% for 4:3:1 plus full series of Hib vaccine, 3 or more doses of HepB vaccine, and 1 or more doses of varicella vaccine. http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2010.htm

No numerators or denominators are available.

Notes - 2010

Data from the National Immunization Survey, Q3/2009-Q2/2010. 4:3:1:3:3:PS rate = 66.2 % (+ 6.8%).

http://www.cdc.gov/vaccines/stats-surv/nis/tables/Q3/2009-Q2/2010/tab29_43133_race_iap.xls
US rate = 75.5 % (+ 1.2%)

Notes - 2009

Data from the National Immunization Survey, Q1/2009-Q4/2009. 4:3:1:3:3 rate = 70.2 % (+ 6.4%).

http://www.cdc.gov/vaccines/stats-surv/nis/tables/Q1/2009-Q4/2009/tab29_43133_race_iap.xls
US rate = 75.7 % (+ 1.2%) for 4:3:1:3:3:1:S

a. Last Year's Accomplishments

Vaccines help prevent infectious diseases and save lives. Vaccines prevent disease in the children who receive them and protect those who come into contact with unvaccinated individuals. Vaccines are responsible for the control of many infectious diseases that were once common in this country, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, and Haemophilus influenzae type b (Hib).

New Jersey had achieved an 82.3% age appropriate immunization rate in 2007, according to the CDC National Immunization Program. To address age appropriate immunizations (National Performance Measure #7), the Vaccine Preventable Disease Program in the Division of Communicable Diseases continues to support immunization at clinics in local health departments,

Federally Qualified Health Centers (FQHCs), and private provider offices and other pediatric clinics. The State's Vaccines For Children Program became available to private practitioners and public health facilities for the first time in 1999. The Division of Family Health Services (FHS) continues to work collaboratively with the Immunization Program to promote age appropriate immunizations.

The NJ Immunization Information System (NJIIS) is the statewide immunization information system serving as the official repository of immunizations administered to children in New Jersey. The NJIIS has been operating since 1997 and is in use at more than 600 sites throughout New Jersey, with more than 6,563 active users with more than 2,790,116 patient records currently in the system. Most children are enrolled in the system through the electronic birth certificate record process. Each year approximately 88,459 more newborns are enrolled into the system.

The New Jersey Department of Health and Senior Services began the "rolling-out" of a re-designed, web based, statewide universal childhood Immunization Registry on May 2, 2003, through a series of introductory efforts sponsored by the regional Maternal Child Health Consortia.

The NJIIS is a confidential, population-based, computerized information system that allows NJDHSS to collect and consolidate vaccination data about children within a geographic area and cumulatively statewide. Registries are an important tool to increase and sustain high vaccination coverage by consolidating vaccination records of children from multiple providers, generating reminder and recall vaccination notices for each child, and providing vaccination history documents, and performing vaccination coverage assessments. Electronic interfaces with practice management and electronic health record systems have increased to over 600.

The NJIIS allows providers to obtain a complete and accurate immunization history for a new or continuing patient, produce immunization records, reduce paperwork, manage vaccine inventories, introduce new vaccines or changes in the vaccine schedule, interpret the complex immunization schedule, and provide immunization coverage data for physician offices, health plans, and other organizations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Immunization Program in Communicable Disease				X
2. NJIIS web-based registry			X	
3. NJ Vaccines for Children Program			X	
4. Local health department child health conferences		X		
5. Universal Child Health Record for all children in child care			X	
6. Legislated immunization requirement for school attendance		X		
7.				
8.				
9.				
10.				

b. Current Activities

All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate. In 2004, the Statewide Immunization Registry Act was signed into law requiring all providers who administer immunizations to children under 7 years of age to input the data into the NJIIS within 30 days of administration. The full implementation of the law and the corresponding rules become effective December 31, 2011. Interfaces with private insurance carriers, Medicaid HMO's, hospitals and public health clinics and physicians billing companies are

populating the registry with vaccination data. Their input has assisted in increasing the number of administered shots in NJ to 28,484,866. Registry interfaces with the programmatic requirements of WIC, Medicaid, Surveillance and the Vaccine Preventable Disease Program continue to enhance the registry's effectiveness as a viable medical tool.

NJDHSS revised the administrative rules (N.J.A.C. 8:57-4) with substantive changes to include the requirement of four new vaccines (Diphtheria and tetanus toxoids and pertussis vaccine, Pneumococcal conjugate vaccine, Influenza vaccine, and Meningococcal vaccine) for school, preschool and licensed child-care center attendance beginning in September 2008. A summary of the changes is available at http://www.state.nj.us/health/cd/documents/vaccine_qa.pdf.

c. Plan for the Coming Year

FHS continues to work collaboratively with the Vaccine Preventable Disease Program to promote age appropriate immunizations. All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate to permit tracking of population-based immunization rates and to promote the completion of immunization schedules through compilation of all immunization data relevant to the specific patient. Over 600 interfaces have been developed that expand the reach of the NJIIS statewide and increase the number of vaccine doses recorded in the system to 28,484,866. Interfaces with private insurance carriers, medical technology vendors and physician offices, as well as hospitals, local health departments and clinics contribute to populating the registry. Advance NJIIS Search Patient functionality, continued implementation of new interfaces with electronic medical record systems and the development of multistate data exchange documents to expand data sharing are a few of the many enhancements underway in the NJIS. All are designed to improve the patient flow of immunization information to providers for the sustaining of continuity of patient care and to increase immunization coverage rates statewide.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	12.3	12.2	12	9.8	9.8
Annual Indicator	12.4	11.9	10.7	9.6	9.6
Numerator	2233	2131	1916	1721	1721
Denominator	180103	179548	179548	179548	179548
Data Source		BC	BC	BC	BC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	9.5	9.5	9.4	9.4	9.3

Notes - 2011

Source: Provisional Electronic Birth Certificate 2010 file as of 6/23/2012, use as provisional estimate for 2011 data.
Denominator from <http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/NJ09single.xls>
Final 2011 data will be available in Fall 2014.

Notes - 2010

Source: Provisional Electronic Birth Certificate 2010 file as of 6/23/2012, use as provisional 2010 data.
Denominator from <http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/NJ09single.xls>
Final 2010 data will be available in Fall 2013.

a. Last Year's Accomplishments

The gradual decline in births to adolescents appears to be leveling in New Jersey. According to Guttmacher, although the number of live births to adolescents has declined in recent years, 20% of adolescents who give birth go on to have another child during adolescence. The majority of teen births are unplanned. A major barrier to improvement is that there are fewer healthcare providers of any type in the rural counties and public transportation is virtually nonexistent.

Eleven family planning agencies with 49 clinical sites provided comprehensive reproductive health services to more than 35,000 adolescents to assist the Title V program in meeting National Performance Measure # 8, reduction of births to teens 15 - 17 years of age. Clinical services include physical assessment, laboratory testing and individual education and counseling for all FDA approved contraceptive methods.

Family planning agencies also provided community education and outreach to the adolescent population. Aimed at schools and community groups, educational activities that deal with decision-making, value clarification and establishing linkages with youth-serving agencies were encouraged. Educational efforts are directed toward primary pregnancy prevention activities that encouraging family communication, promoting self-esteem, postponing sexual activity and promoting effective contraception. All family planning agencies have implemented an enhanced service package, which for Medicaid beneficiaries is a reimbursable service. The program integrates assessment of adolescent risk behavior within routine family planning services. Through direct individual preventive education or through referral, the program promotes behaviors of healthy lifestyle, injury prevention, drug, alcohol and tobacco prevention, as well as sexually transmitted disease (STD) and pregnancy prevention.

MCH resources also continue to support a Young Fathers Program in Newark. The Program provides counseling services to young men between the ages of 15-23 years to enhance their social and emotional functioning, increase their financial independence, and promote responsible behavior.

The Region II Male Involvement Committee (Region II MAC) serves as a forum for the exchange of information and discussion of issues related to males and male services in Title X Family Planning, funded programs in Region II. After much review, this committee decided that male reproductive health providers needed some guidance in defining the scope of reproductive health services needed for males and to set standards for these services. A newly developed document "Guidelines for Male Sexual and Reproductive Health Services" is intended to be a resource used in the development of clinical services for male clients. Each item includes a statement of the "best practice" followed by a statement of evidence or rationale that supports the best practice and finishes with suggestions for methods to implement the recommendation. The committee recommends that the guide be used as a tool by an agency to develop an organizing structure, outlining male services to be included in their program. This document has been distributed to all Title X Family Planning funded programs and other agencies that have the knowledge and interest in issues related to male family planning services. A staff member of the Family Planning Program in Reproductive & Perinatal Health Services is a member of the Region II MAC.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Agencies providing comprehensive reproductive services.	X		X	
2. Collaborate with Dept. of Human Services Adolescent Pregnancy Prevention Program.				X
3. PREP and AEP Grants			X	X
4. Community Partnership for Healthy Adolescents Grants				X
5. Adolescent Health Institute				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Title X, NJ Family Planning agencies with 24 clinical sites continue to provide comprehensive reproductive health services to adolescents free of charge or at a nominal fee. They assure on-going high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families.

In addressing the Teen Birth Rate, collaboration with the DHS, the DOE, the Department of Labor and the Juvenile Justice Commission relative to teen pregnancy prevention activities continues to focus on the promotion and development of statewide County Collaborative Coalitions. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities for Teen Pregnancy Prevention Month (May).

Presently, this interdepartmental workgroup is drafting a long-range strategic plan, which supports the goals and objectives of sustained adolescent pregnancy prevention services and strategies. Also, intradepartmental planning is underway for the 8th Annual Day of Learning, which has recently broadened in scope to include peer leadership training on teen pregnancy and HIV/STD prevention. This program is now referred to as the Teen Prevention and Education Program, and a "Day of Learning" has been held annually in May to highlight pregnancy prevention month.

c. Plan for the Coming Year

Family Planning agencies will continue to provide comprehensive reproductive health services to clients each year to assist the Title V program to meet the National Performance Measure #8, reduction of birth to teens 15 - 17 years of age.

The Family Planning Program hosts an annual Adolescent Health Institute to bring together adolescent stakeholders from throughout NJ to foster networking and collaboration and to provide an opportunity to focus on new information and resources as they pertain to the many issues facing adolescents. The 13th Annual Adolescent Health Institute will be held on November 16th.

The Jewish Renaissance Foundation, in collaboration with the Central NJ Maternal Child and Health Consortium will continue "Comenzando Bien" a culturally appropriate, bilingual prenatal education curriculum created by the March of Dimes, at Perth Amboy High School. It was the belief of the Partnership that this initiative would provide important information and referral

services to teen moms with the expectation of preventing subsequent births.

The Perth Amboy Plain Talk (PAPT) program will continue a collaboration with Planned Parenthood of Central New Jersey (PPCNJ) to provide comprehensive sex education in freshman health classes as well as having PPCNJ meet with the "Walkers and Talkers" to discuss any issues they may have and provide ongoing training on any topics they may feel they need to strengthen.

PAPT has also partnered with the nationally based organization, Advocates for Youth, to create a Youth Activist Network (YAN). YAN informs teens about resources and increases their knowledge and skills around sexual health information including safer sex, STI/HIV prevention, teen pregnancy, and access to contraception. YAN relates this information to their peers through "Pizza Protection Parties". YAN is also launching a Condom Availability Campaign to increase access to condoms for young people at nontraditional places, and a Text Messaging/New Media Campaign to educate peers on sexual health information and where they can access services in Perth Amboy.

The CAHS Program successfully applied for two new federal grants to prevent teen pregnancy. The NJ Abstinence Education Program (NJ-AEP) funds will provide services to youth populations that are at high-risk for teen pregnancy, STDs/STIs, teen births. The purpose of NJ-AEP will be to promote abstinence from sexual activity and, where appropriate, provide options that may include mentoring, counseling and/or adult supervision. The NJ Personal Responsibility Education Program (NJ PREP) will enable New Jersey to replicate evidence-based programs that have proven effectiveness in changing behaviors to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	45	45	46	46	47
Annual Indicator	42	46	46.5	46.4	46.4
Numerator			1197	1664	1664
Denominator			2575	3588	3588
Data Source		Dental Sealant Survey	Dental Sealant Survey	Dental Sealant Survey	Dental Sealant Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	48	48	49	49	50

Notes - 2011

The 2010-2011 oral health survey of third grade children in a sample of elementary schools found that 46.4% of students had a dental sealant on a permanent molar back tooth.

Notes - 2010

The 2010-2011 oral health survey of third grade children in a sample of elementary schools found that 46.4% of students had a dental sealant on a permanent molar back tooth.

Notes - 2009

The 2008-2009 oral health survey of third grade children in a sample of elementary schools found that 46.5% of students had a dental sealant on a permanent molar back tooth.

a. Last Year's Accomplishments

The Children's Oral Health Program (COHP) addresses the beginning of the life cycle and oral health through education for women during pregnancy, emphasizing the importance of dental visits, good oral hygiene practices and oral health issues relevant to pregnant women. For children and adolescents COHP's oral health curriculum supports learning that builds upon prior knowledge emphasizing tooth brushing with a fluoridated toothpaste, regular dental visits, smoking cessation and healthy food choices. In the area of children's oral health, support continues for statewide regional programs that implement a variety of age appropriate oral health education activities for school age children throughout the 21 counties of the state.

COHP promotes the use of dental sealants in a variety of ways. Dental sealants, which are plastic coatings applied to the chewing surfaces of teeth to prevent dental caries are an evidence-based cost-effective preventive measure. Registered Dental Hygienists encourage sealant application with various populations including school-aged children, school nurses, parents including WIC participants, and health professionals. The use of dental sealants is also promoted through the COHP website, the program's biennial school oral health survey, and program newsletters targeted to school nurses, children with special health care needs and their caretakers, and WIC clients. Additionally, the COHP conducted a mailing to all FQHCs in NJ with the goal of increasing the application of sealants among underserved populations and received positive feedback and request for additional information from FQHC dentists. During the 2011-2012 school year, the COHP also emphasized the importance of the use of dental sealants in special needs populations, through its "Special Smiles" school oral health education initiative.

COHP programs include tooth brushing and flossing, use of fluoride as a preventive measure and the school based fluoride mouth rinse program, "Save Our Smiles" which reached approximately 24,000 children in 126 schools during the 2009-2010 school year. The annual mailing of the school newsletter "Miles of Smiles" was mailed to over 3,500 school nurses. This annual publication addresses timely oral health topics of interest, promotes the importance of good oral hygiene practices. Oral health education targeted to school faculty is also included so the school nurse may promote good oral health throughout the school setting.

Dr. Kupiec-Sce of the COHP was also invited to participate in and prepare a "Best Practices Collection" of all initiatives undertaken by the Program. NJ was one of a very few select states invited to participate by the Association of State and Territorial Dental Directors in 2009 and will prepare a revised collection in 2011.

Regional program staffs promote the use of mouth guards for protection from oral injury in school and community-based education programs. In addition, the "Dental Emergency Guide" poster was developed and distributed to all school nurses, high school athletic directors and summer camp directors throughout the State to assist staff in the treatment of minor dental emergencies and oral trauma.

The Dental Advisory Council, established in 2005 by the Division of Medical Assistance and Health Services (DMAHS), meets 3 times a year, but is also convened for special projects. The Council works to bolster communication with the dental community and has representation from

the NJFC HMOs, UMDNJ -- Dental School, FQHCs, NJ State Board of Dentistry, NJ Dental Association, the dental specialties and dentists from private offices. The Council's activities may include study of priorities, standard of care, quality measures, barriers to care and access strategies, utilization strategies, program benefits and cost of care. The council prepares specific recommendations to DMAHS and interprets goals and policies for professional and community interest groups.

The Medical/Dental Directors Meetings occur 2 to 3 times a year and are a forum to allow DMAHS to communicate directly with the medical and dental directors for the NJFC-MCOs on interpretations, expectations or revisions to policies as set forth in NJ Administrative Code (N.J.A.C.) or the HMO Contract.

Insure Kids Now Website -- Information on the dental benefits available to children enrolled with NJFC/Medicaid is posted on this site along with the names and contact information for dentists.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Federally Qualified Health Center (FQHC) Expansion	X			X
2. Physician/Dentist Loan Redemption Program				X
3. Regional Oral Health Promotion Programs			X	X
4. Give Kids a Smile Day			X	X
5. "Save Our Smiles"," school based voluntary Fluoride Mouthrinse Program			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Recognizing that early prevention is necessary for optimal oral health and that pregnancy is an ideal time to educate women about good oral health practices for themselves and their children, the "Pregnancy and Oral Health Initiative" which evolved into Project" REACH has been established.

Dental initiatives undertaken by DHS website under the DMAHS to promote utilization of dental services include:

Oral Health Stuffer -- "Keeping Your Child's Smile Healthy" was updated in 2012 to indicate age referral to dentist should occur by the age of 1. Language was revised to provide information in layman terms while educating the consumer on dental terms. Stuffer is provided in mailings to those in Fee For Service, was provided to HMOs for distribution to their members and to WIC for distribution to their clients. It is posted on the DHS website and on the websites for AAP and Center for Health Care Strategies.

Age for First Dental Visit -- Contract change for NJFC MCOs effective July 1, 2010 indicates that first dental visit can be provided as early as the eruption of the first tooth and is required by age one. Preventive Services by Non-Dental Health Care Providers -- Contract change for NJFC MCOs effective January 1, 2012 allows a trained medical professional to provide risk assessment, fluoride varnish and direct referral to the dentist for young children through the age of five.

c. Plan for the Coming Year

During the school year 2011-2012, the "Sugarless Day to Prevent Tooth Decay" initiative will be expanded to include the 21 counties of the State. The NJ Homeless Shelter Collaboration Project between the COHP and the NJ Dental Hygiene Association will continue and target 5 shelters by providing oral health education and hygiene instruction to children along with oral care resources and personal care items provided by the NJ Dental Hygienists Association. The Pregnancy and Oral Health Initiative Collaboration Project between the COHP and a FQHC that has evolved into Project: REACH will be expanded to other FQHCs utilizing the train the trainer model to educate obstetricians and staff about the importance of oral health for pregnant women. The Service Learning Project between the COHP and Burlington County College School of Dental Hygiene will again take place. Education efforts conducted through county wide library systems in the central region of the State will be part of "Tooth Tales," an interactive reading program targeting pre-K to grade 3 children and families and educating them about good oral health.

The Periodicity of Dental Services for Children in the NJFC Programs titled "When Children in NJ Family/Care Should See the Dentist" was revised in 2012 to be consumer friendly. It was updated to indicate referral to a dentist is required by age one, that a trained medical professional could also provide fluoride varnish and emphasized that needed dental treatment should be provided to primary or "baby" and permanent teeth. This information is posted on the DHS website and on the websites for AAP and Center for Health Care Strategies.

DMAHS has partnered with the AAP on an initiative (AAP Oral Health Initiative) to identify and establish strategies to educate medical providers on the importance of early intervention with an age one dental visit, oral health education, fluoride varnish, risk assessment and dental referral, to educate parents and communities on the importance of good oral health, healthy habits, the need for early and periodic dental visit and treatment and to identify and develop financial strategies to providers for use by payers of services.

Give Kids A Smile -- Each year DMAHS collaborates with the NJ Dental Association to provide volunteers that assist families with NJFC/Medicaid in locating a dentist and to provide enrollment information or location of clinics for those without dental insurance.

NJ Smiles Directory of Dentist Seeing Young Children -- this directory is a listing by county of dentists seeing young children. It includes their HMO or Fee for Service participation, if they are handicapped accessible and if they provide dental care to patients with special healthcare needs. It is updated annually and will be posted on the DHS website and is currently on the websites for AAP and Center for Health Care Strategies.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	1.5	1.3	1.2	1.6	1.4
Annual Indicator	1.7	1.7	0.8	0.8	0.8
Numerator	29	29	14	14	14
Denominator	1693095	1701841	1689425	1689425	1689425
Data Source		CDC	CDC	CDC	CDC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	0.8	0.8	0.8	0.7	0.7

Notes - 2011

Data source - CDC National Center for Injury Prevention and Control
<http://www.cdc.gov/ncipc/wisqars/>
 2009 data is the most recent data available as of 6/23/2012 and has been entered as provisional 2011 data.
 2011 Final data may be available in 10/2014.
 Rates based on 20 or fewer deaths may be unstable.

Notes - 2010

Data source - CDC National Center for Injury Prevention and Control
<http://www.cdc.gov/ncipc/wisqars/>
 2009 data is the most recent data available as of 6/23/2012 and has been entered as provisional 2010 data.
 2010 Final data may be available in 10/2013.
 Rates based on 20 or fewer deaths may be unstable.

Notes - 2009

Data source - CDC National Center for Injury Prevention and Control
<http://www.cdc.gov/ncipc/wisqars/>
 2009 Final data.
 Rates based on 20 or fewer deaths may be unstable.

a. Last Year's Accomplishments

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes has declined since 1997 both in New Jersey and in the United States.

In 2008 the NJDHSS Office of Injury Surveillance and Prevention (OISP) convened a panel of injury prevention experts to provide recommendations in key injury areas which included motor vehicle crashes and unintentional childhood injuries. Recommendations are included in the August 2008 report - Preventing Injury in New Jersey: Priorities for Action.

The main factors that contribute to motor vehicle occupant fatalities in NJ are speed, alcohol, and failure to use restraint options including infant seats, booster seats, and seatbelts. Proper use of occupant restraints plays an important role in reducing fatalities and serious injuries among children in the event of a crash. Seatbelt use in NJ is above the national average, and 2007 data from the NJ Division of Highway Traffic Safety estimated the usage rate at over 91%. A recent "Click it or Ticket" mobilization effort combining education and enforcement resulted in an increase in seat belt use among motorists.

Motor vehicle accidents remain the leading cause of death for teenagers. Teenage drivers are one of the top causes of car accidents. Kyleigh's Law took effect in May 2010 and required probationary drivers, ages 16 and 21, to affix a \$4 pair of red fluorescent decals on their front and rear license plates during a one-year provisional license period. The decals were intended to make it easier for police to identify first-time drivers on the road and ticket them if they violate the provision of the New Jersey's graduated licensing restrictions which prohibit teens from driving between 11 p.m. to 5 a.m., limit car occupants to one other underage passenger, and prohibit any use of "interactive wireless communication." Kyleigh's law was unanimously upheld by a three-

judge panel in February 2011.

The main goal of the NJ Safe Routes to School (SRTS) program is to assist communities in developing and implementing projects and programs that enable and encourage safe walking and bicycling trips to school. Since the program was initiated, NJDOT has awarded 104 grants worth \$13.5 million to local projects affecting 192 schools in 83 communities. These grants have funded both infrastructure projects, such as sidewalks, crosswalks and bike paths, as well as non-infrastructure projects, like education, enforcement and encouragement programs.

Law and Public Safety (LPS) funds numerous awareness and education projects on the county and municipal level throughout the State with the goal of decreasing crash experience, injury and death in this age group. Projects primarily focus on pedestrian, bicycle and child passenger safety. More information is available on the website: www.njsaferoads.com.

NJ Parent Link (www.njparentlink.nj.gov) is the State of New Jersey's web-based Early Childhood, Parenting and Professional Resource Center. In the section titled "Child and Family Safety", there are two links: Pedestrian and Bicycle Safety and Safety: Child Safety Seats & Seat Belts for more information. In the section "Community Resources" there is a link to Safe Kids New Jersey. Safe Kids New Jersey (SKNJ) is the lead organization on preventing motor vehicle deaths in New Jersey. SKNJ focuses on five areas of injuries for children from birth to 14 years old and offers a wide variety of programs to improve the health and well being of New Jersey youth.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Child Care Initiative safety focus NJ Safe Routes to School (SRTS) program			X	X
2. Childhood Lead Poisoning Prevention Project's safety focus				X
3. EMS "Anticipating the Unexpected..." training curriculum				X
4. Law and Public Safety awareness and education projects				X
5. Division of Highway Safety's NJ Traffic Safety curriculum				X
6. Safe Kids New Jersey, in school project				X
7.				
8.				
9.				
10.				

b. Current Activities

The Childhood Lead Poisoning Prevention Projects (CLPPP), provides lead-focused case management and instructs families in child safety, including the use of infant car seats and child restraint systems. This type of instruction contributes to the progress being made on unintentional injury prevention activities, even though it is not specifically focused on deaths due to motor vehicle crashes.

The Healthy Child Care New Jersey (HCCNJ) Initiative continues to emphasize safety at home and in the child care center, and has collaborated with the state's Emergency Medical Services (EMS) for Children program on the training curriculum "Anticipating the Unexpected: Planning for Emergencies in Child Care Setting" (formerly titled "Anticipating the Unexpected in Child Care Settings". The HCCNJ Initiative also partners with Safe Kids Programs whenever possible throughout the year. Safe Kids offers a wide variety of programs to improve the health and well being of New Jersey youth.

Motor vehicle accidents remain the leading cause of death for teenagers. Teenage drivers are one of the top causes of car accidents. Kyleigh's law was unanimously upheld by a three-judge panel in February 2011.

New Jersey's Emergency Medical Services (EMS) for Children program continues to provide training using the curriculum "Anticipating the Unexpected: Planning for Emergencies in Child Care Setting."

c. Plan for the Coming Year

The Healthy Child Care New Jersey Initiative State's Emergency Medical Services for Children program will continue to emphasize safety at home and in the child care center, and has collaborated with using the state's Emergency Medical Services for Children program to develop a training curriculum entitled " " Anticipating the Unexpected: Planning for Emergencies in Child Care Settings". This curriculum has is expected to be provided to child care providers in a variety of venues.

DOT has streamlined the funding process and is getting programs out to the communities who need them more quickly. Applications were due at the end of December 2011 for FY 2012 SRTS Infrastructure Grant program to build projects within two miles of an elementary school. Schools and municipalities with special needs were also able to apply for funds to pay for the design of these projects.

Non-infrastructure projects are being implemented through the NJ SRTS Resource Center, a pilot program at the Alan M. Voorhees Transportation Center at Rutgers University, and a partnership with New Jersey's eight Transportation Management Associations (TMAs): Cross County Connection, Greater Mercer TMA, Hudson TMA, Hunterdon Area Regional Transport, Keep Middlesex Moving, Meadowlink, Ridewise and TransOptions. TMA staff provide technical assistance directly to communities and all municipalities and K-8 schools are eligible to enroll as SRTS partners and receive free SRTS program related services. TMAs have assisted with International Walk to School Day in October 2011 and will take part in the first Walk and Bike to School Day on May 25th, 2012.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	42	46	38	53	45
Annual Indicator	37.3	42	42	42	42
Numerator					
Denominator					
Data Source		NIS, CDC.	NIS, CDC.	NIS, CDC.	NIS, CDC.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	42	43	43	44	44

Notes - 2011

2007 data (42.3% +/- 6.2%) entered for provisional 2011 data. US comparison 43.0% (+/- 1.3%)
 Source: National Immunization Survey, CDC.
http://www.cdc.gov/breastfeeding/data/NIS_data/2007/state_any.htm
 Final 2011 data may be available from the CDC in Fall 2014.

Notes - 2010

2007 data (42.3% +/- 6.2%) entered for provisional 2010 data. US comparison 43.0% (+/- 1.3%)
 Source: National Immunization Survey, CDC.
http://www.cdc.gov/breastfeeding/data/NIS_data/2007/state_any.htm
 Final 2010 data may be available from the CDC in Fall 2013.

Notes - 2009

2007 data (42.3% +/- 6.2%) entered for provisional 2009 data. US comparison 43.0% (+/- 1.3%)
 Source: National Immunization Survey, CDC.
http://www.cdc.gov/breastfeeding/data/NIS_data/2007/state_any.htm
 Final 2009 data may be available from the CDC in Fall 2012.

a. Last Year's Accomplishments

Two hospitals have achieved Baby Friendly hospital status.

In Healthy New Jersey 2010, there are two objectives for breastfeeding: 1) to increase the proportion of mothers who breastfeed their babies at hospital discharge to at least 75.0 percent and 2) to increase the proportion of breastfed infants who are breastfed exclusively at hospital discharge to 90.0 percent. The national breastfeeding objectives are for 75% of mothers to breastfeed in the early postpartum period, for 50% of new mothers to continue breastfeeding until their infants are six months old, for 25% to breastfeed until one year, for 40% to exclusively breastfeed through three months, and for 17% to breastfeed exclusively through six months.

Despite the overwhelming evidence supporting the numerous benefits of and recommendations for exclusive breastfeeding, exclusive breastfeeding rates in the 24 hours prior to hospital discharge in New Jersey continued to decline in 2007 (See Chart 9 attached to Table of Contents), while any breastfeeding (both breastfeeding and formula feeding) rates continued to increase, yielding an overall increase in breastfeeding initiation rates. In 2007, exclusive breastfeeding at hospital discharge statewide was 35.7% while any breastfeeding (exclusive and combination feeding) was 70.5%.

Breastfeeding rates on discharge varied with the minority composition of mothers. Asian non-Hispanic women were most likely to breastfeed (85.7%) while Black non-Hispanic women were least likely to breastfeed (53.3%). White non-Hispanic and Hispanic women initiated breastfeeding at 69.9% and 75.2% respectively.

The exclusive rates were 47.5% for White non-Hispanic women, 36.1% for Asian non-Hispanic women, 22.8% for Hispanic women, and 21.0% for Black non-Hispanic women. Further examination of the disparity in these rates will require information of locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services.

Close collaboration between Maternal and Child Health Services (MCHS) and WIC Services (WIC) is ongoing. Both programs have an interest in breastfeeding protection, promotion and support and have similar constituencies. The CDC Guide to Breastfeeding Interventions was sent to all the delivery hospitals in the State.

In 2008, FHS prepared a report card, Breastfeeding and New Jersey Maternity Hospitals: A

Comparative Report (posted at NJ.gov/health/fhs/professional/breastfeeding_report.shtml), which is endorsed by the State chapter of the American Academy of Pediatrics (NJ-AAP) and the New Jersey Breastfeeding Task Force. The goal of the report is to present breastfeeding initiation as a quality of care issue, and to promote the included self-assessment tools and model hospital policy recommendations as tools for hospitals to improve their breastfeeding policies and practices.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Professional outreach and education through MCH Consortia				X
2. Surveillance from the Electronic Birth Certificate (EBC) and Breastfeeding and New Jersey Maternity Hospital Report			X	X
3. Supporting the development of breastfeeding friendly policies in child care settings				X
4. Surveillance of breastfeeding through the NJ PRAMS survey			X	X
5. Baby Friendly Hospital Initiative				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Many hospitals employ International Board Certified Lactation Consultants who provide early support and information to breastfeeding mothers. WIC Services funds breastfeeding promotion and support services for WIC participants through grants to eight local WIC agencies and three MCH Consortia, which provide services to ten local WIC agencies. WIC lactation consultants and breastfeeding peer counselors provide direct education and support services, literature, and breastfeeding aids, which include breast pumps, breast shells and other breastfeeding aids. WIC breastfeeding staff conducts professional outreach in their communities and education to healthcare providers who serve WIC participants.

c. Plan for the Coming Year

The report card, Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report, will be updated with 2011 data from New Jersey's delivery facilities. Greater emphasis will be placed on exclusive breastfeeding, both in WIC and at hospitals. There will be strong advocacy for hospitals to adopt the Perinatal Care core measure set, which includes a measure for exclusive breast milk feeding and for hospitals to implement evidence-based best practices for infant feeding. The United States Breastfeeding Committee publication, Implementing the Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding, will be recommended to the State's delivery facilities as a tool to help them implement the measure on exclusive breast milk feeding.

Strategies to promote breastfeeding will be addressed as part of the Shaping NJ Partnership to prevent childhood obesity. The ONF received a NPAO grant from the CDC to coordinate Nutrition, Physical Activity and Obesity strategies. One of the six target behaviors is to increase breastfeeding duration and exclusivity. A work group of the Shaping NJ Partnership is working on promoting exclusive breastfeeding through changing hospital policies and practices. ONF is promoting exclusive breastfeeding for new mothers in ten NJ maternity hospitals thru \$10,000 grants to support the Baby Friendly Hospital Initiative.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	99	99.2	99.6	99.7	99.8
Annual Indicator	99.2	99.6	99.7	99.8	99.8
Numerator	111027	108119	105847	102712	99037
Denominator	111876	108514	106185	102930	99228
Data Source		Newborn Hearing Screening Program			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	99.9	99.9	99.9	99.9	99.9

Notes - 2011

Provisional 2011 data from the Newborn Hearing Screening Program based on the provisional 2011 EBC which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Final 2011 data will be available in Fall 2013.

Notes - 2010

Provisional 2010 data from the Newborn Hearing Screening Program based on the provisional 2010 EBC which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Final 2010 data will be available in Fall 2012.

Notes - 2009

Source: Newborn Hearing Screening Program based on the EBC which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

a. Last Year's Accomplishments

In 2011, 99.8% of infants were screened prior to discharge. Rates for children receiving follow-up after referring on inpatient screening continue to rise, but remain an area requiring improvement.

The Early Hearing Detection and Intervention (EHDI) reporting module in the NJ Immunization Information System (NJiIS) is utilized by audiologists and other practitioners, who are conducting hearing follow-up, to report outpatient exams. NJ-EHDI receives approximately 86% of reports through this Web-based application and thirty-two new users were trained during 2011.

The program had an exhibit table at the 2011 annual meeting of the NJ-AAP which was attended by 300 physicians, and did site visits to two pediatrician offices to review EHDI requirements. EHDI staff also gave a presentation to members of the New Jersey Medical Home Resource Team for CYSHCN. The EHDI audiologist presented at a statewide conference for audiologists with 65 attendees.

The EHDI program held regional meetings for hospital EHDI staff in September and October 2011 at northern, central, and southern locations in the State, with each hospital sending at least one representative to one of the three meetings. The program partnered with other service units to include presentations on biochemical and pulse oximetry screening and autism and birth defects reporting. The meetings were held on September 19 with 44 attendees, September 23 with 70 attendees and October 19 with 139 attendees. Individual teleconferences with each hospital began on September 28, 2010 and were completed for 46 hospitals by December 21st, with 6 final hospital calls postponed into 2012.

The biennial Family Learning Conference for families with children who are deaf or hard of hearing was held on April 16, 2011 for 175 attendees. This conference affords parents of children with hearing loss the opportunity to meet deaf and hard of hearing adults, network with other parents, and most importantly, to hear from children themselves about growing up with a hearing loss. Since the Family Learning Conference is a family driven event, normally hearing siblings are also invited.

In April 2011, the NJ Pediatric Hearing Health Care Directory was updated and improved as a searchable on-line directory with the ability to map facility locations and obtain driving directions. This resource enables physicians and families to locate facilities in their area that have the required diagnostic services.

The EHDI program collaborated with staff from the Department of Children and Families (DCF), Division of Youth and Family Services (DYFS) granting NJiIS-EHDI module access to DCF staff nurses who are responsible for health care for children in foster care placement. In April 2011, 235 DYFS staff members attended one of 4 webinars that provided information about the EHDI module and new hires watch a recorded version of the webinar. This effort will help to ensure children in foster care receive appropriate hearing follow-up services since this population has been much more likely to be lost to follow-up.

The EHDI Program continued a project begun in October 2009, where HRSA funding allows case management staff to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up. While EHDI rules give hospitals the primary responsibility for ensuring children receive appropriate follow-up, the level of effort put into this by each hospital and the success of their efforts varies widely. This program provides supplemental contacts to compliment the hospital's outreach efforts. During 2011, the case managers contacted 1,117 families, contributing significantly to the improvement in follow-up rates.

The EHDI program began efforts to improve the documentation of newborn hearing screening for babies that are home deliveries. In 2010, only 23 of the 177 home deliveries in New Jersey had hearing screening reported to the EHDI program. The EHDI program met with midwives to develop an information sheet for midwives and parents that provides information on hearing screening and also other relevant DHSS requirements such as biochemical screening and how to obtain a birth certificate.

Two additional FQHCs purchased equipment to conduct re-screening to supplement the three

centers that began this service in 2010. The FQHCs will provide this service at no charge to the families, to reduce the fiscal barriers to lack of newborn hearing screening follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educational outreach to practitioners (audiologists, pediatricians, otolaryngologists, etc.).				X
2. Hospital level surveillance reports.			X	
3. Increase in follow up and reporting for those who are not screened while inpatient or refer on initial screening.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

To begin using telepractice to benefit children with hearing loss, the EHDI program funded one of the Early Intervention (EI) program's Regional Early Intervention Collaborative's (REIC) to hire 2 part-time consultants. They will use laptops with web-cameras to participate in initial early intervention family meetings via remote access. The consultants are currently developing resource materials and developing the referral process.

The program is planning a webinar for SCHS case managers, EI staff, audiologists and physicians on the impact of unilateral hearing loss. These children are less likely to be enrolled in EI services, possibly due to an erroneous assumption by providers that these children are not eligible for services or would not benefit from services.

Another webinar under development is an EHDI overview for hospital staff responsible for newborn hearing screening. Due to the frequent changes in staff in some hospitals, a recorded webinar will be available to explain the EHDI program's regulatory obligations to ensure and improve hospital compliance.

The EHDI program recently is working with staff from the Communicable Disease Service division to notify the EHDI program of children diagnosed with meningitis. The goal of this collaboration is to ensure that children with hearing loss caused by meningitis receive timely referral for audiology and otolaryngology services, since a delay in can impair the ability for the child to benefit from cochlear implantation.

c. Plan for the Coming Year

The EHDI program will continue to send hospital-level surveillance data to each hospital with maternity services. A report with their overall statistics is sent semi-annually, and in intervening quarters, hospital contacts receive a list of children that are still in need of follow-up after missed or referred inpatient hearing screening.

EHDI staff will provide educational presentations to pediatricians, audiologists, otolaryngologists, special child health service case managers, Early Intervention Service coordinators, and other health care professionals, focusing on the need to decrease rates of children lost to follow-up.

The EHDI program frequently uses Webinars, to make educational outreach efforts more accessible to the target audiences, to decrease staff travel time, and to improve efficiency while decreasing costs.

The parent support services provided through the REIC will continue to develop and expand through the coming year. As contacts with families are implemented the program will adjust the resources and scripts used for the contact and identify weaknesses in the EHDI process that are identified through individual conversations with families.

The program will participate in a National Initiative for Children's Healthcare Quality Learning Collaborative to identify small tests of change to improve hearing screening and follow-up.

The program will expand on efforts to improve screening of babies delivered at home by sending a letter to families of infants born at home, encouraging them to bring their child in for screening.

The EHDI program will begin sending follow-up letters to the primary care provider of infants that are in need of additional follow-up to prompt these providers to refer families for audiologic evaluation.

The EHDI program will be reviewing the interoperability of the EHDI information system and looking for opportunities to utilize Electronic Health Record data to decrease the need for duplicate data entry. As the Bureau of Vital Statistics and Registration begins to implement a new Electronic Birth Registration System, the EHDI program will work with the program to ensure the continued capture of inpatient hearing screening results and risk indicators through this system.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	10	12	11	11	12
Annual Indicator	13.0	14.1	9.1	9.1	9.1
Numerator	288300	288300	199300	199300	199300
Denominator	2217692	2044000	2191600	2191600	2191600
Data Source		CPS	CPS	CPS	CPS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	9	9	9	8.8	8.6

Notes - 2011

2009-2010 data entered as provisional estimate of 2011 data.

Source: two-year (2009-2010) health coverage estimate based on the Annual Social and Economic Supplement (ASEC) to the US Census Bureau's Current Population Survey (CPS).

From <http://www.statehealthfacts.org/>
Final 2011 data may be available in Fall 2013.

Notes - 2010

Source: two-year (2009-2010) health coverage estimate based on the Annual Social and Economic Supplement (ASEC) to the US Census Bureau's Current Population Survey (CPS).
From <http://www.statehealthfacts.org/>

Notes - 2009

Source: two-year (2009-2010) health coverage estimate based on the Annual Social and Economic Supplement (ASEC) to the US Census Bureau's Current Population Survey (CPS).
From <http://www.statehealthfacts.org/>

a. Last Year's Accomplishments

Improving access to preventive and primary care health services for children is a departmental and divisional priority. To provide comprehensive and affordable health insurance to eligible uninsured children, NJ and the Federal government have joined as partners in NJ FamilyCare (formerly NJ KidCare). NJ FamilyCare, administered by the NJ Department of Human Services, started in 1998.

In July 2008 a health care reform bill was signed into law expanding the NJ FamilyCare Program and allowing NJ to reinstitute enrolling parents up to 200% of poverty. The bill also contains a KidsFirst mandate requiring that all children (18-years and younger) have health insurance as of July 2009. Beginning in the 2008 tax year, individuals who file a NJ income tax return must indicate whether their dependents have health insurance and if they do not they will be mailed letters regarding health insurance options. Additionally, there are a number of market reforms in the bill including the introduction of age as a rating factor in NJ's individual insurance market.

As of February 2009, there were 556,000 children enrolled in the expanded NJ FamilyCare initiative and 212,000 parents enrolled in the NJ FamilyCare program. In the course of developing NJ FamilyCare, the State learned that many poor children who are eligible for free health insurance under the State's Medicaid program are not enrolled. The aggressive marketing and outreach programs designed to enroll children in NJ FamilyCare are also being used to increase the number of children enrolled in Medicaid. If all children who are eligible for NJ FamilyCare or Medicaid enroll in these programs, then the percentage of children who are uninsured should drop to four percent. Of the approximately four percent of uninsured children who do not qualify for NJ FamilyCare or Medicaid, many experience temporary gaps in insurance coverage, usually as a result of changes in parental employment. If employer-sponsored health insurance continues to decline, NJ FamilyCare will not be able to reduce the overall number of uninsured children in the State. Unfortunately, the percentage of uninsured children in New Jersey has increased from 8.2% in 1999 to 13.0% in 2008.

The NJ Health Care Reform Act of 2008 directed the Commissioner of the Department of Human Services (DHS) to establish the Outreach, Enrollment, and Retention Work Group (Work Group) to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare or NJ FamilyCare ADVANTAGE, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs.

The Work Group's membership includes representatives from the New Jersey Association of Health Plans, Affiliated Computer Services (ACS) Inc., NJ Policy Perspective, Association for Children of NJ (ACNJ), Legal Services of NJ, the NJDHSS, NJDHS, Banking and Insurance, Labor and Workforce Development, Education, Community Affairs, Agriculture, the Office of the Child Advocate and a public member to represent minorities. The Director of Rutgers Center for State Health Policy and representatives from the Department of Children and Families also participated in Work Group meetings.

Data from Rutgers Center for State Health Policy indicate that 293,790 NJ children (13.3 percent) under age 19 lacked health insurance coverage in 2006-07. Approximately 56,070 or 19 percent of these children live in families with incomes over 350 percent of the Federal Poverty Level (FPL) and are eligible for ADVANTAGE. Most of the remaining uninsured children, about 223,720 or 76 percent, are income eligible for free or subsidized coverage through NJ FamilyCare or Medicaid. According to information from DHS, Division of Family Development (DFD), the recession has caused a 50 percent increase in the number of individuals requesting assistance directly from the County Welfare Agencies from December 2007 to December 2008. Given the current economy and increases in the number of unemployed residents, it is likely that the number of uninsured children in NJ will continue to grow.

Due to state budget cuts, Reproductive and Perinatal Health Services no longer funds the Healthy Mothers, Healthy Babies (HMHB) Coalitions or the Black Infant Mortality Reduction (BIMR) projects which facilitated the FamilyCare enrollment of children whose mothers were served by these projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and Enrollment Plan				X
2. MOU with NJ FamilyCare				X
3. Express Lane Application Flyer (May 2010)				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NJ has one of the nation's most generous programs, available to families of 4 earning up to \$77,175. There is no cost for many families. For those with higher incomes, there is a sliding scale for small co-payments and monthly premiums. For families who earn too much to qualify for NJ FamilyCare, NJ offers NJ FamilyCare Advantage. NJ has simplified enrollment and renewal and reduced paperwork with the use of an express lane application. New Jersey's schools, hospitals, state officials and community agencies have been working together to enroll more children to be insured.

Health Service grants funded by RPHS will continue to require agencies to outreach and facilitate enrollment of potentially eligible children. Outreach to pregnant women will include facilitating access to FamilyCare enrollment to ensure a smooth transition to a pediatric medical home for infants served by the infant mortality reduction projects.

NJ developed an Express Lane Eligibility program to help find and enroll uninsured children in NJ FamilyCare and Medicaid. In addition to the state's Express Lane effort that uses tax forms, NJ is also engaged in a pilot project to partner with 9 school districts and conduct Express Lane Eligibility based on eligibility for the school lunch program.

c. Plan for the Coming Year

Recommendations to reduce barriers to health insurance enrollment for children and reduce the number of uninsured children are included in the Work Groups report - NJ FamilyCare Outreach, Enrollment and Retention Report May 2009 (<http://www.acnj.org/admin.asp?uri=2081&action=15&di=1442&ext=pdf&view=yes>).

All relevant departments, serving children and families, are willing to work cooperatively to reduce unnecessary barriers to coverage for eligible children. New Jersey has made some progress in capitalizing on technology but can do more to achieve efficient use of online applications and other technology. New Jersey also can do more in helping families renew their child's coverage so children are covered for as long as they are qualified and have consistent access to health care. CSH will help spread the word by encouraging parents, teachers, doctors, school nurses and others working with families to visit www.njfamilycare.org or call 1-800-701-0710 to find out if their children are eligible. NJ FamilyCare fact sheets are also available in 15 languages from the NJ FamilyCare website. Federal health insurance reforms and expansion of Medicaid and SCHIP will also positively impact children and families in need of health care services.

Health Service grants funded by Reproductive and Perinatal Health services will continue to require agencies to outreach and facilitate enrollment of potentially eligible children. Outreach to pregnant women will include facilitating access to FamilyCare enrollment to ensure a smooth transition to a pediatric medical home for infants served by the infant mortality reduction projects.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	40	39	35	34	34
Annual Indicator	35.6	35.4	35.9	34.3	32.3
Numerator					
Denominator					
Data Source		WIC PedNSS	WIC PedNSS	WIC PedNSS	WIC PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	32	32	31.5	31.5	31

Notes - 2011

Source: 2011 Pediatric Nutrition Surveillance report for New Jersey, Table 12C. Provided by the NJ WIC Program as compiled by the CDC (see http://www.cdc.gov/pednss/what_is/pednss/index.htm)

Notes - 2010

Source: 2010 Pediatric Nutrition Surveillance report for New Jersey, Table 12C. Provided by the NJ WIC Program as compiled by the CDC (see http://www.cdc.gov/pednss/what_is/pednss/index.htm)

Notes - 2009

Source: 2009 Pediatric Nutrition Surveillance report for New Jersey, Table 12C. Provided by the NJ WIC Program as compiled by the CDC (see http://www.cdc.gov/pednss/what_is/pednss/index.htm)

a. Last Year's Accomplishments

New Jersey has one of the highest obesity rates among low-income children 2 to 5 years of age at 16.5 percent according to the 2011 WIC Pediatric Nutrition Surveillance System.

The 2008 CDC five-year NPAO cooperative agreement award to the DHSS Office of Nutrition and Fitness (ONF) established the ShapingNJ Partnership to enlist the commitment of diverse partners from across the state to develop a NJ NPAO State Plan. Partners worked in seven workgroups: physical activity; fruit and vegetable; breastfeeding initiation, duration and exclusivity; TV viewing; energy dense foods and sugar sweetened beverages; Executive and Sustainability Committee; and, Surveillance and Evaluation. ShapingNJ workgroups were directed to 1) focus on policy and environmental change strategies; 2) target resources to those at greatest risk for obesity and other chronic diseases; 3) promote and utilize evidence-based strategies among all partners; and, 4) establish priority populations (at-risk populations in low-income and minority communities) and strategies, identify available data sources and gaps, and set measurable program objectives.

In 2009, NJ Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Program introduced a new food package. Changes in the WIC food packages align with Dietary Guidelines for Americans and current AAP infant feeding practice guidelines, promote breastfeeding, provide a wider variety of food, and allow greater flexibility in prescribing food packages to accommodate participants with cultural food preferences. The NPAO behavioral strategies of increasing breastfeeding, physical activity and the consumption of fruits and vegetables; and decreasing sugar-sweetened beverages, fatty foods and TV viewing -- are addressed at WIC individual or secondary contact sessions.

WIC held Statewide Grow and Glow trainings to promote breastfeeding and teamwork at WIC state agencies. The goal was to increase the awareness of breastfeeding services available as well as promote a better understanding of staff roles at WIC to better support breastfeeding.

Through September 30, 2011 a pilot project was conducted in collaboration with the Department of Human Services - Division of Family Development, the Office of Nutrition & Fitness - Department of Health & Senior Services and the NJ Association for Child Care Resource & Referral Agencies. Five child care centers in each of NJ's 21 counties (n = 105) participated in an evidence based project (NAP SACC -- Nutrition and Physical Activity Self Assessment for Child Care) aimed at preventing obesity by improving policies and practices in the areas of nutrition, physical activity, screen limitations and breastfeeding support. At the same time, based on NJ childhood obesity data and poor ratings of existing regulations related to obesity prevention, new recommendations were proposed. These proposed regulations were determined through 25 county focus groups and subsequently submitted to the Office of Licensing for review and consideration.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Office of Nutrition and Fitness, CDC NPAO cooperative				X

agreement and establishment of the Shaping NJ Partnership				
2. New WIC food package implemented				X
3. Child care regulations revised, field tested (focus groups) and proposed to the Department of Children & Families - Office of Licensing				X
4. Child Care Best Practices Tool Kit (in development)				X
5. Workshop trainings for child care providers at annual conferences				X
6. Breast Feeding Hospital Initiative Forum (BFHI)				X
7. Baby Friendly Hospital new designations				X
8.				
9.				
10.				

b. Current Activities

ShapingNJ enlisted the commitment of diverse partners from across the state to address the obesity epidemic and develop a NJ NPAO State Plan. Partners worked in seven workgroups: physical activity; fruit and vegetable; breastfeeding initiation, duration and exclusivity; TV viewing; energy dense foods and sugar sweetened beverages; Executive and Sustainability Committee; and, Surveillance and Evaluation. ShapingNJ workgroups were directed to 1) focus on policy and environmental change strategies; 2) target resources to those at greatest risk for obesity and other chronic diseases; 3) promote and utilize evidence-based strategies among all partners; and, 4) establish priority populations and strategies, identify available data sources and gaps, and set measurable program objectives.

c. Plan for the Coming Year

The ShapingNJ Partnership currently has over 200 health, education, parks and recreation, agriculture and business organizations.

In January 2010, the state passed a law requiring food chains with 20 or more locations nationally to provide calorie counts for food and beverages. The law will take effect in 2011. NJ is one of 19 states that have stricter nutritional standards for school lunches, breakfasts and snacks than mandated by federal USDA requirements.

The ShapingNJ Partnership recently received additional federal funding for a 2-year obesity prevention initiative, which will be implemented as part of the partnership's strategic plan. For the school setting, Adolescent Health grantees will implement CDC's Coordinated School Health (CSH) model by creating a school health team of diverse composition; analyzing the strengths and weaknesses of existing school health policies, curricula, programs and services using CDC's self assessment tool: the School Health Index (SHI); and, developing an action plan that prioritizes areas for improvement. For the hospital setting, exclusive breastfeeding will be promoted through grants to support the Baby Friendly Hospital Initiative (BFHI) to change hospital breastfeeding policies and practices.

Through the BFHI, 2 NJ hospitals are certified Baby Friendly: SJH Elmer Hospital (South Jersey Healthcare) and Capital Health Medical Center -- Hopewell.

The ShapingNJ child care workgroup has collaborated on a number of systems efforts. The Office of Licensing posted the revised NJ Manual of Child Care Requirements on February 21, 2012 for a 60 day public comment period ending April 21, 2012. Efforts are underway to engage partners in submitting comments. Simultaneously the workgroup is developing a user friendly child care tool kit, designed to be web-based, to accelerate changes in early care and education.

NJWIC continues to promote physical activity and plans to develop a new lesson on their

NJ WIConline.org website for WIC participants to complete their secondary nutrition education contact.

Moving forward, the ShapingNJ child care workgroup will be tracking the status of proposed child care regulations and conduct outreach on the resulting new regulations. Efforts will be made to: 1) disseminate the child care tool kit through partner networks; 2) highlight 'spotlight' topics on websites & newsletters; 3) share resources through existing NJ Association of Child Care Resource & Referral Agencies training calendars; 4) target information on best practices to parents; and 5) coordinate messages with WIC and the ShapingNJ healthcare workgroup. The ShapingNJ child care workgroup anticipates convening a group of state agencies involved in child care, identifying points of integration between pre-school core standards and the tool kit and, exploring opportunities for connecting pre-service early childhood.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	8	7.8	6	5.8	6.5
Annual Indicator	6.2	6.8	6.8	6.8	6.8
Numerator					
Denominator					
Data Source		NJ PRAMS	NJ PRAMS	NJ PRAMS	NJ PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	6.4	6.3	6.3	6.2	6.2

Notes - 2011

2008 NJ PRAMS data entered as provisional estimate for 2011. Final 2011 data will be available in 2014.

Notes - 2010

2008 NJ PRAMS data entered as provisional estimate for 2010. Final 2010 data will be available in 2013.

Notes - 2009

2008 NJ PRAMS data entered as provisional estimate for 2009. Final 2009 data will be available in 2012.

a. Last Year's Accomplishments

Initiated in 2001 with funding from the NJDHSS-Comprehensive Tobacco Control Program, Mom's Quit Connection (MQC) is New Jersey's maternal child health smoking cessation program. MQC receives fax referrals via healthcare providers, community and social services agencies, and a toll free number is also available for self referral. MQC's trained Tobacco Dependence

Specialists utilize a proactive behavior modification model, offering face-to-face individual counseling at the referring health care facility, on site group counseling or telephone counseling to assist clients in developing a customized quit plan. MQC receives between 400 and 500 referrals annually; these referred clients then receive self help materials or choose to enter case management for individualized counseling. Approximately 100 new clients and another 150 ongoing clients are served through MQC's case management program each year.

Tobacco prevention education and outreach activities are offered statewide in health care, community-based and school settings to pregnant and parenting adults and teens, girls at risk, family members and caregivers of young children. Outreach efforts also target populations most vulnerable to tobacco addiction, such as women receiving substance abuse treatment, families enrolled in parent education and support programs and teens in alternative school settings.

MQC provides free on site Ask, Advise, and Refer Brief Intervention training to maternal-child healthcare providers, hospital staff and physicians, medical and nursing schools, MCH consortia, medical associations, community and social service agencies, statewide. Upon completing the training, MQC provides technical assistance to clinicians and office staff in implementing the fax to quit referral process and ongoing cessation support as a routine component of care. In 2010, MQC provided provider training, education and support to approximately 620 maternal and family health care clinicians.

Maternal cigarette smoking has negative effects on all stages of pregnancy, from conception to birth. Women who smoke cigarettes have an increased risk of complications, including spontaneous abortion and premature birth. Previous studies have shown that babies exposed to tobacco in utero are more likely to have a low birth weight and are at increased risk for sudden infant death syndrome. Current research suggests that these babies are also less likely to self-soothe and are more aroused and excitable than newborns whose mothers did not smoke during pregnancy. In spite of the negative consequences of maternal smoking on pregnancy outcome, women continue to smoke.

An MCHS staff member is a participant in the National Partnership to Help Pregnant Smokers Quit. AMCHP holds quarterly Technical Assistance Conference calls for this group.

Statewide there have been many notable accomplishments to reduce smoking. From 2000 to 2007, cigarette taxes were increased from 80 cents per pack to \$2.575 per pack (among the highest in the country). Legislation to ban smoking in all workplaces and indoor public places was passed in 2006.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Mom's Quit Connection offers 5 A's training throughout the State.		X		X
2. The Perinatal Addiction Prevention Project (PAPP) promotes a screening tool that identifies pregnant women who smoke.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MQC has collaborated with several maternity hospitals statewide in implementing smoke free campuses. Assisting with staff training and development of new policies, MQC has helped to create a sustainable systems change and a standardized referral mechanism for patients and visitors needing cessation support.

MQC works to utilize media to promote the NJ Quitline. The multidimensional promotional campaign utilizes education and engagement of health care providers and systems, cable TV, radio and internet advertising, and the creation of a new website to increase awareness and utilization of the NJ Quitline.

The Perinatal Addiction Prevention Project (PAPP) promotes a screening tool that identifies pregnant women who smoke. These women are then given referral information for available resources to help them quit. The MCHS staff continues to participate in both the state and national partnerships.

Mom's Quit Connection offers 5 A's training throughout the State. These classes are presented to private practitioners as well as large OB/GYN departments.

The Perinatal Addiction Prevention Project (PAPP) promotes a screening tool that identifies pregnant women who smoke. These women are then given referral information for available resources to help them quit. The MCHS staff continues to participate in both the state and national partnerships.

c. Plan for the Coming Year

The PAPP coordinators will continue to strengthen the referral process once a woman is identified at risk for substance use/abuse.

The federal health care reform legislation included provisions to improve access to smoking cessation services for pregnant women. The new legislation prevents states from excluding tobacco cessation drugs from the medications covered by their Medicaid programs and requires Medicaid to cover smoking cessation treatment for pregnant women, including medication and counseling with no cost-sharing requirements. States that voluntarily cover all recommended preventive services and immunizations for all Medicaid enrollees will get an increase in their federal Medicaid reimbursements.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	2.8	4.2	3.7	3.9	3.8
Annual Indicator	4.1	4.1	4.7	4.7	4.7
Numerator	24	24	27	27	27
Denominator	589614	583506	579856	579856	579856
Data Source		WISQARS, CDC	WISQARS, CDC	WISQARS, CDC	WISQARS, CDC
Check this box if you cannot					

report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	4.5	4.5	4.4	4.3	4.2

Notes - 2011

2009 data entered as provisional estimate for 2011 data. Final 2011 data will be available from the CDC in Fall 2014.

Notes - 2010

2009 data entered as provisional estimate for 2010 data. Final 2010 data will be available from the CDC in Fall 2013.

Notes - 2009

Source: WISQAR, CDC - <http://www.cdc.gov/injury/wisqars/index.html>

a. Last Year's Accomplishments

Suicide is the third leading cause of death among adolescents in New Jersey. Suicide rates are highest among non-Hispanic whites. The death rate from suicide for 15-19 year old males is 6.1 per 100,000. The causes of suicide are complex, and have to do with mental illness, particularly depression and/or adverse circumstances. Suicide attempts among younger people tend to be impulsive and communicative acts, often involving non-lethal means. Nearly one-third of New Jersey suicide victims in 2003 had diagnosed mental illness at the time of the suicide and about one fifth were reported to have symptoms of depression at the time of their suicide. The major mechanisms used in suicides in New Jersey are firearms, suffocation (usually hanging), and poisoning, although mechanisms varies with age. Firearms and suffocation are the two most lethal means. Females are far more likely than males to use poisoning. Prevention does work. Prevention efforts are increasingly focused on restricting access to lethal means of suicide, especially, but not exclusively, firearms.

New Jersey has taken much action over the past ten years to decrease the risk of completed suicide by children, youth, and young adults. The creation of the State Legislature of the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC) is part of this effort. Elizabeth Dahms, MS, RNC represents the department on this council. The council wrote the NJ State Suicide Prevention State Plan and it was approved to refine and improve the efforts of its many stakeholders to eliminate suicide. As of 2008, New Jersey ranked 47th lowest of the fifty states for completed suicide rates. The NJYSPAC views this as an excellent indication of the hard work and efforts already put into suicide prevention throughout the State. However, the loss of one life and the promise lost of that person's potential is irrecoverable. The pain and grief that is experienced by the survivors of the loss is immeasurable. Therefore, the Council will encourage the State to use this plan to continue and increase the current efforts for suicide prevention.

DHSS supports the Mercer County Traumatic Loss Coalition, which brings together a wide variety of community partners (including schools, local government, police, fire and EMS, and health care providers) to develop plans to prevent and address suicide and other sudden traumatic

death among children and adolescents.

A clergy conference, "Suicide: A Compassionate Approach to Intervention and Healing" this time for the Jewish clergy on October 29, 2008. Rabbis, Cantors, religious educators, youth leaders and bereavement group facilitators participated in this event held in West Orange, New Jersey.

Through collaboration with the Department of Human Services and the University of Medicine and Dentistry of New Jersey, the following trainings were provided: There were 341 attendees at the 6th Annual Suicide Prevention Conference "We Have Many Children but None to Spare" held on November 18, 2008 in East Hanover, New Jersey and on November 19, 2008 in Somerset, New Jersey.

A free Trauma and Grief in Youth Workshop was held in three locations: January 5, 2009 at University Behavioral Health Care in Piscataway, New Jersey and on January 6, 2009 in Wayne, New Jersey and on January 8, 2009 in Pomona, New Jersey. Over 380 participants were registered.

The Traumatic Loss Coalitions for Youth publishes a newsletter. Over 3,000 individuals are in receipt of this newsletter.

A full day training on Suicide Assessment of Suicide Events and Grief and Trauma in youth on September 24, 2009, approximately 90 participants attended. A full day training entitled "A Compassionate Presence in the Eye of the Storm" was presented by Nicci Spinazzola, LPC on September 30, 2011. A manual from the American Foundation of Suicide Prevention entitled "After Suicide: A Toolkit for Schools" was distributed.

The Mercer County facilitated memorialization protocols for Mercer County schools. They hosted a full day seminar "Adolescent Anxiety and School Refusal" for 120 participants. Nursing contact hours were awarded.

The New Jersey Suicide Prevention quilt was displayed in the resource room at the 12th Annual Adolescent Health Institute on November 13, 2011. 130 school administrators and nurses and family planning providers attended. Nursing contact hours and professional development certificates were provided.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. NJ Youth Suicide Prevention Advisory Council				X
2. Traumatic Loss Coalitions in 21 counties		X		X
3. "Managing Sudden Traumatic Loss in the Schools" - Manual				X
4. Annual Suicide Prevention Conference				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Mercer Traumatic Loss Coalition (a model funded by DHSS and currently there is one in every NJ county) holds monthly Traumatic Loss Meetings. Participants include local school counselors, administration, law enforcement, clergy, and mental health organization staff.

Recently the discussion revolved around a local High School regarding recent loss of students. The New Jersey Suicide Prevention Quilt is displayed and suicide prevention information is distributed in the resource room at the Annual Adolescent Health Institute, this year it is scheduled for in November 2012. The Traumatic Loss Newsletter is distributed twice a year.

The Mercer TLC co-sponsored the 8th Annual Youth Suicide Prevention Conference, Preventing and Responding to Adolescent Suicide Focusing On Contagion on December 1, 2010 for 350 participants. A Garrett Smith grant application was submitted in February 2011, it included the New Jersey State Suicide Plan.

c. Plan for the Coming Year

DHSS continues to work with a wide variety of community partners, such as the Mercer County Traumatic Loss Coalition, to develop plans to prevent and address suicide and other sudden traumatic deaths and losses among children adolescents and families.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	80	80	83	86	85
Annual Indicator	76.7	82.6	85.6	84.3	84.3
Numerator	1315	1446	1358	1359	1359
Denominator	1714	1751	1587	1613	1613
Data Source		EBC	EBC	EBC	EBC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	85	86	86	86	87

Notes - 2011

Provisional 2010 data from the Electronic Birth Certificate file entered as estimate for 2011 data. Final 2011 data may be available in Fall 2014.

Notes - 2010

Provisional 2010 data from the Electronic Birth Certificate file as of 6/23/2012. Final 2010 data may be available in Fall 2013.

Notes - 2009

Provisional 2009 data from the Electronic Birth Certificate file as of 6/23/2012. Final 2009 Birth Certificate data may be available in Fall 2012.

a. Last Year's Accomplishments

Very low birthweight (LBW) is an important risk factor for future health conditions, disability, and death. Factors that have contributed to this increase are: the increases in multiple births, which are more likely to result in VLBW infants than singleton births (though singleton LBW has

also increased); obstetric interventions such as induction of labor and cesarean delivery; infertility therapies; and delayed childbearing.

Despite improvements in Neonatal Intensive Care Units (NICU) and community-base efforts that focus on early entry to prenatal care and comprehensive services, NJ has not experienced improvements in the rate of infants born at low birth weights. Overall trends in both low and very low birth weights indicate a small but steady increase in the number of infants born at these weights. A significant refinement in the reporting of LBW rates is the reporting of singleton LBW and singleton VLBW rates as Health Status Indicators. The increase in multiple births due to assisted reproductive technology has influenced overall LBW and VLBW rates. Singleton LBW and singleton VLBW rates are stable or slightly decreasing.

The percent of VLBW infants delivered at facilities for high-risk deliveries and neonates has increased through continuous quality improvement activities, which are coordinated on the regional level by the Maternal and Child Health Consortia (MCHC). The Reproductive and Perinatal Health Services (RPHS) coordinates regional continuous quality improvement activities within each of the regional MCHCs. Regional quality improvement activities include regular monitoring of indicators of perinatal and pediatric statistics and pathology, including 1) transports with death; 2) non-compliance with rules regarding birth weight and gestational age; 3) cases in which no prenatal care was received; 4) all maternal deaths; 5) all fetal deaths over 2,500 grams not diagnosed as having known lethal anomalies; 6) selected pediatric deaths and/or adverse outcomes; 7) immunizations of children 2 years of age; and 8) admissions for ambulatory care sensitive diagnoses in children.

Quality improvement is accomplished through fetal-infant mortality review and maternal mortality review systems, as well as analyzing data collected through the electronic birth certificate (EBC). Currently, all hospitals providing maternity services report births through the EBC. The TQI Committee reviews the data and makes recommendations to address either provider specific issues or broad system issues that address multiple providers or consumer groups within each Consortium region.

As a follow-up to the Perinatal and Pediatric Bed Need Task Force, a statewide collaborative partnership to gather and analyze data related to quality of care for newborn infants and their families was convened. Most of the Regional Perinatal Centers (RPCs) are members of the Vermont Oxford Network (VON) and believe that the prenatal and postnatal data available through this network could improve the system of total quality improvement on a regional and statewide level.

The Directors of Neonatology of the RPCs have been meeting to develop the NJ NICU Collaborative. All 15 RPCs have submitted the documents necessary to participate in the NJ Neonatal Collaborative to establish a statewide reporting program based on the hospital-level NICU performance data submitted to the Vermont Oxford Network, Inc.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Consortia TQI Activities				X
2. Perinatal Designation Level regulations				X
3. Development of the NJ VON Collaborative				X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The regional quality improvement activities within each of the 6 MCHCs coordinated by RPHS include the regular monitoring of indicators of perinatal and pediatric statistics, fetal-infant mortality review, maternal mortality review, and maternity services reporting through the EBC.

The Directors of Neonatology of the RPCs have initiated a NJ VON Collaborative to ensure: the development of a voluntary, collaborative network of neonatal providers, to support a system for bench marking and continuous quality improvement activities for perinatal care; the opportunity to develop a responsive, real time, risk-adjusted, statewide perinatal data system; and the ability to integrate existing state and front-end perinatal data systems.

All of the regional perinatal centers (RPC) in the State currently participate in the NJ NICU Collaborative. The initial education effort centered on hand hygiene. The NICU Collaborative achieved active infection reduction activity at all centers.

The NJ NICU collaborative has joined the State Collaborative Group, a sub unit of the Vermont Oxford Network (VON).

The Chair of the NJ NICU Collaborative provided a progress report on the infection indicator at the annual March of Dimes NJ Chapter, professional conference. Over 100 health care professionals attended this event.

c. Plan for the Coming Year

The NJ NICU Collaborative plans to continue to address infections as the common indicator in all of the RPC's. Site visits to include best practices will be conducted regionally. The collaborative has planned six meetings for the year, with three being conducted via the web. Education will be an ongoing goal of the collaborative.

The NJ NICU Collaborative is participating with 7 other states in the NCABSI (catheter-associated bloodstream infection) collaborative, a multistate initiative to eliminate central-line associated blood stream infections in the NICU. The NCABSI project is part of the overall AHRQ-funded On the Cusp: Stop BSI national initiative.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	79.2	79.2	79.4	79.6	81.4
Annual Indicator	76.6	78.4	79.5	81.3	81.3
Numerator	86363	85891	85018	84198	84198
Denominator	112715	109539	106944	103586	103586
Data Source		EBC	EBC	EBC	EBC
Check this box if you cannot report the numerator because					
1. There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	81.4	81.5	81.5	81.6	81.7

Notes - 2011

Source: 2010 provisional data from the Electronic Birth Certificate file entered as estimate of 2011 data. Final 2011 data will be available in 2014.

Notes - 2010

Source: 2010 provisional data from the Electronic Birth Certificate file as of 6/23/2012. Final data will be available in 2013.

Notes - 2009

Source: 2009 provisional data from the Electronic Birth Certificate file as of 6/23/2011. Final data will be available in 2012.

a. Last Year's Accomplishments

In February 2008 a Commissioner's Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in NJ. The Task Force was comprised of physicians, nurses, administrators and others with expertise in maternal and child health. The Task Force presented a report and recommendations to Commissioner Howard in July 2008. Commissioner Howard launched a public awareness campaign statewide using a variety of venues including Healthy Mothers, Healthy Babies, MCH Consortia, hospitals, federally qualified health centers, colleges and others. A request for applications was developed to implement recommendations contained in the Commissioner's Prenatal Care Task Force Report. This competitive request for applications sought to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. It is anticipated that projects seeking funding should be able to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and or increasing access for reproductive age women and their partner for preconception and interconception care. Nine projects were funded within the Access to Prenatal Care Initiative representing a variety of best practice models.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Consortia outreach and education activities				X
2. Commissioner's Prenatal Care Task Force				X
3. Access to Prenatal Care Initiative				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Based on recommendations from the Prenatal Care Task Force, Infant mortality reduction funding was redirected from Healthy Mothers, Healthy Babies (HM,HB) Coalition outreach and education to the Access to Prenatal Care Initiative request for applications. Activities from the 8 HM,HB Coalition including outreach to identify women in need of prenatal or postpartum care and case management, were phased out during the end of 2009.

Following recommendations from the Prenatal Care Task Force, RPHS issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

The 8 Access to Prenatal Care Initiative (APCI) agencies provide access to prenatal care services as a means to decrease infant mortality rates (described in next section). Projects are located in the highest need areas of 13 of the 21 counties. All of the projects address health disparities as seen in the local communities.

c. Plan for the Coming Year

The APCI grantees utilize evidence-based models including Patient Navigators, Centering Pregnancy and Doula, and will be in year 3 of a 3 year grant project period.

Central NJ MCHC will implement a Preconception, Interconception and Prenatal Education awareness campaign targeting women of childbearing age, youth and men in the target area, and will provide a patient navigator to serve at-risk pregnant and/or interconception women within the service region.

Hudson Perinatal Consortium will provide outreach and education, coordination of health benefits including insurance coverage, a medical home, and WIC services for program participants who are entering prenatal care. Hudson Perinatal Consortium will coordinate doula training and childbirth education sessions.

Children's Home Society will target outreach to the Latino and African American community with emphasis on adolescents. Children's Home Society will provide access to prenatal care, interconception and preconception care and outreach and education services in the target area.

Southern Jersey Family Medical Center will provide an integrated service delivery model for reproductive healthcare; partnering with Planned Parenthood of Southern NJ and the Southern NJ Perinatal Cooperative.

Southern NJ Perinatal Cooperative will establish a regional practice collaborative to foster a comprehensive approach to community awareness, provider training, service integration and improved access to prenatal care, interconception and preconception care.

Northern NJ MCHC will provide a patient navigator model of care with expansion of the Paterson Healthy Mothers Healthy Babies Coalition model.

Gateway Northwest MCH Network will provide a technology based prenatal education/outreach model for pregnant/postpartum clients with special emphasis on adolescents through use of text messaging and email.

Regional Perinatal Consortium of Monmouth and Ocean Counties will provide and coordinate subgrants for direct care including Centering Pregnancy and intensive case management services.

Newark Community Health Center will provide a Centering Pregnancy model with special emphasis on pregnant women with HIV/AIDS.

Beginning with the SFY2013, the DHSS is restructuring the APCI Grants to include preconception/interconception counseling incorporating the Life course model into the projects. This component would emphasize the health of reproductive age women including linkages with healthy lifestyles and medical home. All projects will promote cultural competence. Funding would come from reduction of infrastructure costs due to the MCHC mergers and reductions to grantees with extended vacancies of grant funded positions. In addition, the MIEC Home Visiting projects complement the services provided in the APCI.

D. State Performance Measures

State Performance Measure 1: *The percentage of Black non-Hispanic preterm infants in New Jersey*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	13	13	13	13	9.9
Annual Indicator	11.3	11.0	10.6	10.0	10.0
Numerator	1945	1861	1744	1573	1573
Denominator	17256	16858	16507	15725	15725
Data Source		EBC	EBC	EBC	EBC
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	9.8	9.7	9.6	9.5	9.4

Notes - 2009

Provisional 2009 data from the Electronic Birth Certificate file as of 6/23/2010. Final 2009 data will be available in 2012.

a. Last Year's Accomplishments

Maternal and Child Health Services chose the percent of black preterm births in New Jersey as State Performance Measure #1. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

Maternal and Child Health Services has a long history of addressing perinatal health disparities with special emphasis on the Black Infant Mortality Reduction Initiative which was initiated in 1985. In February 2008 a Commissioner's Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in New Jersey. Health disparities was identified as a priority. The overall goal of the Access to Prenatal Care Initiative is to increase the rate of first trimester prenatal care in New Jersey to at least 90% to coincide with the National Healthy People 2010 goal, with emphasis on racial and ethnic disparities.

The Department's commitment to reduce black infant mortality has been demonstrated in previous sections concerning the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign, the Commissioner's Prenatal Care Task Force and the Access to Prenatal Care Initiative.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Access to Prenatal Care Initiative		X	X	X
2. Healthy Start		X		X
3. Preconceptual health counseling/training				X
4. Black Infant Mortality Reduction				X
5. MCH Consortia outreach and education activities			X	X
6. Commissioner's Prenatal Care Task Force				X
7.				
8.				
9.				
10.				

b. Current Activities

Reproductive and Perinatal Services has implemented program evaluation of all funded BIMR activities.

c. Plan for the Coming Year

Following recommendations from the Commissioner Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

Nine health service grants were awarded for the Access to Prenatal Care Initiative providing statewide representation. The agencies and their activities have been previously described in the National Performance Measure #18 section.

The eight Access to Prenatal Care Initiative agencies provide access to prenatal care services as a means to decrease infant mortality rates. Projects are located in the highest need areas of 13 of the 21 counties. All of the projects address health disparities as seen in the local communities. The projects utilize evidence-based models including Patient Navigators, Centering Pregnancy and Doula's will be in the third year of a three year grant project period. Beginning with the SFY2013, the Department is restructuring Access to Prenatal Care Grants to include preconception/interconception counseling incorporating the Life course model into the projects. This component would emphasize the health of reproductive age women including linkages with healthy lifestyles and medical home. All projects will promote cultural competence. Funding would come from reduction of infrastructure costs due to the MCHC mergers and reductions to grantees with extended vacancies of grant funded positions. In addition, the MIEC Home visiting projects complement the services provided in the Access to Prenatal Care initiative,

The Department is a partner with the March of Dimes NJ Chapter in the Healthy Babies are Worth the Wait a program to reduce preterm births among African American women in Newark.

State Performance Measure 2: *The percentage of children with elevated blood lead levels (≥ 20 ug/dL).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	0.2	0.2	0.2	0.1	0.1
Annual Indicator	0.2	0.1	0.1	0.1	0.1
Numerator	350	261	231	252	229
Denominator	161776	175053	175732	185055	180681
Data Source		Childhood Lead Prevention Program Database			
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	0.1	0.1	0.1	0.1	0.1

Notes - 2010

Source: Childhood Lead Prevention Program Database, MCCH, FHS.
 2009 data entered as provisional 2010 data.
 Final 2010 data will be available in Fall 2011.

Notes - 2009

Source: Childhood Lead Prevention Program Database, MCCH, FHS.
 Final 2009 data will be available in Fall 2011.

a. Last Year's Accomplishments

Children with elevated blood lead levels are at increased risk for behavioral problems, developmental delays, and learning disorders. Increased childhood morbidity will result from undetected and untreated lead poisoning. The percentage of children with elevated blood lead levels (State Performance Measure # 3) was chosen because children in New Jersey have a higher than average exposure to lead in their environment and a higher percentage of elevated blood lead levels than the national average. In CY 2011 0.78% of children tested for lead poisoning in New Jersey had elevated (> 10 ug/dL) blood lead levels.

Significant progress was made toward SPM # 3 regarding childhood lead poisoning prevention. During CY 2011, more than 230,000 blood lead tests were reported on 217,110 children. Of the children tested during CY 2011, 83.32% were under the age of 6 years. Among these children, 0.6% had results > 10 ug/dL and 0.1% had results > 20 ug/dL. Of all the children tested, 101,497 were between six months and 29 months of age, the ages at which state rules require all children to be screened for lead poisoning. This is 45.5% of all children in that age group. Looking at all blood lead tests reported since 1999, it is estimated that 75% of children have had at least one blood lead test by the age of two years, and 54% of children have had at least one blood lead test by the age of 1 year.

The web-based data and surveillance system, LeadTrax, containing medical and environmental case management modules continued to be customized, and remained CDC data requirements compliant. The expansion of the LeadTrax local health department users base continued to be a priority, providing hands-on training and access for the intended users of the remaining local

health departments in the State.

In August 2011, the NJ DHSS published the FY 2010 Annual Report on Childhood Lead Poisoning in New Jersey for dissemination of this data to local health departments and the public.

During CY 2011, because of ongoing efforts, the percentage of electronic reporting increased to 99% from the CY 2010 rate of 98%. DHSS is in the process of assisting remaining laboratories to make the transition from hard copy to electronic reporting. Through LeadTrax, more laboratories will be able to report electronically because of the system's capability to accept HL7 and Microsoft Excel reporting templates, which were developed exclusively for screening sites that use LeadCare analyzers.

Collaborative efforts with Medicaid and its contracted managed care providers continue in order to monitor and increase the number of Medicaid-enrolled children screened for lead poisoning.

A conference, held on April 16, 2010, was sponsored by the Interagency Task Force on the Prevention of Lead Poisoning as a means to highlight the State's accomplishments and new collaborations and initiatives that address lead poisoning prevention. The conference's three tracks (health, housing, and the environment) provided timely information for the 300 registered attendees. DHSS provided technical assistance to the thirteen Lead-Safe Model Cities to assist them in the implementation of their signed agreements with the Department of the Public Advocate.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Surveillance system enhancements and universal electronic reporting.			X	X
2. Newark Partnership for Lead Safe Children.			X	X
3. Regional Childhood Lead Poisoning Prevention Coalitions.			X	X
4. Plan for Elimination of Childhood Lead Poisoning Prevention Coalitions in NJ.			X	X
5. Nurse case management and environmental investigation protocol enhancements for highest risk jurisdictions (≥ 10 ug/dl).			X	X
6. Targeted screening enhancements (children exposed to parental occupational exposure, refugee children to age 16 years).			X	X
7.				
8.				
9.				
10.				

b. Current Activities

The expansion of the LeadTrax local health department users base continues to be a priority with an expected completion date of December 2012. However, this process is expected to continue beyond that due to staffing changes, requiring new staff to be trained and given access to LeadTrax as they are hired or reassigned to CLPP. LeadTrax was customized to meet CDC data requirements and data collection requirements due to changes in state regulations.

DHSS continues to place a greater focus on implementing primary prevention initiatives and strengthening strategic partnerships at all levels. Efforts focus on identifying and addressing lead hazards prior to young children moving into units or homes, as well as identifying lead-safe housing for families in need of emergency relocation due to a lead poisoned child. Monitoring of

the Elimination Plan continues to be coordinated by DHSS to assure that the state is collectively making progress to eliminate childhood lead poisoning.

In the highest risk city, Newark, the CLPP Program, located within the Newark Department of Child and Family Well-Being, continues to administer the Newark Partnership for Lead Safe Children. The Partnership's focus is on empowering health, social services, and housing organizations to build local capacity to address the lead problem in NJ's largest city.

c. Plan for the Coming Year

DHSS will fully incorporate a healthy homes approach into its services provided by local health departments that provide case management and environmental intervention services for children with elevated blood lead levels. Training on healthy homes principles and procedural protocols for staff of local health departments and home visitation-based programs in the Department of Children and Families (DCF) will continue. DCF's home visitation programs, funded in part by NJ's MIEC Home Visiting Formula Grant, provide services to pregnant women, infants, and young children in addition to assessing the suitability of homes for placement of children who have entered foster care or are registered as family child care homes. Emphasis will be on developing strategic partnerships with additional home visitation agencies that serve highest-risk, hard to reach populations as identified in the HH/LPP work plan and with communities involved in environmental justice issues including but not limited to exposure to sources of lead.

DHSS was notified in August 2011 of its awarding of a 3-year grant from the Centers for Disease Control and Prevention (CDC) for the support of a Healthy Homes and Lead Poisoning Prevention (HH/LPP) program. A condition of the award is to establish a HH/LPP Advisory Committee and subsequently develop a Strategic Plan during the first project year that commenced on September 1. This initiative's focus is on training of health, human services, and housing home visitation staffs, establishment of an assessment tool with related resource and referral processes, enhanced data collection into a singular database built upon LeadTrax, and emphasis on compliance and enforcement of protective policies and laws.

State Performance Measure 3: *The number of Regional MCH Consortia conducting community-based Fetal and Infant Mortality Review (FIMR) Teams and implementing recommendations through a Community Action Team.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					100
Annual Indicator		100.0	100.0	100.0	100.0
Numerator		6	6	6	5
Denominator		6	6	6	5
Data Source		MCHS	MCHS	MCHS	MCHS
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2010

Source: Reproductive and Perinatal Health Services in MCHS in FHS.

Notes - 2009

Source: Reproductive and Perinatal Health Services in MCHS in FHS.

a. Last Year's Accomplishments

State Performance Measure #2 was selected to monitor progress toward the implementation of recommendations from community-based Fetal and Infant Mortality Review Teams (FIMR) through Community Action Teams (CATs). This infrastructure building service will impact on National Performance Measures #15, #17, #18 and all of the perinatal outcome measures. Increasing the understanding of the circumstances and factors associated with fetal and infant deaths will advance the State's ability to assess needs, improve the social and health care delivery system, and target resources and policies toward specific locations.

On a local level, the MCH Consortia have used FIMR as a component of their quality improvement program both for need assessment and program development. Findings are shared with member hospitals for use in quality assurance activities. Policy has been implemented, such as the promulgation of fetal autopsy guidelines and consumer and professional education initiatives have addressed findings such as inadequate knowledge of fetal kick count and premature labor, and bereavement support issues.

Until the implementation of the NJ FIMR, there has not been a statewide approach to FIMR. Therefore, FIMR findings have not played a major role in need assessment and quality improvement at the state level. NJDHSS and the MCH Consortia are now working collaboratively to use the information obtained from NJ FIMR for policy development and continuous quality improvement activities on the state and local level. In addition to issuing a Statewide Annual NJ FIMR report, common areas of concern identified from the local reviews will be addressed as a collaborative effort by all local projects through statewide initiatives. Each MCH Consortia has a Community Action Team (CAT) which consists of a diverse group of community leaders. The CAT reviews recommendations from the Case Review Team, prioritizes identified issues and designs and implements intervention in a variety of ways.

Related to FIMR is New Jersey's system of Maternal Mortality Review (MMR), which was established, in the late 1970s and revised in 1999. The revised New Jersey Maternal Mortality Review is based on the National Fetal-Infant review process, using a multidisciplinary model, data abstraction, de-identified case summary, and Community Action Teams to implement programs to effect change. The FHS/Reproductive Health and Perinatal Services coordinates the New Jersey MMR process.

All pregnancy-associated deaths occurring in 1999 through 2005 have been reviewed. The Case Review Team, which also serves as the Community Action Team, has reviewed the findings and made recommendations. A report of the findings and recommendations for the years 1999-2005 is expected in the summer of 2010.

A birth certificate, death certificate and hospital discharge data matching strategy is used to improve identification of maternal deaths using the CDC expanded definition of a pregnancy-associated death. Once cases are identified, Reproductive and Perinatal Health Services verifies the cases by reviewing the death certificate, autopsy report, Report of the Investigation of the Medical Examiner, law enforcement records, or by contacting the hospital or health care provider directly. Cases deemed pregnancy-associated deaths are entered into a log. A copy of the log and death certificates is forwarded to the Central New Jersey Maternal and Child Health Consortium for data abstraction. The CNJMCHC coordinates data abstraction through a grant from DHSS. Data abstractors are nurses with extensive maternal and child health backgrounds, trained in medical data abstraction, and case summary development.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementing NFIMR in six MCHC Regions.				X

2. Implementation of FIMR process uniformly across all projects.				X
3. Reporting of data and local findings to NJDHSS for inclusion in statewide database.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The number of FIMR projects statewide continues to be 9, of which 7 are funded with MCH Block Grant monies through the 6 regional MCH Consortia. In order to assure a process that will allow for coordination of NJ FIMR findings from a statewide perspective, the process is implemented uniformly across all projects. All local projects of NJ FIMR follow the National FIMR guidelines for community FIMR with modifications as needed for NJ. The data collection process includes both chart abstraction and a maternal interview. A multidisciplinary case review team reviews the information and based on findings, makes recommendations to a Community Action Team. Data and findings from FIMR projects are submitted to the NJDHSS for inclusion in a statewide database.

Obtaining the maternal interview continues to be an impediment to the process. The success in obtaining maternal interviews has improved through the use of nurses through contracting with a local health department or VNA. However, obtaining a maternal interview continues to be a challenge.

c. Plan for the Coming Year

All local projects of NJ FIMR will follow the National FIMR guidelines for community FIMR in order to assure a process that will allow for coordination of NJ FIMR findings from a statewide perspective. Data and findings from local FIMR projects will continue to be submitted to the NJDHSS for inclusion in the statewide database. The Reproductive and Perinatal Health Services will continue to coordinate the NJ Maternal Mortality Review process modeled after the National FIMR process.

State Performance Measure 4: *Reduce the proportion of children and adolescents who are overweight or obese.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					24.5
Annual Indicator		26.6	24.5	24.5	24.5
Numerator					
Denominator					
Data Source		NJ Student Health Survey			
Is the Data Provisional				Provisional	Provisional

or Final?					
	2012	2013	2014	2015	2016
Annual Performance Objective	24	23.5	23	23	23

Notes - 2011

Source: NJ Student Health Survey, numerator and denominator are not available.

Notes - 2010

Source: NJ Student Health Survey, numerator and denominator are not available.

Notes - 2009

Source: NJ Student Health Survey, numerator and denominator are not available.

a. Last Year's Accomplishments

Three CSH regional grantees (one each located in a northern, central and southern region of the state) and 1 local grantee project in Newark and Montclair in Essex County and 28 school partners, including schools with disparate student populations began to implement CDC's Coordinated School Health (CSH) model during the 2010-2011 school year. Activities included: identifying a School Health Coordinator at each school; creating a school health team of diverse composition; analyzing the strengths and weaknesses of existing school health policies, curricula, programs and services using CDC's self assessment tool: the School Health Index (SHI); and, developing an action plan that prioritizes areas for improvement. Grantees assured that all school partners purchased and piloted the use of Fitnessgram software; conducted one youth focus group and one school health awareness/educational event; created a Youth Advisory Council.

The CDC-funded CSH staff provided professional development (PD) and technical assistance for the DHSS grantees and included: Fitnessgram, School Health Index, HECAT and PECAT, Food Service Directors' Workshop, Hands on Health (NJ AHPERD) and Fitnessgram Train the Trainer. During 2010 -2011, CDC funded CSH staff convened student Focus Groups with schools and shared guidance with DHSS grantees. Collaboration continued monthly as CDC CSH staff participated in conference calls and meetings, offering CDC resources and updates on upcoming PD events. DOE, through a cooperative agreement with CDC, conducted the 2011 Student Health Survey.

The ShapingNJ Partnership included over 100 health, education, parks and recreation, agriculture and business organizations. In 2011, the CDC NPAO cooperative agreement directed the state to concentrate its efforts on five settings: schools, communities, child care centers, worksites and health care facilities.

ShapingNJ accomplishments included: 1) CDC approval of the NJ NPAO State Plan for obesity prevention and supplemental funding for ShapingNJ strategies in the areas of child care, baby friendly hospitals and community health; 2) creation of a farmer's market at Beth Israel Hospital Farmer's Market, Newark;3) Conducting community focus groups to ensure that intervention strategies would resonate with the target populations; 4) development of ShapingNJ Partnership Objectives: a) increase the number, reach, and quality of policies and standards set in place to support healthful eating and physical activity in various settings; b) increase access to and use of environments to support healthful eating and physical activity in various settings; c) increase the number, reach, and quality of social and behavioral approaches that complement policy and environmental strategies to promote healthful eating and physical activity.

Effective January 2011, state law required food chains with 20 or more locations nationally to provide calorie counts for food and beverages. New Jersey was also one of 19 states that have stricter nutritional standards for school lunches, breakfasts and snacks than mandated by federal

U.S. Department of Agriculture requirements.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. NJ NPAO State Plan developed				X
2. CDC's CSH model implemented by DOE (2008 CDC cooperative agreement and DHSS, Adolescent Health (2010).				X
3. ShapingNJ Partnership identifies 2 venues- child care centers and schools- directly relevant to children and adolescents for implementation of E-B strategies				X
4. Secured funding to implement strategies in child care, baby-friendly hospitals and healthy communities				X
5. Farmers market established in a high risk area (Newark)				X
6. Community focus groups				X
7. Annual regional Sustainability meetings with State, grantees & schools				X
8. Bi-/tri-annual State-wide sustainability workgroup meetings				X
9.				
10.				

b. Current Activities

A collaborated effort for CSH implementation between DOE and DHSS is underway as coordination of meetings and sharing of resources becomes more established. For the current school year (2011-12), the DHSS CSH grantees are implementing the School Health Action Plans (SHAPs) developed by the 28 school partners at the end of the 2010-2011 school year. Schools focusing on NPAO prevention strategies will be identified and changes in school health and wellness policies monitored. There is a state-level CSH sustainability workgroup that has met twice: January and February 2012. Each regional grantee is coordinating sustainability meetings with school administrators and school health coordinators. The southern region held a meeting on March 1, 2012. The northern region is scheduled for May 14th and the central region on May 24th. Each region is coordinating a youth leadership development training. A State-wide school garden directory is under development and is expected to be posted on the FHS web-site by the start of the school year September 2012.

The DHSS CDC CSH liaison is actively involved with ShapingNJ school strategies. The liaison convened a webinar addressing the "How To" of School Wellness Council development. CDC CSH continued to offer professional development opportunities including a Leadership Academy, two regional Food Service Panel Workshops, NASPE Pipeline training, two regional physical education best practices workshops (April 2012), and a Grant Writing w

c. Plan for the Coming Year

CSH grantees will be expected to promote the Healthier US Schools Recognition sponsored by the USDA or the Alliance for a Healthier Generation (AHG) recognition. Year 3 grant requirements will include: 1) school outreach for LHD involvement; meet and greet between County Education Specialists and County SHS; Coordinate the School Health Team and School Climate Team; introduction of DCF County CIACC and point person at school w/ SHC 2) Youth advocacy/policy training; the SH Wellness Team = "Youth/Adult Partnership"; 3) School match of \$1,500 to fund the SHC stipend; 4) Next steps for Fitnessgram implementation; 5) Regional grantees collaborating to create/maintain Facebook/other social media page; 6) Grantees and schools to register to receive ShapingNJ e-newsletter; 7) Schools to identify and monitor one academic indicator in need of improvement.

The CDC funded DOE staff will provide professional development opportunities including: to MCSH CDC CSH. The "Healthy Schools Communities "event planned for October will support community partnering, highlighting physical activity for families and students. This workshop supports sustainability through community involvement. The CSH sustainability action plan will be implemented with key strategies in place for CDC CSH schools. When the CDC cooperative agreement ends February 28, 2013, funding availability for a competitive application is uncertain. However, States are being strongly encouraged to partner with their State Chronic Disease Program to use schools as a venue for the implementation of prevention strategies.

State Performance Measure 5: *Percentage of newborns who are discharged from NJ hospitals, reside in New Jersey, did not pass their newborn hearing screening and who have outpatient audiologic follow-up documented.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective				77	79
Annual Indicator		74.3	79.0	86.1	78.1
Numerator		2247	2356	2425	2115
Denominator		3023	2981	2818	2707
Data Source		EHDI	EHDI	EHDI	EHDI
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	81	83	85	86	87

Notes - 2011

Data for 2011 is incomplete, follow-up reports are still being received for these children.

a. Last Year's Accomplishments

Provisional data indicates that for 2011, 78.9% of infants received follow-up after referring on inpatient screening. This statistic continues to rise slowly, it was 70% in 2007, and is an area EDHI is working on improving.

The Early Hearing Detection and Intervention (EHDI) reporting module in the NJ Immunization Information System (NJiIS) is utilized by audiologists and other practitioners, who are conducting hearing follow-up, to report outpatient exams. NJ-EHDI receives approximately 86% of reports through this Web-based application and thirty-two new users were trained during 2011.

The EHDI Program continued a project begun in October 2009, where HRSA funding allows case management staff to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up. While EHDI rules give hospitals the primary responsibility for ensuring children receive appropriate follow-up, the level of effort put into this by each hospital and the success of their efforts varies widely. This program provides supplemental contacts to compliment the hospital's outreach efforts. During 2011, the case managers contacted 1,117 families, contributing significantly to the improvement in follow-up rates.

In April 2011, the NJ Pediatric Hearing Health Care Directory was updated and improved as a searchable on-line directory with the ability to map facility locations and obtain driving directions. This resource enables physicians and families to locate facilities in their area that have the required diagnostic services.

The EHDI program collaborated with staff from the Department of Children and Families (DCF), Division of Youth and Family Services (DYFS) granting NJiIS-EHDI module access to DCF staff

nurses who are responsible for health care for children in foster care placement. In April 2011, 235 DYFS staff members attended one of 4 webinars that provided information about the EHDI module and new hires watch a recorded version of the webinar. This effort will help to ensure children in foster care receive appropriate hearing follow-up services since this population has been much more likely to be lost to follow-up.

Two additional FQHC purchased equipment to conduct re-screening to supplement the three centers that began this service in 2010. The FQHCs will provide this service at no charge to the families, to reduce the fiscal barriers to lack of newborn hearing screening follow-up.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educational outreach to practitioners (audiologists, pediatricians, otolaryngologists, etc.).				X
2. Hospital level surveillance reports.			X	
3. Increase in follow up and reporting for those who are not screened while inpatient or refer on initial screening.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

To begin using telepractice to benefit children with hearing loss, the EHDI program funded one of the Early Intervention (EI) program's Regional Early Intervention Collaborative's (REIC) to hire two part time consultants. They will use laptops with web-cameras to participate in initial early intervention family meetings via remote access. The consultants are currently developing resource materials and developing the referral process.

The program is planning a webinar for SCHS case managers, EI staff, audiologists and physicians on the impact of unilateral hearing loss. These children are less likely to be enrolled in EI services, possibly due to an erroneous assumption by providers that these children are not eligible for services or would not benefit from services.

Another webinar under development is an EHDI overview for hospital staff responsible for newborn hearing screening. Due to the frequent changes in staff in some hospitals, a recorded webinar will be available to explain the EHDI program's regulatory obligations to ensure and improve hospital compliance.

The EHDI program recently is working with staff from the Communicable Disease Service division to notify the EHDI program of children diagnosed with meningitis. The goal of this collaboration is to ensure that children with hearing loss caused by meningitis receive timely referral for audiology and otolaryngology services, since a delay in can impair the ability for the child to benefit from cochlear implantation.

c. Plan for the Coming Year

The EHDI program will continue to send hospital-level surveillance data to each hospital with maternity services. A report with their overall statistics is sent semi-annually, and in intervening quarters, hospital contacts receive a list of children that are still in need of follow-up after missed

or referred inpatient hearing screening. New audiology facility reports will be created and routinely distributed to let facilities know how well they are doing with timeliness of outpatient follow-up and referral into Early Intervention services.

The EHDI program will begin sending follow-up letters to the primary care provider of infants that are in need of additional follow-up to prompt these providers to refer families for audiologic evaluation.

EHDI staff will provide educational presentations to pediatricians, audiologists, otolaryngologists, special child health service case managers, Early Intervention service coordinators, and other health care professionals, focusing on the need to decrease rates of children lost to follow-up. The EHDI program frequently uses Webinars, to make educational outreach efforts more accessible to the target audiences, to decrease staff travel time, and to improve efficiency while decreasing costs.

The parent support services provided through the REIC will continue to develop and expand through the coming year. As contacts with families are implemented the program will adjust the resources and scripts used for the contact and identify weaknesses in the EHDI process that are identified through individual conversations with families.

The program will participate in a National Initiative for Children's Healthcare Quality Learning Collaborative to identify small tests of change to improve hearing screening and follow-up.

The EHDI program will be reviewing the interoperability of the EHDI information system and looking for opportunities to utilize Electronic Health Record data to decrease the need for duplicate data entry. As the Bureau of Vital Statistics and Registration begins to implement a new Electronic Birth Registration System, the EHDI program will work with the program to ensure the continued capture of inpatient hearing screening results and risk indicators through this system.

State Performance Measure 6: *Percent of live children registered with the BDARS who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					70
Annual Indicator			65	65	65
Numerator					
Denominator					
Data Source			BDARS	BDARS	BDARS
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	75	80	85	85	86

Notes - 2011

Actual data is not yet available. Provisional 2011 data is an estimate. Final data will be available in late 2012.

Notes - 2010

Actual data is not yet available. Provisional 2010 data is an estimate. Final data will be available in 2012.

Notes - 2009

Actual data is not yet available. Provisional 2009 data is an estimate. Final data will be available in 2012.

a. Last Year's Accomplishments

This new SPM was chosen to improve the timeliness and effectiveness of using the Birth Defects and Autism Reporting System (BDARS), which has been an invaluable tool for surveillance, needs assessment, service planning and research, to link families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking registered children to health services. Since 1985, NJ has maintained a population-based registry of children with all defects. Starting in 2003, the Early Identification and Monitoring (EIM) Program received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses, was renamed the Birth Defects & Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects up to age 6, and added severe hyperbilirubinemia as a reportable condition. The system refers all living children and their families to our SCHS Case Management Units. The newly implemented case management module will monitor the progression into the service stream.

NJ has been very successful in linking children registered with the Birth Defects Registry (also known as the Special Child Health Services Registry) with services offered through our county based Special Child Health Services Case Management Units (CMUs). However, the system did not track children and families to determine if and what services were offered to any of the registered children. To address this weakness, a second module was added to the Birth Defects and Autism Reporting System (BDARS) and was fully implemented in January 2012. This module will be used by the CMUs to track and monitor services provided to the children and their families. It will electronically notify a CMU when a child living within their jurisdiction has been registered. Also included in the module is the ability to create and modify an Individual Family Service Plan, track services and service providers for each child, create a record of each contact with the child and child's family, create standardized quarterly reports and other reports, and register previously unregistered children.

The case management module of the BDARS will allow CMUs to receive registrations in real time and will allow for faster family contact and in assisting a registered child in gaining access to appropriate health and education services.

We have chosen to add this performance measure to show our commitment to continually improving access to services for families having children with special health care needs.

In 2011, CDC continued to fund the BDARS through a cooperative agreement for improvements in the Birth Defects Surveillance. Rutgers, the State University -- Bloustein Center for Survey Research (BCSR) continued the deployment of the new Case Management Module for the BDARS. The BCSR continued to work with EIM Program staff and staff from the SCHS county-based CMUs to finalize the development of the case tracking and management component of the BDARS. The SCHS Case Management Module of the BDARS was rolled out starting in August 2011. As each unit went on-line, notification of a newly registered child living within their jurisdiction switched to the electronic system, replacing the need to mail paper copies of the registration. The full rollout of the case management component continued over the next several months, with all CMUs utilizing the new system by January 2012. As of the end of 2011, most case management units were able to access and manage new cases through the BDARS.

BDR staff continued to provide training to birthing facilities, autism centers, and CMUs in the use of the electronic BDARS. They also continued to assist the units as they transition from the paper-based system to the electronic system. Staff continued to monitor the implementation of

the electronic BDARS and will assist reporting agencies with concerns.

In 2011, the SCHS Registry:

- Processed approximately 9,800 registrations,
- Identified 9,540 new children with birth defects and other special health needs,
- Referred nearly 9,180 families to the SCHS CMUs, and
- Received nearly 2,200 new autism-related registrations

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Annual Audits				X
2. Case Management level service reports.			X	
3. Increase in # of families being offered services.	X	X		
4.				
5.				
6.				
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b. Current Activities

BDARS staff continue to collaborate with staff from the Family Centered Care Program (FCCP) and BCSR to implement the case management module for the electronic BDARS. Registry staff held meetings with FCCP staff and BCSR to determine the content for the case management module and to assure the final product met specifications.

In 2012, CDC will continue to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance. The Bloustein Center for Survey Research will continue the making improvements to the BDARS. The major enhancement will be the addition of a Pulse Oximetry Screening module which will be used for the reporting of all infants who fail their mandated pulse oximetry screen. Registry staff will follow-up with hospital staff to determine the status of each child who failed their screen.

Site visits will be conducted in each of NJ's birthing hospitals and CMUs to ensure proper usage of the new BDARS. Also BDARS and FCCS staff will be reviewing the CMUs performance in linking referred families to services. Facilities having the lowest levels of appropriate reporting, based upon results of the audits, will receive remedial assistance from staff of the BDARS and FCCS.

c. Plan for the Coming Year

In 2013, CDC will continue to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance. Rutgers, the State University -- Bloustein Center for Survey Research will continue the making improvements to the Birth Defects & Autism Reporting System (BDARS).

BDR staff will continue to provide training, on an as-needed basis, to birthing facilities, autism centers, and Case Management Units in the use of the electronic BDARS. They will also continue to provide assistance to these entities as they transition from the paper-based system to the electronic system. Staff will continue to monitor the implementation of the electronic BDARS and will assist reporting agencies with concerns. Modifications and improvements will be added

to the BDARS to ensure it fully meets the needs of both the SCHS Registry and Case Management staff.

Site visits will be conducted in each of New Jersey's birthing hospitals and County Case Management Units to ensure proper usage of the new BDARS. Also BDARS and FCCS staff will be reviewing the CMUs performance in linking referred families to services. Facilities having the lowest levels of appropriate reporting, based upon results of the audits, will receive remedial assistance from staff of the BDARS and FCCS.

BDARS staff will continue to work with the agencies to ensure complete and appropriate referral to services, especially during the transition from paper forms to electronic registration.

Surveillance activities will expand due to the increase in readily available electronic data. These will include identifying any relationships between diagnoses, geographic and temporal patterns, and other descriptive statistics. BDR staff will continue to work with the agencies to ensure complete and appropriate referral to services, especially during the transition from paper forms to electronic registration.

State Performance Measure 7: Average age of diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					4.5
Annual Indicator			4.6	4.2	4.5
Numerator					
Denominator					
Data Source			SCHEIS, BDARS	SCHEIS, BDARS	SCHEIS, BDARS
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	4	3.5	3	3	3

Notes - 2011

Final 2011 data will be available Fall 2012.
 Numerators or denominators are not applicable.

a. Last Year's Accomplishments

This State Performance Measure was chosen to measure the timeliness of diagnosing autism in children. Early diagnosis is important for initiation of services, as children who receive services at an early age have better functional outcomes. Based on the most recent data available from the BDARS, the average age of initial diagnosis of an Autism Spectrum Disorder of children reported to the New Jersey Autism Registry is 4 years old. Although there is no time-line for diagnosing autism, the Registry encourages all reporting agents to quickly report children diagnosed with the Autism Spectrum Disorders because we link them to SCHS Case Management services.

While the causes of autism are not known, genetic and environmental factors are individually and in combination believed to have contributing roles. While there is no cure for autism, there are indications that a child's speech and cognitive development can be improved with early and intensive intervention. Appropriate diagnosis at an early age is an important precursor to ensuring

that families gain access to early and intensive intervention. In New Jersey, the average age of initial diagnosis of an Autism Spectrum Disorder of children reported to the registry decreased from 4.4 years old in 2009 to 4.2 in 2010. We believe this is due to our work with the Governor's Council on Medical Research and Treatment of Autism's Clinical Enhancement Center grant program which increased the number of diagnostic evaluations conducted during the grant months. Unfortunately funding for these clinical centers ended in the early part of 2011, thus, potentially affecting the timeliness of new diagnostic evaluations as seen in the slight increase of age of first diagnosis in 2011.

In order for this performance measure to be accurately determined, patients with autism in New Jersey need to be reported to the Autism Registry by licensed health care providers. BDARS staff have conducted outreach to educate and inform physicians and health facilities about the registry, how they can register children with autism living in New Jersey, and the rules regarding the Registry. Registry staff have visited and trained staff from medical centers specializing in child development and developmental evaluations. Additionally they have trained staff from several private pediatric practices. These included the six grant recipients of the Governor's Council for Medical Research and Treatment of Autism's Clinical Enhancement Center Program, located across the state, nine Child Evaluation Centers, and several psychiatric/behavioral departments located within hospitals. Staff from the Registry presented information concerning the Autism Registry to state and county case managers as part of training on the case management electronic component to the BDARS. Staff continues to conduct mailings to facilities, providers, organizations, and stakeholders who diagnose or treat children with autism, and continue to send out mailings on a periodic basis to newly identified providers. Staff has also created materials for both providers and families about autism. These include an autism website and conference presentations and exhibits.

DHSS has also addressed this performance measure by creating the Governor's Council on Medical Research and Treatment of Autism's Clinical Enhancement Center grant program. Through grant funding, clinical centers have increased the number of diagnostic evaluations that they conducted and have decreased their wait times for an evaluation, both factors that have the potential to impact age at first diagnosis. Additionally, several of the Centers provided outreach to primary care physicians to educate them about the red flags for autism and about the American Academy of Pediatrics' recommendation about screening for autism at specific well-child checks. NJ Pediatric Council on Research and Education (PCORE), through a subcontract with one of the funded Autism Clinical Enhancement Centers, has developed a curriculum to present at physician offices with the goal of increasing autism screening and therefore early identification and subsequent referral of those patients who are at risk of autism.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Audits of charts a yearly basis				X
2. Provider education				X
3. Annual Audits				X
4. # of families being offered services	X	X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2011, over 2,600 children were newly reported to the BDARS. This includes 381 registrations where the family chose to remain anonymous. Staff has stressed the importance of quickly reporting children diagnosed as having Autism by continuing to provide outreach about the Autism Registry through conference presentations and focused meetings. Staff participated in several exhibits including one at the NJ-AAP and one at the Autism NJ annual conference and have presented to a number of private pediatric offices throughout NJ. Staff continue to send out mailings on a periodic basis to newly identified providers and have recently created the layout of a new Autism Registry webpage which will include information for parents, providers, and researchers. This new website will go live next month.

Providers with untimely reporting to the Registry were contacted and reminded of the mandate to report and of the importance of the linkage to SCHS CMUs. Providers were educated as to their importance in the registration process and how faster registration enables children and families to more quickly obtain services through the SCHS CMUs. The electronic reporting component of the BDARS facilitated timelier reporting by facilities and since the BDARS added the SCHS CMU component, referral of these children to services is significantly faster.

c. Plan for the Coming Year

DHSS is addressing this performance measure through the Governor's Council on Medical Research and Treatment of Autism's Clinical Enhancement Center grant program. The first round of grants came to a close this year, but Registry staff continue to work closely with the Centers so that awareness of the Registry and the importance of linking children with autism to services early is emphasized. Additionally, several of the Centers continue to provide outreach to primary care physicians to educate them about the red flags for autism and about the AAP's recommendation about screening for autism at specific well-child checks. NJ Pediatric Council on Research and Education (PCORE) continues to present their curriculum to local physician offices to further the goal of increasing autism screening so that early identification and subsequent referral of those patients who are at risk of autism is achieved.

Staff will continue to focus on the importance of early identification of Autism. Outreach efforts will begin with harder to reach providers such as office-based pediatric offices and those not affiliated with a major hospital through mailings and collaboration with other state Departments such as the Department of Education and the Department of Human Services. Providers with less timely reporting to the Registry will continue to be contacted and reminded of the mandate to report and of the importance of the linkage to SCHS Case Management Units. The case management component of the BDARS will allow for an electronic assessment of referral rates. Registry staff will be able to use these reports to monitor timeliness as well as numbers. Quality Assurance visits to the sites of the six Governor's Council for Medical Research and Treatment of Autism funded Autism Clinical Enhancement Centers as well Child Evaluation Centers and other hospital based providers will be developed and completed to verify reported information.

The Department of Health and Senior Services committed to continuing efforts to reduce the age of first diagnosis of autism. The Governor's Council for Medical Research and Treatment of Autism has posted a new RFA to create a Statewide Autism Center of Excellence that contributes to efforts to reduce the age at which children with an ASD are identified.

E. Health Status Indicators

State MCH program activities have considerable breadth. In order to adequately describe those activities which fall outside the parameters of priority needs and National and State performance

measures outlined above, Health Status Indicators are reported separately on the HSI Forms 20 to Forms 21.

F. Other Program Activities

During CY 2011, the Family Health Line received and assisted 12,491 calls, and made 12,457 referrals. The Reproductive and Perinatal Health Services monitors the grant with the Family Health Line that is a component of the Center for Family Services, Inc. The Reproductive and Perinatal Health Services provides the Family Health Line with consultation, technical assistance and educational material support to facilitate its participation in community events and networking. The Family Health Line employs three clinical staff members who are responsible to answer the Perinatal Mood Disorders Speak Up When You're Down calls. They screen the callers and coordinate working with Mental Health Providers. During 2012, the Family Health Line made 758 referrals to programs supported by the Division of Family Health Services.

G. Technical Assistance

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	11683598	10024111	11683598		11883893	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	114269877	111691532	122664877		102687908	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	0	0	0		0	
7. Subtotal	125953475	121715643	134348475		114571801	
8. Other Federal Funds <i>(Line10, Form 2)</i>	66614954	66614954	61063711		72993711	
9. Total <i>(Line11, Form 2)</i>	192568429	188330597	195412186		187565512	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	7499733	9326280	7189574		6433878	
b. Infants < 1 year old	5126372	5483825	5266214		5463612	

c. Children 1 to 22 years old	6609841	10025854	6673794		7018560	
d. Children with Special Healthcare Needs	105600037	95885756	114226155		94676811	
e. Others	0	0	0		0	
f. Administration	1117492	993928	992738		978940	
g. SUBTOTAL	125953475	121715643	134348475		114571801	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	93713		97260		97260	
c. CISS	132000		0		0	
d. Abstinence Education	0		913938		913938	
e. Healthy Start	500000		500000		500000	
f. EMSC	0		0		0	
g. WIC	42885265		34535963		34535963	
h. AIDS	2260049		2318550		2318550	
i. CDC	3822731		2622765		2622765	
j. Education	10865873		10828899		10828899	
k. Home Visiting	0		0		11930000	
k. Other						
Family Planning	3534841		0		3143662	
HRSA	0		2870472		2870472	
PREP	0		0		1412929	
School Program	0		0		75598	
Social Service Block	0		1743675		1743675	
Coordinated School H	0		75598		0	
Family Planning	0		3143662		0	
PREP	0		1412929		0	
Others	2520482		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	88460440	91393396	101314434		81287527	
II. Enabling Services	18329977	15848433	18329977		18544278	
III. Population-Based Services	12459391	7533286	7009391		7209323	

IV. Infrastructure Building Services	6703667	6940528	7694673		7530673	
V. Federal-State Title V Block Grant Partnership Total	125953475	121715643	134348475		114571801	

A. Expenditures

Annual expenditures are summarized in below. The State Title V Programs Budget and Expenditures by Types of Service, parallels the MCH pyramid which organizes MCH Services hierarchically from direct health care services through infrastructure building services.

B. Budget

New Jersey has traditionally maintained commitment of State funding support for maternal and child health activities. Since 1989, maintenance of effort has included State appropriations for children with special health care needs and support for population based outreach and education for pregnant women and their infants to name a few.

State appropriations support a number of maternal and child health programs. In the State fiscal year 2013 budget most programs and services are maintained at the SFY 2012 levels. Due to the continuing state fiscal crisis, the proposed SFY 2013 budget includes reductions in a few service areas including postpartum depression education and the elimination of state funding for family planning. However, based on the critical nature of the budget deficit in the state the proposed budget demonstrates an ongoing commitment on the part of the State to support to the best of its ability services to the maternal and child health population. The following are the funding levels for programs and services for FFY 2013 that reach maternal and child health populations in New Jersey:

Birth Defects Registry	\$ 564,000
Cleft lip and palate projects	\$ 690,000
Infant mortality reduction including a new project focused on reduction of black infant mortality	\$ 2,000,000
Sudden Infant Death Syndrome	\$ 221,000
Newborn screening (revenue)	\$ 3,900,000
Postpartum Depression screening and referral	\$ 1,900,500
Early intervention for developmental delay/disabilities	\$ 88,300,000
Childhood lead poisoning prevention	\$ 985,000
Hemophilia services	\$ 1,245,000
Catastrophic illness in children relief fund	\$ 1,700,000
Handicapped children's fund, which is used to support subspecialty care and case management services	\$ 2,500,000
Fetal Alcohol Syndrome	\$ 570,000
MCH Services	\$ 5,500,000
Council Physical Fitness and Sports	\$ 50,000
Autism Registry	\$ 500,000

All of the funding sources are considered in the programmatic narrative portion of this application. There have been few variations in the allocation and expenditure of the federal/state partnership funds for maternal and child health over the last few years. This year state appropriations do not include cost of living increases and reductions are evident in a few areas including family

planning and early intervention.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.