



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

**State Narrative for  
New Jersey**

**Application for 2009  
Annual Report for 2007**



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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.***

### **B. Face Sheet**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **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; expires May 31, 2009.

### **E. Public Input**

***/2009/ To include public input into the annual development of the MCH Block Grant Application and Annual Report, a public hearing was held on May 20, 2008. A draft of the application narrative was posted on the Department's website four weeks prior to the public hearing. Notice of the public hearing was published in local newspapers throughout the State. Notification of the public hearing and availability of the draft application on the Department's website was be mailed to over 300 individuals on the Division of Family Health Services mailing list. Testimony was presented by five individuals.***

***Lauren Agoratus, a parent and NJ Coordinator for Family Voices at the Statewide Parent Advocacy Network, presented testimony supporting programs developed with MCH Block Grant funds for children with special health care needs (CSHCN) and voiced concern with the proposal of the Regional Early Intervention Collaboratives to be the single point of entry into early intervention. Marilyn Cohen from the NJ Federation of Cleft-Craniofacial Centers provided testimony supporting the MCH Block Grant in the areas of transitioning CSHCN to adulthood and oral health, and raised the issues of underinsurance and inadequate reimbursement for the management of clefts and craniofacial conditions. Susan Freedman, a county case manager for Special Child Health Services, and Kelly Hartigan, a parent, provided support for the county based case management system for CSHCN and called for additional funding support. Linda Doherty, the President of the NJ Food Council, voiced concern for the new WIC regulations and asked for flexibility in planning for their implementation.***

***The draft of the application narrative posted on the Department's website received over 950 viewer hits between April and June of 2008.***

***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 //2009//.***



## **II. Needs Assessment**

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

*An attachment is included in this section.*

### **C. Needs Assessment Summary**

The Needs Assessment must be submitted every five years. The last Needs Assessment was submitted in 2005, with the 2006 application and the 2004 annual report.

There have not been any significant changes to the Needs Assessment process that would require an update to the previously submitted Needs Assessment.

Attached is a brief seven page summary and overview of the Needs Assessment process.

### **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), contains a wealth of information concerning 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 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 with 8.7 million residents, it has no single very large city. Only six municipalities have more than 100,000 residents.

Compared to the nation as a whole, New Jersey is more racially and ethnically diverse. According to the 2006 New Jersey Population Estimates, 76.4% of the population was white, 14.5% was black, 7.4% was Asian, 0.3% was American Indian and Alaska Native, and 1.3% reported two or more races. In terms of ethnicity, 15.6% 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 2006, 25.9% of mothers delivering infants in New Jersey were Hispanic, 48.2% were white non-Hispanic, 15.1% were black non-Hispanic, and 9.1% 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 improving access to health services, reducing disparities in health outcomes and increasing cultural competency of services as three priority goals for the MCH population. Specific attention has been placed on the reduction of racial and ethnic disparities in black infant mortality, preterm births, childhood lead poisoning, obesity prevention, asthma prevention, newborn biochemical screening, reduction of risk taking behaviors among adolescents, and women's health.

In order to improve New Jersey's commitment to maternal and child health, Commissioner Heather Howard convened a Task Force charged to:

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

The Task Force is comprised of physicians, nurses, administrators and others with expertise in maternal and child health. The Task Force will meet monthly for approximately four months and develop concrete proposals to address this critical issue.

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 2008, \$5 million in state funding was again appropriated to enhance capacity of the health centers to increase primary care for underserved populations. In addition, \$40 million has been dedicated to reimbursement of uninsured primary care encounters through the FQHCs. In SFY 2009, reimbursement for uninsured care is expected to remain at \$40 million.

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 services, especially for children with special health care needs. Even with reduced financial barriers to health care for children, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services.

According to the Centers for Disease Control and Prevention's (CDC) most recent prevalence figures released through its Morbidity and Mortality Weekly Report (MMWR) of February 7, 2007, one of every 94 children in New Jersey has autism, which is the highest rate among the states examined by the CDC in the most comprehensive study of the prevalence of autism to date. Legislated initiatives within DHSS to address the needs of children and families affected by autism and autism spectrum disorders include:

- The transfer of the Governor's Council for Medical Research and Treatment of Autism (the Council) from the University of Medicine and Dentistry of New Jersey (UMDNJ) to the Division of Family Health at DHSS.
- Creation and maintenance of an Autism Registry which will include 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.
- Development of guidelines for health care professionals to use in evaluating infants and toddlers living in the State for autism to ensure timely referral to appropriate services as well as dissemination of information on the medical care of persons with autism to health care professionals and the general public.

To increase public awareness of Postpartum Mood Disorders (PPMD), in SFY 2006 a statewide campaign was launched "Recognizing Postpartum Depression: Speak Up When You're Down". The campaign includes a webpage that contains information on PPMD for women/families and a Webinar for health professionals. Brochures are available in English and Spanish and several other languages. A video in English and Spanish was produced. A toolkit containing brochures and a video was distributed to over 3000 professionals. Postpartum Depression Screening Legislation was enacted by the Senate and General Assembly and approved on April 13, 2006. The Act, P.L.2006, c. 12 amends N.J.S.A. 26: 2-175 et seq. and took effect on October 10, 2006. This law states that physicians, nurse midwives and other licensed health care professionals who provide prenatal care to women shall provide education to women and their families about PPD. Both fathers and appropriate family members shall be included in both the education and treatment processes to help them better understand the nature and causes of PPD. The law also requires health care professionals to screen all new mothers for PPD prior to and after being released from the hospital after giving birth. This campaign continues and new resources including support groups statewide are not available to women in need of services.

Both nationally and in New Jersey, obesity is a growing epidemic. The New Jersey Council on Physical Fitness and Sports, created under Public Law 1999 Chapter 265, held the 2nd Annual Leaders' Academy for Healthy Community Development conference in May 2007. Mini-grants of \$2,500-\$10,000 were awarded through a competitive grant process, to community based agencies/organizations (CBO's) to address the obesity problem within their community. The Leaders' Academy provides valuable information and skills for communities to develop plans which promote health and physical activity to impact obesity at the local level. The Second Annual Leaders' Academy for Healthy Community was held in May 2007. Additional mini-grants of \$2500 - \$10,000 will be awarded through a competitive grant process.

The Obesity Prevention Task Force, created under Public Law 2003, Chapter 303, was created to study, evaluate, and develop recommendations. The Obesity Prevention Action plan was

presented and accepted by the Governor in June 2006. On May 21, 2007 the DHSS announced the creation of a new Office of Nutrition and Fitness (ONF) to help lead New Jersey's fight against obesity. The ONF will work to implement the New Jersey Obesity Prevention Task Force's recommendations outlined in its 2006 report. The full report can be viewed on the department's web site at [www.nj.gov/health/fhs/documents/obesity\\_prevention.pdf](http://www.nj.gov/health/fhs/documents/obesity_prevention.pdf).

DHSS signed a multi-year memorandum of agreement to collaborate with Rutgers Cooperative Extension (RCE) for a statewide obesity prevention campaign called. "Get Moving, Get Healthy New Jersey! (GMGH NJ!). The goals of the GMGH NJ Obesity Prevention Campaign are two-fold: 1) New Jersey youth and families will make healthy eating and physical activity choices a part of their daily lives and 2) New Jersey DHSS and RCE will be recognized as the state leadership facilitating the collaboration of public and private partnerships to create a healthier New Jersey. DHSS submitted an application to the CDC in response to their funding opportunity announcement (FOA) for a Nutrition, Physical Activity, Obesity (NPAO) Program. If approved, funding in the amount of \$922,132 would provide core funding for our Department's efforts to prevent and control obesity and other chronic diseases through strategic public health efforts aimed to decrease obesity, increase physical activity and increase healthy food choices.

Promoting healthy and safe early childhood programs has also been on the State's agenda. In September 2005 New Jersey was one of 18 states that were awarded an Early Childhood Comprehensive Systems (ECCS) Implementation grant. The ECCS Team continues to work with a myriad of public and private agencies, including the Build NJ -- Partners for Early Learning and the Department of Human Services, Office of Children's Services that are charged with two other grant supported projects with similar and complementary goals. A priority of the ECCS Plan for 2007 is to launch a website as a resource for parents and caregivers. The website will include topical issues reflecting the five ECCS components -- access to care, social and emotional development, early care and education, parent education, and family support.

As a project with the Healthy Child Care New Jersey (HCCNJ) grant, a PLAY (Physical Lifestyles for Active Youngsters) Task Force was established in 2003 on the recommendation of the participants of the HCCNJ Advisory Board. The PLAY Task Force has now joined with the Interagency Council on Osteoporosis (IOC) to combine its efforts: 1) to promote physical activity in young children from birth to five and 2) to include early childhood nutrition principles and practices to develop lifetime habits for healthy eating. The work of the expanded PLAY Task Force includes the development of a preschool nutrition curriculum for children three to five years of age and was piloted at the 16th Annual Health in Child Care Conference on May 30, 2007. Ninety participants attended two workshop sessions. The Task Force will also be making recommendations to the Department of Children and Families, Office of Licensing to strengthen nutrition and physical activity regulations for children in licensed child care centers and registered family child care homes.

Systems building partnerships have expanded to include the newly established Department of Children and Families, Division of Prevention and Community Partnerships, the Head Start-State Collaboration Project and the Governor's Office. New Jersey was one of three states awarded the National Governor's Association Grant entitled "Supporting Gubernatorial Leadership for Building Early Childhood Systems". This grant will oversee coordination efforts across state agencies that work on early care and education initiatives with a particular emphasis on funding and data issues.

The Newborn Biochemical Screening Program currently screens every baby born in New Jersey for twenty disorders. The Newborn Screening Laboratory is currently working on validating its computer system and new mass spectrometers in order to prepare for expansion of its newborn screening panel to 45 disorders.

The Office on Women's Health (OWH), in the DHSS, has been very active over the past year. The OWH successfully implemented a women and heart disease awareness campaign by

supporting and coordinating with the Women's Heart Foundation in New Jersey. The second annual Women's Heart Walk was held, and throughout the past year professional and public educational activities have been conducted. Collaboration is essential to the success of this office.

## **B. Agency Capacity**

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 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 CSHCN.

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

The mission of Maternal, Child and Community Health Service (MCCH) 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. Reproductive and Perinatal Health Services, within MCCH, coordinates a regionalized system of care of mothers and children through the six 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.

The eight funded Healthy Mothers, Healthy Babies (HM,HB) Coalitions continue to reduce infant morbidity and mortality through outreach and education. The HM,HB Coalitions act as the Community Action Teams for Fetal Infant Mortality Review (FIMR) project.

In the Central New Jersey Maternal and Child Health Consortia (MCHC) through the Fetal and Infant Mortality Review (FIMR) maternal interviews, gaps in maternal services as well as knowledge of such issues as fetal movement were identified. The Central New Jersey MCHC is currently in the process of launching the "Have You Felt Your Baby Move Today" campaign. This initiative involves providers as well as consumer components. Additionally, the "My Prenatal Care Card" Initiative has been launched region wide.

The Regional Perinatal Consortium of Monmouth and Ocean's FIMR Case Review Team also found "lack of fetal movement awareness" and lack of maternal action an educational issue. The action plan included creating and mass distributing bookmark-sized education tools entitled "Did Your Baby Kick Today?" to all OB practices and prenatal clinics in the area.

The HM,HB Coalitions all provide formal and informal outreach worker training. Training topics include: immunizations, personal safety, lead screening, domestic violence, child growth and development, dental health, AIDS, asthma, smoking cessation, BMR, cultural competency, home safety, car safety, fatherhood, STI, nutrition, breastfeeding, postpartum depression, mental health, stress reduction, addictions, parenting and other topics identified by the outreach workers.

Outreach activities range from door to door canvassing to large community events. The HM,HB Coalitions sponsor community events such as Baby Showers, Baby Safety Showers, "Pregnant Pause" and Health Fairs; school-based events such as the "Game of Life", and Teen Awareness Days, and presentations for community groups and faith-based initiatives. Outreach efforts are also conducted wherever women gather such as grocery stores, hair and nail salons, laundromats and clinics.

HM,HB Coalition activities include the hiring of multicultural, multilingual staff and the recognition of changes in existing client bases. The New Brunswick Coalition has seen an increase in the Mexican population, the Paterson Coalition an increase in the Middle Eastern population and the Jersey City Coalition an increase in the Hispanic population. Religious affiliations are also changing with increases in the Muslim and Hindu populations. In addition to cultural changes the family unit is also changing - increased single-father households, increased multiple births, increased adolescent pregnancies and an increase in grandparents raising grandchildren. The Coalitions are responding by increasing Coalition membership from these groups. Professional and consumer education is also being expanded to include the unique needs of the population. The HM,HB Coalition of Jersey City awarded a subgrant to a community-based organization that demonstrated the capability to provide grassroots outreach and education that link vulnerable populations to community-based health care services. The Coalition is currently funding the Women Reaching Women program. This initiative targets African American women in the neighborhoods that have been identified as having the highest risk of poor birth outcomes. Through intensive outreach efforts, the Women Reaching Women program brings pregnant women into early prenatal care and through education the program promotes prevention and positive health choices. The program conducts comprehensive sexuality education in middle and high schools and provides cultural competence training for health care providers and community-based agencies.

Perinatal Addiction Prevention Services are also part of the Reproductive and Perinatal Health Services Program. Professional, public and patient education is offered regarding the effects of using alcohol, drugs and tobacco during pregnancy. Prenatal providers are encouraged to use a standardized screening tool with their patients.

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

The Child and Adolescent Health Unit, within MCCH, focuses on prevention initiatives in the areas of lead poisoning, injury and violence (including bullying and gangs), risk behavior reduction, through positive youth development approaches, obesity prevention through improved

nutrition and increased physical activity and school health. Special emphasis has been placed on outreach and education of health care providers and the public, to ensure the screening of children under six years of age for lead poisoning.

The Children's Oral Health Education Program provides a variety of age appropriate educational activities to school age children through support of regional programs. The voluntary weekly fluoride mouth rinse program, "Save Our Smiles" is targeted towards high risk children in areas that do not have optimally fluoridated water.

Adolescent Health primarily funds the Community Partnership for Healthy Adolescents initiative and FamCare's Adolescent Parenting Program in Cumberland County.

The Childhood Lead Poisoning Prevention (CLPPP) home visiting program is an outreach and lead case management system for children six years of age or younger. Thirteen sites throughout the State receive funding through this program to assess blood lead levels, immunization status, nutritional status, growth and developmental milestones, and parental-child interaction and then provide education and supportive guidance as required.

The goal of the CLPPP is to promote a coordinated support system for lead burdened children and their families through the development of stronger linkages with Medicaid HMOs, DYFS, community partnerships, Special Child Health Services, the Department of Education, Department of Community Affairs, and other community agencies providing early childhood services. Only through a coordinated effort by all these entities will the intensive case management needs of these families be addressed and preventive health strategies initiated.

Child Care Health Consultant Coordinators (CCHCCs) are located in the county resource and referral agencies statewide and are supported by Child Care Development Block Grant funds. In addition to providing on-site consultation, a broad range of health and safety topics are provided to child care providers, parents and children.

### 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. A priority for SCHEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. SCHEIS receives monthly printouts from the Social Security Disability Determination Unit that identify all children recently determined eligible for Social Security Insurance (SSI). Copies of the printouts are sent to the appropriate County Case Management Units. County Case Management Units outreach to all SSI applicants to offer information, referral, and case management services.

/2007/ This process is targeted for update in 2007 to improve transmission and management of data as well as follow-up and monitoring. Electronic transmission of SSI data from the State office to the County Case Management Units will be explored and piloted.//2007//

/2008/ Following input from the SCHS County Case Managers, the monthly SSI print-out format was revised into two reports: unduplicated live new referrals by month with an annual end-of-year cumulative report; and terminated children only. The intent of these revisions was to streamline the volume of data for improved ease in follow-up and improve control for duplicate referrals. State staff participated in an Office of Information Technology demonstration of the State Portal as a potential method for the County Case Managers to gain electronic access to the SSI print-out. Input from the end-users is being explored to determine needed hardware, training and cost for future implementation.//2008//

***/2009/ Revisions to the SSI print-out and the ability to use the State portal for access to an electronic report remain priorities.//2009//***

In addition, Individual Service Plans that address the medical, dental, developmental, rehabilitative, social, emotional, and economic needs of the child and/or family are developed. Periodic monitoring of needs and progress toward attaining services are also conducted.

/2007/ The Case Management monitoring tool currently used by State staff to evaluate development of Individualized Service Plans, compliance with SSI printout, reporting of linkage with medical home, and transition to adulthood is being revised and will be piloted in 2007.

//2007//

/2008/ The revised monitoring tool was used by State staff during site visits conducted twice a year and enabled staff to more closely target grantees' strengths, areas of improvement and need for technical assistance in a concise format. State staff is exploring further uses of the tool, including the development of a monitoring database.//2008//

/2007/ Maternal and Child Health Block grant funds were used in 2006 to support two significant initiatives intended to better provide transition to adulthood services for children and youth with special health care needs. Funding was allocated to support a collaborative effort with the Statewide Parent Advocacy Network for development of a New Jersey specific transition to adulthood tool intended for use by families of CSHCN and providers. This effort is slated for continuation in 2007, through a Letter of Agreement proposed by the DHSS and the New Jersey Council on Developmental Disabilities. In addition, funding also has been allocated to support a Memorandum of Agreement with Rutgers University to conduct a transition to adulthood needs assessment. This transition to adulthood activity is targeted for completion in 2006 and will include an analysis of State and Local Area Integrated Telephone Survey (SLAITS) data, interviews with 48 families of CSHCN, and interviews of pediatric and adult providers.//2007//

/2008/ The New Jersey specific Roadmap to Transition CD was developed and is being distributed statewide, including plans to post to SPAN and the Department's websites. Updates to the CD will continue as funding allows. Champions for Progress is exploring posting the CD on its website as an example of State interagency collaboration. //2008//

/2008/ A transition to adulthood needs assessment was conducted by Rutgers University which included a New Jersey specific analysis of 2000-2002 SLAIT data, pediatric specialist and adult medical provider interviews and interviews of families of children with special needs aged 16-26 years with one of the following diagnoses: Cleft Palate, Spina Bifida, Diabetes or Sickle Cell. The needs assessment was intended to determine a better understanding of the factors and issues that facilitated successful transitions as well as those barriers which prohibit the transition process. Although the sample sizes were small, the findings suggested several resources that may be helpful in facilitating transition, including family supports in the form of educational resources, workshops and tools such as lists of providers. These families would also benefit from more assistance from social service providers about their specific adult services and involvement of their pediatricians and adult doctors throughout the transition process. Physicians would also benefit from more assistance from specific providers and information on special needs, such as having a case manager to help adolescents moving toward adulthood, parent support resources and creating a "transition time." //2008//

**/2009/ The 21 Special Child Health Services Case Management Units continue to distribute resources to families of children with special health needs, including information from the Roadmap to Transition. This computer disk (CD) was developed through a collaborative agreement with the Statewide Parent Advocacy Network, Inc. (SPAN). SPAN likewise distributes fact sheets excerpted from the CD to pediatrician's offices where they are made available to parents or reviewed by the health practitioners in preparation for a doctor visit. //2009//**

Although not directly supported by Title V funds, a statewide family service network providing comprehensive medical and social services to women, infants, children and adolescents for children and their families affected by HIV are also administered within SCHEIS. Through Robert Wood Johnson Medical School, the Network employs a Community Liaison to publicize the Network, provide education related to HIV disease management for consumers and providers,

and provide linkages for clients to ancillary services. This network consisting of seven sites has enabled service to over 4,200 clients in 2004.

/2007/ Access to clinical trials remained a priority for Ryan White Part D clients, and the Network facilitated enrollment of 69 children, 73 adolescents, 49 adult women and 19 adult males, 2,341 patients received clinical trial education.//2007//

/2008/ Access to clinical trials remained a priority for RWTIV clients, and the network facilitated enrollment of 71 children, 115 adolescents and adult women and 8 men. //2008//

SCHEIS works with parent groups, specialty providers and a statewide network of case managers to provide family-centered, community-based, coordinated care for Children with Special Health Care Needs (CSHCN) 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.

SCHEIS attended the Champions for Progress Meeting in April of 2004. The meeting was sponsored by HRSA and the University of Utah. The purpose of the meeting was to gather information on how Title V agencies across the varied states work cooperatively with their Medicaid counter parts and their parent networks. The meeting was attended by a resource parent from SPAN and a representative from Medicaid Managed Care, as well as a nurse consultant from SCHEIS. An opportunity was offered to apply for a project grant. SCHEIS case management offered technical assistance to SPAN to apply for this stipend. SPAN has received the grant and will use the monies to enhance adolescent children's transition to adulthood. Representatives from SCHEIS Case Management and Specialized Pediatric Services participate on the SPAN Champions Center Incentive Award titled Transition from Youth to Adult Services within a Culturally Competent Medical Home for Youth with Disabilities or Special Health Care Needs, providing technical assistance and support, and liaison between the Champions and MCH Block activities.

/2007/ In August 2005, SCHEIS and SPAN attended the national Champions for Progress Meeting in Utah, presenting a poster-board overview of their collaboration on transition to adulthood activities, including the statewide Transition Roadmap Advisory Committee activities. The focus of the Transition Roadmap Advisory Committee is to address the healthcare disparities surrounding children and adolescents with special health care needs in accessing their transition to adult services. An interactive CD Roadmap is being developed to assist adolescents, families and professionals to know about the availability of services in New Jersey.//2007//

/2008/ Using a combination of financial support from the Champions for Progress initiative, Title V, and in-kind support from students and teachers at the Academies at Englewood the New Jersey specific Transition Roadmap was completed. This New Jersey specific tool was widely distributed statewide for use by youth, parents and professionals in planning and implementing transition to adulthood.//2008//

***/2009/ The Roadmap to Transition CD has been revised and updated. It serves as a resource to youth with special health care needs and their parents through the Case Management Units.//2009//***

An additional collaboration targeting improving access to specialty care and coordination with primary care for new and current patients with Epilepsy was launched in 2005. SCHEIS supported the Epilepsy Foundation of NJ, Inc.'s application to HRSA, and funding was obtained to collaborate with community based specialty providers, including Jersey Shore University Medical Center. In 2005, SCHEIS served on the statewide learning collaborative to explore community based health care needs for children with epilepsy.

/2008/ SCHEIS continued to participate with the statewide learning collaborative. This collaborative effort yielded a Toolkit for parents and physicians that included information and resources related to seizure disorders.//2008//

/2008/ SCHEIS Birth Defects Registry and Family Centered Care Services staff were invited to

participate on an E-MCH Webcast: Birth Defects and Developmental Disabilities Prevention: State and Local Collaborative Efforts. Sponsored by the National Association of County and City Health Officials (NACCHO) and CityMatCH the broadcast provided a forum by which New Jersey shared its system of early identification, care coordination and State and local health department collaboration in serving CSHCN.//2008//

***/2009/ State SCHEIS staff presented resources and supports for families with children with special health needs during the SPAN, Inc. sponsored Lunchtime Teleconference Health Advocacy Series. This collaborative presentation reached nearly 100 parents and providers statewide. //2009//***

Project Care, in existence since 1986, provides statewide family support by fourteen paid parents of CSHCN housed in 10 County Case Management Units. In addition, financial support through Project Care partially subsidized the annual SPAN conference for CSHCN.

/2007/ This process is targeted for update in 2007 to improve transmission and management of data as well as follow-up and monitoring. Electronic transmission of SSI data from the State office to the County Case Management Units will be explored and piloted.//2007//

/2008/ SPAN and SCHEIS have continued to collaborate to identify resources to expand the number of Resource Specialists (trained support specialists) on site at the SCHS Case Management Units particularly in the southern New Jersey counties. This effort remained pending. On average, statewide the Resource Specialists reported individual parent and professional contacts of approximately 1,050 per quarter.//2008//

***/2009/ Contingent upon the availability of funding, an additional five Parent Resource Specialists have been trained and will be housed this spring at the following five southern counties; Cape May, Cumberland, Burlington, Salem and Gloucester. Funding to support this expansion of family support resources at the SCHS Case Management Units was identified by SPAN through a parent training grant. This collaborative initiative will bring the total number of case management units with onsite part-time family support up to 15 counties. //2009//***

Parent-to-Parent is a telephone support service that matches trained volunteer support parents with other parents of children who have similar health care needs. Nearly 81 support parents were trained in SFY 2004 and 174 matches were made.

/2007/ Matches remained stable in 2005. In January 2006, the ninth anniversary of NJ Parent to Parent, a major milestone was achieved with celebration of the 1,000 match since inception of the project. In addition, SPAN is piloting an outreach and support program to parents of babies hospitalized in neonatal intensive care, based on the NJ Parent to Parent model.//2007//

/2008/ Parent to Parent is anticipated to lead the planning effort and collaborate with the New Jersey EHDI program in sponsoring the 2nd annual Family Learning Day. The focus of the event is to provide hearing loss related educational materials and resources to parents, children and youth as well as professionals. In 2006, Parent to Parent averaged over 25 parent matches per quarter and continues to outreach and support families of CSHCN.//2008//

***/2009/ Parent to Parent continues to train volunteer support parents, having matched 1,380 families to date. Planning for the spring 2009 3rd Family Learning Conference for families of children who are deaf and/or hard of hearing is underway and Parent to Parent is collaborating with the DHSS, Early Hearing Detection and Intervention, Family Centered Care Services staffs; DHS, Division of the Deaf and Hard of Hearing staff, and other non-profit agencies to plan the event. //2009//***

The third program within Family WRAP, Family Voices New Jersey (FVNJ), focuses on education, advocacy, medical home, and expanded outreach to families of CSHCN. The New Jersey Coordinators of FVNJ provided training and technical assistance in the first 9 months of SFY 2004 to approximately 12,000 parents and professionals. A brochure describing Family WRAP is provided to each family served through the county case management units.

/2007/ In 2005, a total of 20,000 combined parent and professional contacts were reported by the FVNJ Coordinators.//2007//

/2008/ FVNJ continued its outreach and support of families of CSHCN, with an average of 7,000

contacts/quarter, providing information and technical assistance to parents and professionals. On average, SPAN reported nearly 11,600 hits to the Family WRAP component of the SPAN website, and 3,335 visits to the Medicaid Managed Care fact sheets.//2008//  
***/2009/ FVNJ continued its efforts to outreach and support families of CSHCN, and provided information and technical assistance to 7,953 parents and providers. //2009//***

SCHEIS and SPAN have successfully collaborated to apply for supplemental funding for Family WRAP activities from local philanthropic organizations including the Essex Healthcare Foundation targeting Essex County and the Van Houten Foundation targeting Bergen and Passaic efforts, and the Health Resources Services Administration's Early Hearing Detection Intervention (EHDI) project. In FY 2004 Family WRAP's involvement with New Jersey's EHDI project included: targeted outreach to parents, organizations, and agencies that provided family support to children who are deaf or hard of hearing; training of 8 volunteer support parents of children that are deaf and/or hard of hearing; and development of a flyer (in English and Spanish) to educate parents about newborn hearing screening follow-up. Expanded cultural competency efforts include recruiting support parents among the Chinese and Haitian/Creole communities to organize focus groups and enhance outreach efforts.

### **C. Organizational Structure**

The organizational structure of the New Jersey Title V program has not changed since the submission of the FFY 2002 application. All Maternal and Child Health (MCH) programs including programs for Children with Special Health Care Needs (CSHCN) continue to be 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.

Attached to this section is an organizational Chart for the Division of Family Health Services.

An organizational chart for the New Jersey Department of Health & Senior Services is available at <http://atdhss/hr/orgmain.pdf>.

***An attachment is included in this section.***

### **D. Other MCH Capacity**

Maternal and Child Health Epidemiology Program

The Maternal and Child Health Epidemiology Program (MCH Epi) is under the direction of Lakota Kruse, M.D., M.P.H., Medical Director for the Division of Family Health Services. The Office of the Medical Director provides medical and epidemiological consultation for all the division's programs. The mission of 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. Ingrid Morton is the Program Manager for MCH Epi, which is comprised of four 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.

## Maternal, Child and Community Health (MCCH)

MCCH is comprised of two program managers, 39 professionals, and 24 support staff. All staff members are housed in the central office. Dr. Linda Jones-Hicks became the Service Director for MCCH in January 2004. Dr. Jones-Hicks is a pediatrician with specialty training in Adolescent Medicine and experience with several MCH coalitions in New Jersey. Among the professional staff are individuals with nursing, social science, environmental, nutrition, statistical, epidemiology, and other public health backgrounds.

/2007/ MCCH has three major programs: Reproductive and Perinatal Services, Child and Adolescent Health and the Children's Oral Health Education Program.//2007//

/2008/ MCCH is comprised of two program managers, 29 professionals, and 18 support staff. //2008//

Reproductive and Perinatal Health Services is staffed by 14 professionals and 7 support personnel and a Program Manager, Sandra Schwarz. 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, the HealthStart comprehensive maternity services, Family Planning, the Black Infant Mortality Reduction Initiative, perinatal addictions and fetal alcohol syndrome prevention projects, post partum wellness initiative and preconceptual health. Resources for staff have been from Federal MCH Block, Federal Title X, Preventive Health and Health Services Block, and Healthy Start Grants.

The Child and Adolescent Health Unit is comprised of a staff of 13 professionals, 6 support personnel and a Program Manager. Resources include: State MCH funds, Federal MCH Block Grant, Preventive Health and Health Services Block Grant, Centers for Disease Control and Prevention, 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 is divided into early childhood and adolescent health sections. The early childhood section has a coordinator and eight professionals. The Project Director for the Healthy Child Care New Jersey Project and New Jersey's Early Childhood Comprehensive Systems grant is included in the early childhood section. The adolescent health section includes school health, the Community Partnership for Healthy Adolescents initiative, an Adolescent Parenting Program and is headed by a Program Manager with a staff of three professionals. Child and Adolescent Health staff have varied professional backgrounds including nursing, nutrition, family counseling, health education, environmental health, and research and data analysis.

/2007/ The Program Manager for the Child and Adolescent Health Unit is Cynthia Collins.//2007//

/2008/ In concurrence with the NJ Department of Education (DOE) and DHSS, Governor Corzine determined that New Jersey could not assure compliance to the eight elements as mandated in the federal 2007 State Abstinence Education Program application. In particular, New Jersey's concern relates to the required mandate of teaching that abstinence until marriage is the only expected standard of behavior and that sex outside of marriage has harmful psychological and physical effects. As specified in the guidelines for funding, these tenets are not meant to be limited to children only. The State has an inclusive approach to comprehensive sexuality education as specified in the Core Curriculum Content Standards. In addition, N.J.S.A. 18A: 35-4.20 et seq. requires schools to emphasize abstinence and also permits contraception instruction, but the law does not mandate an "abstinence-only" approach as required by Title V funding. Therefore DHSS made the decision not to apply for federal fiscal year (FFY) 2007 State Abstinence Education Program funds from the U.S. Department of Health and Human Services.//2008//

**/2009/ In Collaboration with the DOE, New Jersey submitted a successful application to the CDC for a Coordinated School Health Program. Funding in the amount of \$420,000 per year began March 1, 2008. This funding provides one dedicated FTE school health position in DHSS, Child and Adolescent Health Unit and two dedicated FTE school health positions in the DOE.**

***DHSS submitted an application for the CDC in response to a funding opportunity announcement for a Nutrition, Physical Activity, Obesity (NPAO) Program. Funding in the amount of \$922,132 has been requested. If approved, funding would begin June 30, 2008 and support positions and activities in the Office on Nutrition and Fitness. //2009//***

The Children's Oral Health Education Program comprised of 1 professional and 1 support staff 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.

#### Special Child Health and Early Intervention Services (SCHEIS)

Special Child Health and Early Intervention Services (SCHEIS) consists of the following programs and services: Early Identification and Monitoring, Newborn Screening and Genetic Services Program, Family Centered Care Services, and Early Intervention Services. Gloria Rodriguez is the Director of SCHEIS. All SCHEIS staff members are housed in the central office. 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.

***//2009/ Dr. Marilyn Gorney-Daley returned to SCHEIS in November 2007. As the Medical Director, she oversees all autism initiatives, including the Governor's Council for Medical Research and Treatment of Autism; she is board certified in General Preventive Medicine and Public Health. //2009//***

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), Early Hearing Detection and Intervention, the New Jersey Center for Birth Defects Research and Prevention and the National Down Syndrome Study. 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. An additional 5- year CDC cooperative agreement was awarded to the EIM Program in September 2003. This funding will be utilized to enhance data linkage and exchange between the SCHS Registry and the Family Centered Care Program.

*//2007/ The CDC Cooperative agreement for the Centers for Birth Defects Research and Prevention and the NIH funded National Down Syndrome Study ended in 2005. One professional staff member retired and another was reassigned to the MCCH Program.//2007//*

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 8 professionals and two support staff.

*//2008/ In addition, there are three vacant Public Health Representative 1 positions and one Public Health Representative 1 Bilingual position. The Newborn Screening Program has requested and received permission to fill these vacant positions and the hiring process is currently underway. Funding for staff, as well as specialized pediatric treatment programs is provided through a Newborn Screening Laboratory fee and MCH Block Grant as well as State designated appropriation. Dr. Tajwar Aamir, a board certified pediatrician, currently serves as the Program Director for Newborn Screening and Genetic Services as well as Medical Director for Special Child Health and Early Intervention Services.//2008//*

***//2009/ In FY 2008, two open positions for Public Health Representative I were filled. The***

***third position was changed into a bilingual position and a Public Health Representative II-bilingual was hired. This move was necessary in order to better serve the diverse population of New Jersey. The program currently has three open positions, which are one Public Health Representative I, Research Scientist I and a secretarial position. The Program is awaiting exemption determination from the state wide hiring freeze in order to fill these positions. //2009//***

The Family Centered Care Program (FCCS) 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 Lisciotto, RN, MSN. The Coordinator of Special Child Health Services, Case Management is Mrs. Bonnie Teman, RN, MSN.

***//2009/ Mrs. Bonnie Teman, Coordinator, SCHS Case Management and Mrs. Pauline Lisciotto, Program Manager, Family Centered Care Services attended the National Family Voices conference and accepted the Mary Clarkson Professional Partner Commitment to Kids Award on behalf of New Jersey's CSHCN programs efforts to support children and families. //2009//***

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.

## **E. State Agency Coordination**

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. Specific programs include the activities of eight Healthy Mothers Healthy Babies Coalitions, Perinatal Addictions Prevention Projects, Post Partum Depression education projects, preconceptional health counseling, regional Childhood Lead Poisoning Prevention Coalitions, and facilitation of the Black Infant Mortality Reduction initiative. These activities have continued to expand during the reporting period and have gained the attention of other department programs.

A representative from Reproductive and Perinatal Health Services serves as the liaison to two of the NJ Healthy Start Projects and is responsible for the collaboration and coordination of the New Jersey Healthy Start Projects with Department activities and programs. This collaboration helps to assure integration of services and the effective use of both State and Healthy Start funds to eliminate disparities in women's and infant's health.

The DHSS has a seat on the Child Fatality and Near Fatality Review Board (CFNFRB). Staff from Family Health Services represents the Commissioner of Health and Senior Services on this board. A major outcome of the relationship with the CFNFRB is to work towards a coordinated effort of mortality/morbidity review in New Jersey.

Staff from Reproductive and Perinatal Health Services participates in the Steering committee for

Promoting Safe and Stable Families (Title IV-B) within the Department of Human Services. Efforts continue to enhance and increase the community-based delivery of family-preservation, family support, time-limited family re-unification and adoption promotion and support services.

***/2009/ The Perinatal Addictions Prevention Project addresses prevention of Fetal Alcohol Spectrum Disorders (FASD) and other substance use/abuse issues through screening, prevention, education and referral to treatment. Through the Office of Prevention of Mental Retardation and Developmental Disabilities (OPMRDD), the Fetal Alcohol Spectrum Disorder (FASD) Task Force was convened to assess and make recommendations regarding FASD prevention. The Task Force has expanded its focus to include alcohol, tobacco and other drug use during pregnancy. The five year strategic plan was finalized in 2008. //2009//***

In SFY 2002, state funds became available for establishment of prevention, diagnosis and treatment centers for Fetal Alcohol Spectrum Disorders (FASD). In SFY 2003, \$450,000 was again awarded to SCHEIS, Specialized Pediatric Services, to continue the Centers of Excellence for diagnosis, treatment, and education. With these funds, four child evaluation centers (2 are multi-agency collaborative projects), continue to function as centers of excellence and in FY 2003, one center also received a CDC regional centers grant to develop a core curriculum to be used nationwide to educate health care professionals on FASD. The staff of the Centers are in contact with the FASD Task Force, the MCH Consortia, the Department of Education, The ARC, and other state and community agencies who serve the FASD community. Additional funds in the amount of \$400,000 were awarded to the Reproductive and Perinatal Health Services for the Perinatal Addictions Prevention Project through the MCH Consortia. This program provides for professional and community education regarding the use and abuse of alcohol, drugs and tobacco during pregnancy. This regional approach reaches both the public and private sector providers of care to ensure access to risk reduction assessment and intervention.

A function of the FASD Centers is to provide FASD community based outreach and education for the public and providers. Audiences targeted for outreach and education included Department of Children and Families, schools, parent-teacher organizations, Head Start, medical grand rounds and radio public service announcements. The Centers also developed and maintain an education and resource based web site, [www.fasnj.org](http://www.fasnj.org), which is in its fourth year of operation.

Teen pregnancy prevention is at the forefront in NJ. The Advisory Council on Adolescent Pregnancy Prevention held its first meeting in April 1999. The Council is in, but not of, the Department of Health and Senior Services. Representation includes designees from the Departments of Human Services, Education, Community Affairs, and Labor. Some of the Council's responsibilities include development of policy proposals, promoting a coordinated and comprehensive approach to the problems of adolescent pregnancy and parenting, and promoting community input and communication. The Council has established working groups on data, male involvement, school-based services and teen parenting. In 2003, the Council developed a three-year strategic plan to guide the work of the Council and focus on specific areas of interest.

The WorkFirst Teen Pregnancy Prevention Work Group is another example of successful interdepartmental collaboration. The Department of Human Services serves as lead agency for this initiative and the group has been charged with planning, developing and implementing new initiatives. Using TANF grant funds, \$1.1 million was allocated for Teen Pregnancy Prevention Initiatives. Youth-to-youth programs and mentoring projects are now underway and a Teen Pregnancy Resource Center has been established. MCCH staff participate along with representatives of the Departments of Human Services and Education.

More emphasis is also being placed on facilitating health and safety in child care settings. Collaboration between the DHSS and the NJ Department of Human Services, Division of Family Development over the past four years has resulted in the establishment of an infrastructure to promote the health and development of young children in child care settings. A child care health

consultant coordinator is on staff at each of NJ's 21 county child care resource and referral agencies. Nurses from local health departments and other community agencies have been trained to be health consultants to their local child care providers.

The collaboration between DHSS and the NJ Department of Children and Families includes not only the Division of Family Development but also the Office of Child Care Licensing. Staff from both Divisions actively participate on the Early Childhood Comprehensive Systems Team, HCCNJ Executive Board, the PLAY Task Force, and the Medication in Child Care and Communicable Disease Committees. A particular benefit from the collaboration with the Office of Child Care Licensing has been the ability to make recommendations based on the National Health and Safety Performance Standards for Out-of-Home Child Care Programs that have strengthened child care regulations in NJ concerning health and safety issues.

/2007/ The first meeting of the Public Health Practice Standards Task Force for Infants and Preschool Children was convened on February 23, 2005. Members of that Task Force include representatives from public health nursing, county Child Care Health Consultants Coordinators, child care resource and referral agencies, health officers, child care center and family child care providers, Head Start, NJ State Nurses Association, NJ Society for Public Health Educators and parents. Four strategies (child health conference guidelines for service, child care health consultation, home visiting and professional development to support the first three) have been selected with recommendations to be made to the Office of Public Health Infrastructure by October 1, 2006.//2007//

/2008/ Recommendations were presented to the Office of Public Health Infrastructure in October 2006. The priority for the current grant year is the development of assessment, documentation, tracking and evaluation tools to support the implementation of the recommendations. Also to be developed is a Maternal and Child Health Community Assessment Tool to identify the needs of the early childhood population and to set priorities accordingly. The quarterly Child Health Regional Network meetings will be utilized as one of the professional development venues to support the Performance Standards recommendations.//2008//

/2008/ The theme for the annual Health in Child Care Conference in May 2007 is "Partnerships for Healthy Lifestyles". Margaret Fisher, MD, FAAP, Medical Director of The Children's Hospital at Monmouth Medical Center, presented the keynote address concerning preventing obesity beginning in early childhood. Participants in the four-day child care health consultation training have included a number of school nurses providing health services in Abbott preschool programs, particularly in Essex and Mercer County.//2008//

**/2009/ The theme for the Annual Health in Child Care Conference in May 2008 was "Making a Difference for All Children". A keynote panel presented on "Hope for Children with Autism: Research & Experience."//2009//**

/2008/ A collaborative project with Prevent Child Abuse New Jersey and the Prevention Subcommittee of the NJ Task Force on Child Abuse and Neglect, Home Visiting Workgroup, resulted in the development of a model for a Comprehensive System for Home Visiting in New Jersey. This work also resulted in the application and award of a Robert Wood Johnson grant for a statewide Home Visiting Training Academy. One of the priorities for 2007 is the development and piloting of a training curriculum for public health nurses.//2008//

**/2009/ A two-day public health nurse home visiting curriculum pilot training was conducted on June 15 and 22, 2007. Participants to this training included 17 public health nurses from seven counties. Incorporated into the pilot training was the piloting of various assessment and documentation tools. Most important was the Maternal and Child Health Community Assessment tool, designed to be used to identify early childhood population needs and gaps as well as to set priorities for service delivery within their identified community.//2009//**

In January 2004 the DHSS initiated a process to develop an Early Childhood Comprehensive Systems (ECCS) Plan for NJ and in September 2005 NJ was awarded a grant to implement its

plan. Partners with DHSS on the ECCS Planning Team include the NJ Departments of Human Services, Education, Community Affairs, Environmental Protection, and Labor, and the Juvenile Justice Commission. Community partners include the Association for Children of NJ, the Youth Consultation Service, Healthy Child Care NJ, Children's Futures, and the University of Medicine and Dentistry of NJ. The Planning Team also includes three parent members. To facilitate the process, the ECCS team is collaborating with an existing statewide program, the BUILD NJ Partners for Early Learning initiative and the Department of Human Services, Office of Children's Services, Division of Prevention and Community Partnerships (OCS/DPCP).

/2007/ As part of the OCS/DPCP efforts for systems building, DHSS was invited to join with the Department of Education to pilot a Strengthening Families Initiative (SFI) in eight communities statewide. The SFI was launched on January 31, 2006 with teams comprised of individuals from the participating Abbott Pre-K programs and child care centers, and parents from each of those sites, and representatives from the health, education, child care and social services community who will be implementing SFI principles in each of the pilot sites.//2007//

/2008/ Due to reorganization within the Department of Human Services and the subsequent establishment of the Department of Children and Families, the SFI activities were interrupted but reconvened in the fall of 2006. The Division of Prevention and Community Partnerships is supporting the efforts of SFI and has also announced the expansion of home visiting grants that promote healthy growth and development of children and preventing child abuse and neglect through parent education and family support. The Early Childhood Health Link quarterly newsletter is being used to promote the adoption of SFI principles in child care centers across the state. The lead article in the 2007 Spring Edition of the newsletter will be the first in a series of articles to provide ways that early childhood professionals can support families in their children's healthy growth and early learning. With funding from the ECCS a three-day Parent Leadership training was conducted in October 2006 by the Statewide Parent Advocacy Network with 30 parents statewide to enhance parent involvement in advocating for the needs of children and their families.//2008//

***/2009/ This year the Division of Prevention & Community Partnership (DPCP) has worked closely with eight pilot sites monitoring their progress as they implemented the Strengthening Families Initiative Framework. A statewide Strengthening Families Task Force played a key role in promotion the program and developing strategies to incorporate its use throughout the state.//2009//***

The Children's Oral Health Education Program works with a variety of collaborating partners on oral health education age appropriate activities. The DHSS maintains a Memorandum of Agreement (MOA) with the University of Medicine and Dentistry-NJ Dental School for the provision of dental health consultative services to the Program. Arnold Rosenheck, D.M.D., Assistant Dean at UMDNJ continues to serve as dental consultant.

/2008/ In support of the ECCS grant goals and objectives for early childhood systems building, a collaboration with the Head Start-State Collaboration Project, a federal grant was submitted and awarded to convene an Early Childhood Oral Health Forum in May 2007 to address the oral health needs of underserved children in Head Start, Early Head Start, and children in child care settings. The forum was held on May 10th and the outcome from the forum provided information for the development of a state wide pediatrics oral health plan for children zero to six. The plan is expected to be completed in the spring of 2008.//2008//

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.

In February 2005, an intradepartmental meeting was held to build relationships and improve

intradepartmental communication; identifying existing resources (programs/services) so that a "Resource Guide to School Health Programs" can be developed; identify a plan for marketing the adoption of the Coordinated School Health Program (CSHP) model across all State Departments; and strengthen the joint statement between the Departments by establishing an interdepartmental memorandum of understanding (MOU) that would outline the roles and responsibilities of each Department. The intent of the MOU would be to institutionalize a CSHP within the current structure of the NJ state government. In other words, create infrastructure capacity for a CSHP. /2007/ The "Resource Guide to School Health Programs" report was created and distributed.//2007//  
/2008/ The "Resource Guide to School Health Programs" was updated and distributed.//2008//  
**/2009/ DHSS/Collaborated with DOE on its successful application to CDC-DASH for a Coordinated School Health Program. Funding began on March 1, 2008. Funding will provide one FTE School Health Coordinator in DHSS. //2009//**

Another collaborative training between DHSS and the Department of Education and facilitated by the Association of Maternal and Child Health Programs (AMCHP), took place in January 2005. The training focused on strengthening a State and Education Agency Partnership to Improve HIV, STD and Unintended and Teen Pregnancy Prevention in Schools. As a result of attendance at this training, NJ's draft vision statement is "To create and maintain a collaborative infrastructure that maximizes resources and results in more assessable and effective sexual health programs (including health services) for youth". In the next 6 months, the NJ team plans to: 1) contact and invite School-Based Youth Service Programs and Family Planning to join the State team; and 2) DHSS/DOE to share in scheduling and planning 2 meetings between February and June 2005 to discuss funding sources/budget, grant priorities, objectives, projects and activities.

/2007/ In January 2006 the partnership scheduled a meeting with Public/Private Ventures to present information on the Annie E. Casey Foundation's Plain Talk model program for possible joint funding.//2007//

/2008/ In January 2007, FHS provided funding support to the Division on AIDS for the implementation of the Annie E Casey Foundation's model program: Plain Talk in Vineland Cumberland County "Plain Talk" is a pro-active, community-based intervention that outreaches to adults-parents, family or other supportive adults -- and educates them on adult/teen communication related to responsible sex, access to contraception and comprehensive sexual education. It is proven to be effective in reducing teen pregnancy, STI's and HIV/AIDS in Latino, African American, white and Asian teens. The cost of implementing this model in NJ is approximately \$85,000 for a community size of 5-7,000.//2008//

**/2009/ The Plain Talk Coordinator and the Executive Director of the implementing agency, Martin Luther King in Vineland, both vacated their positions after the completion of the mapping process. This has resulted in a significant delay in program implementation, with the potential threat that Plain Talk will not implemented. //2009//**

The Community Partnership for Healthy Adolescents (CPHA) is coordinating with the Office of Public Health Infrastructure's Community Health Partnerships. The Community Health Partnerships are being implemented in each NJ county with funding from the CDC and NACCHO. The funding supports a team that includes a planner, public health partnership coordinator, health educator/"risk communicator", public health nurse, information technology person, secretary, and perhaps, a part-time medical director. The Community Health Partnerships were established in the fall of 2004 and by spring of 2005, they are expected to be implementing MAPP (Mobilizing for Action through Planning and Partnerships) where information and data will be collected for a comprehensive needs assessment.

/2007/ In 2006 the Community Health Partnerships are expected to begin the MAPP (Mobilizing for Action through Planning and Partnerships) process, collecting information and data for a comprehensive needs assessment.//2007//

/2008/ The Community Health Partnerships have completed their comprehensive needs assessment of the MAPP process. The top five prior public health issues, by county, should be available by June 2007.//2008//

**/2009/ The CPHA Adolescent Coordinators have been given contact information for the**

**Community Health Partnership Coordinators and encouraged to partner/coordinate/collaborate on shared issues including nutrition, physical activity and obesity; violence; and school health. //2009//**

Coordination between the State's Primary Care Association and Federally Qualified Health Centers continues. In 2005, a new Office of Primary Care was created. The Coordinator of Primary Care works out of the Office of Primary Care. The Federal Primary Care Cooperative Agreement is administered by this office.

Special Child Health and Early Intervention Services (SCHEIS) and the Statewide Parent Advocacy Network (SPAN) continue to collaborate to improve services to CSHCN, including transition to adulthood services. The Essex County SPAN Resource Specialist, (parent of a CSHCN) initiated a pilot project on transition to adulthood. A transition to adulthood information packet template evolved from the pilot project. County specific resources are incorporated to include local resources, and the packet is given to youth served through the SCHEIS case management units.

/2008/ In addition, a collaboration between SCHEIS, SPAN, the Academies at Englewood, NJ Council on Developmental Disabilities and Champions for Progress has produced a NJ specific transition to adulthood compact disc (CD) for use by youth, parents and professionals. The CD was widely distributed statewide. //2008//

To assist families of children with special needs in navigating the Medicaid Managed Care system a Medicaid Managed Care Alliance was formed in October 1999. This alliance is comprised of parents, advocacy groups, representatives from the DHS Office of Managed Care, NJ FamilyCare, HMO case managers, SCHEIS case managers and others. It promotes collaboration between HMO case managers and the County Case Management Unit staff which has proven valuable in problem solving access to appropriate specialized pediatric services, payments for non-covered medical and or social services for CSHCN, and smoother transition between systems of care such as Early Intervention, Medicaid model waivers, and special education. In October 2002, Medicaid Managed Care Alliance members were invited to participate in a meeting focusing on the reorganization of SCHEIS services and ongoing efforts to achieving community based systems of care for CSHCN and their families. This meeting successfully linked SCHEIS state staff and grantees with parents, Medicaid HMO case managers and the Department of Human Services Quality Assurance and Monitoring staff, and led to closer working relationships at the county and provider agency level. This cooperative relationship continues between the county case management units, the Medicaid HMO case managers and the DHS Quality Assurance and Monitoring staff. Likewise, it has facilitated dialogue between the specialized pediatric services' providers and families in easing access to pediatric specialty care. **/2009/SCHEIS representatives participate on the statewide Medical Assistance Advisory Council (MAAC). Administered by the DHS, MAAC participants include intergovernmental, community based providers, consumers and advocates. This workgroup provides a forum for discussion of process, updates and changes to State Medicaid programs that could affect services to the disabled community, and affords participants the opportunity to provide input into access to services.**

**/2009/ The Reproductive and Perinatal Health Services (RPHS) coordinated the Preconceptional Health Promotion/Folic Acid Initiatives in 2007. More recently in 2008, FCCS staff participated in the Medical Assistance Advisory Council (MAAC). Housed in the Department of Human Services, the MAAC is a formal interagency committee with a diverse membership representing managed care providers, consumers, advocates and State agencies. The Council meets quarterly and the Director of the Division of Medical Assistance and Health Services provides an update on Medicaid, especially Medicaid managed care. The MAAC provides a forum for sharing updates and issues as well as lack of folic acid intake, were selected for educational emphasis through the six Maternal and Child Health Consortia (MCHC). The RPHS continued its affiliation with the National Council on Folic Acid (NCFA), and received monthly "Folic Acid News" updates that were,**

*electronically, transmitted to the Folic Acid Coalition of NJ membership. //2009//*

*//2009/ During CY 2007, the Reproductive and Perinatal Health Services distributed 11,010 preconception health brochures, 3,230 folic acid, and 3,885 Postpartum Depression (PPD) equal to a grand total of 18,125 brochures in English and Spanish among target group populations. These materials were disseminated through the eight Healthy Mothers, Healthy Babies (HMHB) Coalitions, the Family Health Line that operates the 1-800-328-3838 hotline, health fairs and community events. Some of the events were the Latino Expo Women's Trauma Conference, the Adolescent Health Institute with the Binational Health Fair of the United States and El Salvador//2009//*

/2007/ In 2005, SCHEIS and the five Cleft Lip Cleft Palate Craniofacial Centers comprising the NJ Federation of Cleft Palate-Craniofacial Centers, Inc. initiated dialogue with the Department of Human Services, Office of Medicaid Managed Care dental consultant to facilitate access to comprehensive center based care. Issues discussed included reimbursement for team services and coordination of in and out of network benefits. This dialogue has further developed and a productive meeting was conducted in March of 2006, including representatives from Medicaid, the Medicaid Managed Care Organizations, the Cleft Lip Cleft Palate Craniofacial Centers, the regional Medicaid Assistance Customer Centers and State staff to network, clarify roles and ensure that patients may be treated by a team without fragmentation of care or services.//2007//

/2008/ A positive outcome of this collaboration was a clearer understanding of roles and responsibilities as well as communication regarding clients' needs.//2008//

SCHEIS has a seat on the Division of the Deaf and Hard of Hearing's (DDHH) Advisory Council. EIM Staff and staff from the DDHH have implemented quarterly meetings in order to coordinate and implement activities to strengthen the Early Hearing Detection and Intervention Program.

/2008/ SCHEIS staff provided in-kind support at Family Day, a parent training and resource day held at Katzenback School for the Deaf. This collaborative effort organized by the DDHH served approximately 50 families of children that are deaf or hard of hearing as well as nearly 50 professionals.//2008//

The "Children's System of Care" initiative has been initiated in three (3) counties, which will be a new system of comprehensive services for children with mental illness or severe emotional and behavioral problems. State funds of \$39 million have been committed to create this centralized system. SCHEIS staff both welcome and anticipate collaborative efforts regarding this initiative. Currently, SCHEIS staff is represented on the Community Mental Health Board and Planning Council.

Through the activities of the NJ Center for Birth Defects Research and Prevention, staff from Special Child Health and Early Intervention Services are building collaborative relationships with numerous agencies in NJ. Additionally, Centers' staff has developed a strong network with the other ten national Centers and other researchers. The focuses of the collaborations have been to improve the surveillance of birth defects and to initiate a variety of research projects to further the understanding of the causes of birth defects. Among the funded projects is the formation of a fetal abnormality registry, which will document the occurrence of birth defects among pregnancies as opposed to live births. This data is critical for calculating accurate rates of the occurrence of birth defects, including better information on the evaluation of the impact of folic acid on pregnancies affected by neural tube defects. Other examples of local research projects are a study of hypercoagulability study and the investigation of the role of endocrine disruptors on the occurrence of hypospadias.

## **F. Health Systems Capacity Indicators**

### **Introduction**

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

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	61.7	54.4	47.7	50.1	50.1
Numerator	3529	3138	2687	2801	2801
Denominator	571925	577339	563900	558994	558994
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	Provisional

**Notes - 2007**

Final 2006 data reported as required estimate for 2007. Final 2007 data will be available in 2009.

**Notes - 2006**

Source: 2006 Hospital Discharge Records from the New Jersey DHSS Health Care Financing Systems.

Hospital discharge records count unique hospital stays for children not unique children hospitalized.

**Notes - 2005**

Source: Provisional 2005 Hospital Discharge Records from the New Jersey DHSS Health Care Financing Systems.

Hospital discharge records count unique hospital stays for children not unique children hospitalized.

Population from US Census -

<http://www.wnjpin.net/OneStopCareerCenter/LaborMarketInformation/lmi02/NJ06AgeSex.xls>

**Narrative:**

The DHSS funds the American Lung Association of MidAtlantic (ALAMid), to support the infrastructure of the Pediatric/Adult NJ Jersey Thoracic Society. It has developed the "Pathway to Asthma Control in NJ," that outlines strategies and initiatives to address the asthma burden. PACNJ maintains 6 task forces including: Quality, Community, Schools, Child Care, Environment, and Evaluation. The 6 task forces are an integral component to PACNJ's success. The task forces meet to identify, review and design the various objectives and interventions. With the support of staff and resources from PACNJ and its member organizations, the task forces design and implement the various strategies/activities identified in the implementation plan. The Asthma Coordinator and Epidemiologist for FHS serves on the PACNJ Coordinating Committee. The Coordinator is co-chair of the Environmental Task Force and the Epidemiologist is co-chair of the Evaluation Task Force. Other state staff, particularly those on the State Asthma Committee, attend PACNJ meetings and participate in activities.

***/2009/ The Asthma Awareness and Education Program (AAEP) and PACNJ redefined and expanded its scope in addressing asthma statewide, the major goal will be to: improve health outcomes for NJ residents with asthma. This goal will be accomplished through: 1) a delivery of care systems change in the NJ FQHCs; 2) increasing the use of Asthma Treatment Plans (ATPs); 3) improving provider and consumer knowledge of asthma management; 4) creating a systems change in schools and day care centers to***

accommodate a healthy environment for children with asthma; 5) reporting work related asthma (WRA) triggers and providing interventions to prevent the occurrence of asthma-related emergencies in the workplace; 6) creating a system that provides feedback to FQHCs regarding their patients that visit the ED and which triggers follow-up care by the FQHCs for those patients; and 7) implementing public health activities to reduce asthma mortality and morbidity, with particular emphasis on asthma in children and other disproportionately affected populations.

**Significant accomplishments include:**

On October 12, 2007, the Third Annual NJ Asthma Summit was held with over 230 healthcare professionals attending the half-day event in New Brunswick. The Summit was co-sponsored by the Central NJ Maternal and Child Health Consortium. The conference focused on various approaches to asthma management and the objectives included: 1) Increase understanding of the CDC approach to addressing asthma; 2) Enhance awareness about the role of cultural competency in the management of asthma; 3) Increase knowledge of work-related asthma and associated interventions; and 4) Increase understanding of the importance of environmental exposure in the control of asthma. Summit presentations were on: 1) Topics covered National Perspective on Asthma Care and Public Health Initiatives; 2) Asthma and Cultural Competency; 3) Occupational Asthma and 4) Environmental Asthma.

Emergency department visits have decreased in Black and Hispanic children < 5 years (7% from 2004 to 2006 per group).

Asthma hospitalization rates for Black children < 5 years has decreased by 18% from 2004 to 2006 and for Hispanic children < 5 years a decrease of 25% from 2004 to 2006.

PACNJ continues to serve as the statewide coalition on asthma awareness. PACNJ has over 150 participating member organizations and 6 active task forces working with schools, physicians, health insurance companies, community groups, and environmental agencies to reach all individuals in NJ with the most effective methods for managing their asthma. The PACNJ is undertaking the following initiatives:

- School nurse asthma training;
- Policies and practices for asthma friendly childcare trainings;
- Distribution of the Asthma Action Plan, a form that allows parents, school nurses and pediatricians to personalize for individual children a plan for managing their asthma;
- Pilot train the trainer programs in 3 cities with highest asthma hospitalization rates;
- "PACNJ Asthma Friendly School Award" recognizes schools for their commitment to enhance the quality of education for students and staff with asthma. To date, over 300 schools have received the AFSA;
- PACNJ testified before the Assembly Regulatory Oversight Committee meeting on the coalition's asthma activities and sustainability;
- Received EPA's Indoor Air Quality Tools for Schools "Special Achievement Award" for outstanding commitment to a healthy school environment; and
- Referenced as a coalition model in the Institute of Medicine's report "The 1st Annual Crossing the Quality Chasm Summit." //2009//

**Health Systems Capacity Indicator 02:** The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	87.6	94.7	94.7	0.0	90.5

Numerator	29639	35668	35668	0	36166
Denominator	33845	37646	37646	56371	39971
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

**Notes - 2007**

Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 3/17/2008.

**Notes - 2006**

Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 3/15/2007.

Numerator: 56.371

Denominator: 39,762

Numerator exceeds denominator due to multiple screens reported for the same individual under 1 year of age.

**Narrative:**

Medicaid in NJ is administered by the Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in Medicaid.

One of the major focuses of the Childhood Lead Poisoning Prevention Projects (CLPPP) is to promote proper use of preventive health services by the families of children who are lead burdened and at high risk of preventable health and developmental problems. CLPPP nurse case managers work with the parents of these children to encourage their enrollment in Medicaid or NJ FamilyCare (if eligible), and the use of preventive and primary care pediatric services, particularly immunization and lead screening. There are CLPPPs in 13 communities.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1	1	1	1	1
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

**Notes - 2007**

Data for HSCI #3 is currently not available. An estimate of the indicator using the percentage of periodic screenings for all New Jersey FamilyCare enrollees under age 1 is available from the Annual EPSDT Participant Report. The estimate for 2007 is 36,166 / 39,971 = 90.5%.

**Notes - 2006**

Data for HSCI #3 is currently not available.

**Narrative:**

New Jersey FamilyCare is New Jersey's SCHIP. It is administered by the Division of Medical Assistance and Health Services (DMAHS) in the New Jersey Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in NJ FamilyCare.

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	64.5	65.2	65.3	65.0	65.8
Numerator	69617	72865	72085	72675	72506
Denominator	107927	111749	110364	111727	110168
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	Provisional

**Notes - 2007**

Source provisional 2007 Electronic Birth Certificate file.  
HSCI #04 - 2007 provisional data is for percent of NEWBORNS

Final 2007 data will be available in 2009.

**Notes - 2006**

Source 2006 Electronic Birth Certificate file.  
HSCI #04 - 2006 data is for percent of NEWBORNS

**Notes - 2005**

HSCI #04 - 2005 provisional data is for percent of NEWBORNS (not mothers 15 - 44) born to women 15-44 whose observed to expected prenatal visits are >= to 80% on the Kotelchuck Index from the EBC (as of 5/25/2006). Birth records with missing information necessary to calculate the Kotelchuck Index have been excluded from the demonimator.

**Narrative:**

The Healthy Mothers, Healthy Babies (HM, HB) Coalitions promote early and continued prenatal care through community education and outreach. Education is provided to both the consumer and the provider. Consumers are educated on the importance of prenatal care at community events and at formal and informal education sessions. Educational sessions are held in the community at housing developments and places of worship and at provider locations such as the WIC clinic and Social Service office. Health and social service providers are educated on how to eliminate barriers to the receipt of early and continued prenatal care including cultural competency, flexible scheduling, public transportation friendly locations and hiring of multi lingual, multi cultural staff. Outreach efforts included door to door canvassing to identify pregnant women and connect them to care, case management of high risk women to ensure the continued receipt of care and locating pregnant women who have missed a prenatal appointment and reconnecting them to care.

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	96.8	97.5	57.7	59.4	61.8
Numerator	182592	181724	290478	317312	335797
Denominator	188557	186477	503008	534469	542985
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

**Notes - 2007**

Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 3/17/2008.

Numerator reports eligibles (0-21 yrs) receiving at least one initial or periodic screen which is an under estimation of Medicaid eligibles receiving a service paid by the Medicaid Program. A report that documents Medicaid eligibles receiving a service paid by the Medicaid Program has been requested but is not available from DHS. Monthly enrollments are available at their website [http://www.state.nj.us/humanservices/dmahs/enrollment\\_reports.html](http://www.state.nj.us/humanservices/dmahs/enrollment_reports.html)

**Notes - 2006**

Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 3/15/2007.

Numerator reports eligibles (0-21 yrs) receiving at least one initial or periodic screen which is an under estimation of Medicaid eligibles receiving a service paid by the Medicaid Program.

**Notes - 2005**

Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 2/18/2006.

Numerator reports eligibles (0-21 yrs) receiving at least one initial or periodic screen which is an under estimation of Medicaid eligibles receiving a service paid by the Medicaid Program.

**Narrative:**

New Jersey FamilyCare is New Jersey's Medicaid Program. It is administered by the Division of Medical Assistance and Health Services (DMAHS) in the New Jersey Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in NJ FamilyCare.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	33.3	33.9	33.3	39.9	43.7
Numerator	29393	31823	36065	41222	51042
Denominator	88358	93858	108419	103251	116822
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

**Notes - 2007**

Source: Form CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services  
2007 report dated 3/17/2008.

**Notes - 2006**

Source: Form CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services  
2006 report dated 3/15/2007.

**Narrative:**

Based upon 2007 data, a total of 51,042 (43.7%) eligible 6 -- 9 year old children received dental services during 2007 out of 116,822 children eligible for EPSDT services. Dental initiatives undertaken to promote utilization of dental services are:

-MD Education Regarding Dental Referrals -- EPSDT Screenings: A letter was sent to all Medicaid/NJ FamilyCare Primary Care Physicians (General Practice, Family Practice, Internal Medicine, Pediatricians) and Nurse Practitioners (Family, Pediatrics, Community Health, School Health) enlisting their help in the eradication of childhood dental disease by performing a dental inspection during the EPSDT physical examination and making referrals to a dentist within the timeframes recommended by the Medicaid/NJ FamilyCare program or whenever dental disease is identified.

- Oral Health Stuffer: A stuffer, aimed at increasing utilization of dental services by educating beneficiaries and/or parent/caretakers about the importance of good oral health and the relationship to good overall health, was developed and distributed to Medicaid/NJ FamilyCare families.
- Quarterly Dental Director's Meetings: Office of Quality Assurance conducts quarterly meetings with the HMO dental directors to discuss quality issues including EPSDT.
- Annual Report of EPSDT Performance Measures: The Office of Quality Assurance contracts with the Peer Review Organization of New Jersey to conduct an annual study of HMO

EPSDT performance.

- HMO Annual Assessment: DMAHS conducts annual assessments of HMO performance, which includes questions in the dental element regarding measures taken to improve utilization of dental services for EPSDT eligibles.

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	73.3	62.5	60.0	60.0	58.4
Numerator	5500	5000	4800	4500	4500
Denominator	7500	8000	8000	7500	7700
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	Provisional

**Notes - 2007**

Estimated by SCHEIS from monthly SSI reports. Final 2007 data will be available in 2009.

**Notes - 2006**

Estimated by SCHEIS from monthly SSI reports.

**Narrative:**

SCHEIS continues to ensure that Supplemental Security Income (SSI) beneficiaries less than 16 years old received rehabilitation services. Although SCHEIS does not provide direct rehabilitative services to SSI beneficiaries, the program does provide the outreach and case management services to ensure that SSI beneficiaries receive these necessary services. In New Jersey, SSI beneficiaries who meet family income guidelines are eligible for comprehensive Medicaid benefits, which include the rehabilitative services of audiology, physical, occupational, and speech therapy. All New Jersey children applying for SSI disability are referred by the State SCHEIS office to the County Case Management Units through a letter of agreement with New Jersey Department of Labor, Disability Determinations.

In 2004, approximately 3100 SSI beneficiaries less than 16 years old will have had an Individual Service Plan including rehabilitative services developed for them by the County Case Management Units. Approximately 25% of the children in active case management caseload are SSI recipients. In an effort to improve outreach to SSI beneficiaries, the Department has modified the database forwarded by Disability Determinations to access beneficiary's telephone numbers. It is anticipated that this additional information will improve outreach efforts and result in an increase in SSI beneficiaries served.

//2007/ In 2005, approximately 3,000 children served through County Case Management were identified as SSI recipients. The referral process is targeted for update in 2007 to improve transmission and management of data as well as follow-up and monitoring. Electronic transmission of SSI data from the State office to the County Case Management Units will be explored and piloted.//2007//

/2008/ Approximately 3,000 children served through the County Case Management Units were identified in 2006, and 26% of the children in the active case management caseload were SSI beneficiaries. Efforts to revise the report were successful in reducing duplicate referrals per month. Plans for 2007 include further revising the report format to presort live and expired referrals, and piloting an electronic report.//2008//

**/2009/ The SSI report generated by the State Data Exchange was revised to reflect; live, terminated, and terminated-expired children to facilitate timely follow-up and referral.//2009//**

**Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)**

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2003	matching data files	9.4	7.8	8.1

**Narrative:**

The BIMR, HM,HB, FIMR, FAS, Perinatal Addictions, Post Partum Depression Initiative and HealthStart initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR projects are designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of direct health service grants. HM,HB Coalitions are designed to improve early prenatal care utilization (NPM #18) and birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FAS and Perinatal Addictions Prevention Projects (SP #9) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. The HealthStart initiative provides comprehensive health services and maternity and newborn services for high-risk women and infants.

See Chart #5 'Low Birthweight by Race/Ethnicity' attached to Section III. State Overview for trend data.

**Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births**

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000	2003	matching data files	7.6	6.5	6.7

live births					
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**Narrative:**

The BIMR, HM,HB, FIMR, FAS, Perinatal Addictions, Post Partum Depression Initiative and HealthStart initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR projects are designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of direct health service grants. HM,HB Coalitions are designed to improve early prenatal care utilization (NPM #18) and birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FAS and Perinatal Addictions Prevention Projects (SP #9) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. The HealthStart initiative provides comprehensive health services and maternity and newborn services for high-risk women and infants.

See Chart #7 Infant Mortality Rates by Race/Ethnicity' attached to Section III. State Overview for trend data.

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2003	matching data files	57.3	85.2	80

**Notes - 2009**

Data is from a file created by the MCH Epidemiology Program by matching the Electronic Birth Certificate file to the Hospital Discharge files and Infant Death Certificate files. Most recent year available is 2003. Calculated rates/percents may not match rates/percents from the official Birth Certificate files.

**Narrative:**

The BIMR, HM,HB, FIMR, FAS, Perinatal Addictions, Post Partum Depression Initiative and HealthStart initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR projects are designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of direct health service grants. HM,HB Coalitions are designed to improve early prenatal care utilization (NPM #18) and birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FAS and Perinatal Addictions projects (SP #9) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The

hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. The HealthStart initiative provides comprehensive health services and maternity and newborn services for high-risk women and infants.

***//2009/ In order to improve New Jersey's rate of first trimester prenatal care, the DHSS Commissioner convened a Prenatal Care Task Force of stakeholders with representatives from the following organizations: American College of Obstetricians and Gynecologists (ACOG); New Jersey Obstetric and Gynecologic Society (NJOGS); New Jersey Maternal Fetal Medicine Society; New Jersey Academy of Family Physicians; Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN); American College of Nurse Midwives; New Jersey State Nurses Association (NJSNA); March of Dimes, New Jersey Chapter; New Jersey Family Planning Association; New Jersey Hospital Association; Hospital Alliance of New Jersey; New Jersey Primary Care Association; Maternal and Child Health Consortia and The Department of Human Services, Division of Medical Assistance and Health Services.***

***It is expected that the Task Force would meet for a period not to exceed six months. Background material and data trends along with other references will be provided to the Task Force at the first meeting. The Task Force will submit a report to the Commissioner upon completing their deliberations. //2009//***

See Chart #2 '1st Trimester Prenatal Care Initiation by Race/Ethnicity' attached to Section III. State Overview for trend data.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2003	matching data files	52.6	67.8	60.1

**Notes - 2009**

Data is from a file created by the MCH Epidemiology Program by matching the Electronic Birth Certificate file to the Hospital Discharge files and Infant Death Certificate files. Most recent year available is 2003. Calculated rates/percents may not match rates/percents from the official Birth Certificate files.

**Narrative:**

The BIMR, HM,HB, FIMR, FAS, Perinatal Addictions, Post Partum Depression Initiative and HealthStart initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR projects are designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of

direct health service grants. HM,HB Coalitions are designed to improve early prenatal care utilization (NPM #18) and birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FAS and Perinatal Addictions projects (SP #9) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. The HealthStart initiative provides comprehensive health services and maternity and newborn services for high-risk women and infants.

***//2009/ In order to improve New Jersey's rate of first trimester prenatal care, the DHSS Commissioner convened a Prenatal Care Task Force of stakeholders with representatives from the following organizations: American College of Obstetricians and Gynecologists (ACOG); New Jersey Obstetric and Gynecologic Society (NJOGS); New Jersey Maternal Fetal Medicine Society; New Jersey Academy of Family Physicians; Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN); American College of Nurse Midwives; New Jersey State Nurses Association (NJSNA); March of Dimes, New Jersey Chapter; New Jersey Family Planning Association; New Jersey Hospital Association; Hospital Alliance of New Jersey; New Jersey Primary Care Association; Maternal and Child Health Consortia and The Department of Human Services, Division of Medical Assistance and Health Services.***

***It is expected that the Task Force would meet for a period not to exceed six months. Background material and data trends along with other references will be provided to the Task Force at the first meeting. The Task Force will submit a report to the Commissioner upon completing their deliberations. //2009//***

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Infants (0 to 1)	2007	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Infants (0 to 1)	2007	350

**Narrative:**

The Medicaid Program in New Jersey is located in the Department of Human Services. Pregnant women with incomes below 185% of the Federal Poverty Level are eligible for Medicaid Health Start comprehensive maternity services. The comprehensive services include medical care, case coordination, health education and psychological services.

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
---	-------------	--

<b>pregnant women.</b>		
Medicaid Children (Age range 1 to 18) (Age range to ) (Age range to )	2007	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 18) (Age range to ) (Age range to )	2007	350

**Notes - 2009**

Medicaid eligibility guidelines are summarized at  
<http://www.njfamilycare.org/pages/whatItCosts.html>

**Notes - 2009**

Source: SCHIP eligibility guidelines at  
<http://www.njfamilycare.org/pages/whatItCosts.html>

**Narrative:**

The Medicaid Program and SCHIP Program in New Jersey are located in the Department of Human Services. Pregnant women and children with incomes below 185% of the Federal Poverty Level are eligible for Medicaid. The comprehensive services include medical care, case coordination, health education and psychological services.

The percent of poverty level for eligibility in the SCHIP Program for infants and children 1 to 18 is 350%.

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2007	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2007	350

**Notes - 2009**

Source: <http://www.state.nj.us/humanservices/dmahs/pregnantwomen.html>

**Narrative:**

The Medicaid Program and SCHIP Program in New Jersey are located in the Department of Human Services. Pregnant women with incomes below 185% of the Federal Poverty Level are eligible for Medicaid. The comprehensive services include medical care, case coordination, health education and psychological services.

The percent of poverty level for eligibility in the SCHIP Program for pregnant women is 350%. Several initiatives including Healthy Mothers/Healthy Babies and Healthy Start promote the early enrollment and full participation in the Medicaid and SCHIP Programs.

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

**Notes - 2009**

**Narrative:**

The goals of the State Systems Development Initiative (SSDI) grant within the MCH Epidemiology Program focus on Health Status Indicator (CHSI) #9A for building data capacity in MCH. The first goal of the grant focuses on improving linkages of MCH datasets and the second goal of the grant focuses on improving access to MCH related information. Linking MCH related datasets is important to the needs assessment process for communities and the evaluation of program services. Assuring access of FHS to MCH related datasets is important to improving the reporting of Title V MCH Block Grant Performance/Outcome Measures and to improving the delivery of services to the MCH population.

Our vital statistics files, Medicaid files and programmatic data files all provide some information

about the status of health in the MCH population and the effectiveness of MCH programs. However, no file alone provides the full picture of what happens to pregnant women, infants and children. In order to accurately assess the continuum of events that lead to favorable or unfavorable outcomes, files and information systems should be linked.

MCH Epi has been able to both link records across files and longitudinally across health care related events in a mother's life. A combined dataset was created for the years 1996 through 2003 containing the electronic birth certificate, mother and newborn hospital discharge records, and infant death certificates for all NJ births. Data from this dataset are used to support research projects that focus on welfare reform and immigrant health, foreign-born mothers and issues related to health disparities, and maternal mortality review in New Jersey.

Six years of asthma-related hospital discharge data have been longitudinally linked to create a wealth of information surrounding hospitalizations for children with asthma. This dataset is being used to enhance our asthma surveillance system as well as examine issues related to repeat admissions, and asthma severity.

The MCH Epidemiology Program with CDC funding has also implemented the Pregnancy Risk Assessment Monitoring System (PRAMS) Survey in collaboration with the Bloustein Center for Survey Research at Rutgers University. Additional funding was obtained from the Comprehensive Tobacco Control Program within the NJDHSS to include questions concerning maternal smoking. Data from this survey will be used to identify high-risk pregnancy groups and to target programmatic interventions.

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	No
New Jersey Youth Tobacco Survey	3	No

**Notes - 2009**

**Narrative:**

The New Jersey Youth Tobacco Survey (YTS), based on a model developed by CDC, is administered by the Comprehensive Tobacco Control Program. This bi-annual survey is administered to a sample of students in grades seven through twelve.

***/2009/ The 2006 YTS report is available at the website - [http://www.state.nj.us/health/as/ctcp/documents/2006\\_njyts\\_report.pdf](http://www.state.nj.us/health/as/ctcp/documents/2006_njyts_report.pdf). Current cigarette smoking prevalence among high school students fell from 27.6% in 1999 to 15.8% in 2006./2009//***

## **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 the next page, 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.

### **B. State Priorities**

#### **SP #1. Reduction of Adolescent Risk Taking Behaviors**

DHSS currently funds 8 Community Partnerships for Healthy Adolescents (CPHA) in 7 counties. In 1998, 9 grantees were selected through a competitive process to develop Community Partnerships. In 2003, these grants were re-competed, resulting in the current funding of 8 grantees. Each of the grantees has an Adolescent Health Plan to address the priority health issues of its adolescent population and has implemented activities since July 2003.

The goal of these Partnerships is for local health departments, community-based organizations, schools, and health care providers to coordinate and collaborate on programs and activities that reduce risk-taking behaviors and promote healthy behaviors among adolescents. Each Partnership's activities are based on a local needs assessment that prioritized the adolescent health issues in that community. An Adolescent Health Plan is developed by a network of stakeholders to comprehensively address these issues. DHSS guidelines encourage the Partnerships to address sexual behaviors (unintended pregnancy, and sexually transmitted infections including HIV), injury and violence including bullying and gang prevention, nutrition and physical activity and substance use/abuse.

The CPHA function through an established infrastructure which consists of youth-serving stakeholders and youth. The interventions implemented by the Partnerships incorporate youth asset development and utilize "best practices" or "model" programs.

/2007/ Approximately 64,100 adolescents, 10-17 years old, were served in 2005.//2007//

/2008/ Almost 56,000 adolescents, 10-17 years old, were served in 2006.//2008//

#### **SP #2. Reducing Black Infant Mortality**

The Northern NJ MCH Consortium has been funded to serve as the Black Infant Mortality Reduction (BIMR) Resource Center under the BIMR Initiative since 1999. The Center acts as a clearinghouse, providing literature, statistics, and other information on black infant mortality. In 2004, Dr. Jones-Hicks and Ilise Zimmerman were invited to the federal Department of Health and

Human Services to present New Jersey's approach to reducing the high incidence of black infant death.

//2008/ In 2006, a Request for Proposal was released for BIMR. This RFP focused on modifying the behaviors, lifestyle and conditions that affect birth outcomes, by improving and providing quality care during the prenatal and infant period. 7 health service grants addressing BIM were awarded in December 2006.

The Central NJ MCH Consortium will implement an initiative to take a culturally sensitive, multi-facet approach to the BIMR program. They will conduct education workshops for the general community and establish county-based groups for working professional pregnant women. They will educate healthcare providers on issues related to cultural competency, psychosocial stressors, risk behaviors and other topics associated with BIMR.

The Hudson Perinatal Consortium will provide outreach to pregnant and childbearing black females and conduct intensive and individualized education and provide referrals to other social and health care services. The program will co-sponsor presentation on BIMR and culturally competent care.

The Newark Department of Health and Human Services will provide prenatal and postnatal healthcare and social service support to the Newark black mothers, their infants and their families. These women enrolled in to the BIM program will receive a risk assessment, care plan, and referral to needed services and follow-up. The program will provide educational sessions on BIM to all women of childbearing age and their family.

The Southern Jersey Family Medical Centers, Inc is a federally qualified health center and Health Start provider, which provides primary health and social services. The Center will provide case management, health education and social services to black pregnant women and their infants.

The Isaiah House will provide direct service to the client population as well as to the staff of agencies and care providers who serve them. "Portable" information and educational material will be developed in the form of video-taped presentations, discussion groups and other health resources which will be converted to DVD format and distribute to black women of childbearing ages. All of the information and videos will also be available on a webpage added to Isaiah House's website.

The Northern NJ Maternal Child Health Consortium will establish a multi-faceted communication program to reduce the incidence of BIM in their region. The goal of the program is to provide preventive education and increase access to health and social services for black women of childbearing age and their children.

The Regional Perinatal Consortium of Monmouth and Ocean Counties, Inc will provide programs to achieve an increase in awareness of BIM issues in Monmouth and Ocean counties through comprehensive education, social support, and culturally competent case management. These services will focus on African Americans in an effort to close the gaps in education, healthcare services, and social services provision that currently exist in their region.//2008//

### SP #3. Reducing Teen Pregnancy

Several inter-agency initiatives have been developed to address this priority.

The Advisory Council on Adolescent Pregnancy Prevention was established in 1999 to develop policy proposals, to promote a coordinated and comprehensive approach to the problems of adolescent pregnancy and parenting, and to promote community input and communication. In 2003, the Council developed a 3-year strategic plan to guide the work of the Council and focus on specific areas of interest. The WorkFirst Teen Pregnancy Prevention Work Group lead by the DHS has been charged with planning, developing and implementing new initiatives. Youth-to-

youth programs and mentoring projects and a Teen Pregnancy Resource Center have been established.

The DHS, the DoE, the Department of Labor and Workforce Development and the Juvenile Justice Commission have collaborated with NJDHSS on the development of statewide County Collaborative Coalitions relative to teen pregnancy prevention activities. 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 and events for Teen Pregnancy Prevention Month (May).

Family planning agencies with 57 clinical sites continue to provide comprehensive reproductive health services to adolescents. Family planning agencies also provided community education and outreach to the adolescent population. Aimed at schools and community groups, educational activities focus on primary pregnancy prevention activities that encourage family communication, promoting self-esteem, postponing sexual activity and promoting effective contraception. The program integrates assessment of adolescent risk behavior within routine family planning services.

/2008/ The Governor's Advisory Council for Adolescent Pregnancy Prevention successfully planned a "Children of Children" exhibit during May 2006 at The Robert Wood Johnson Center for Health and Wellness. The Kick-off of the exhibit was preceded with a legislative reception. The exhibit featured 50 black and white photographs with audio stories on how teenage pregnancy impacts the lives of families shown in the photographs. A total of 1336 middle and high school age children attended the exhibit in addition to interested adults. //2008//

#### SP #4. Increasing Healthy Births

Increasing Healthy Births is a state priority that encompasses NPM #8, 15, 17, 18. Several initiatives address healthy births including Healthy Mothers, Healthy Babies Coalition outreach activities, Healthy Start outreach activities, and Community Action Team projects based on FIMR findings. 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.

#### SP #5. Improving Nutrition and Physical Activity

Improving Nutrition and Physical Activity is a state priority related to NPM #14 and SPM #5 and the Health System Capacity Indicator (HSCI) #9. DHSS funds 3 Community Partnership for Healthy Adolescents to address this priority.

/2007/ Pedometer projects involving almost 400 youth were implemented in Fall 2005 to Spring 2006.//2007//

/2008/ Additional pedometers will be distributed to youth and community based organizations in 2007.//2008//

In 1999, State law established the NJ Council on Fitness and Sports, which is in, but not of, the DHSS. The Council promotes the health and wellness of NJ citizens by developing safe and enjoyable recreational and sports activities and programs. In 2004, DHSS provided funding to two professional organizations - the NJ Society for Public Health Education (NJ SOPHE) and the NJ Association for Health, Physical Education, Recreation and Dance (AHPERD) - to support pilot projects implementing recommendations of the Council. It is also funding one community-based organization in Trenton to promote nutrition and physical activity for the Trenton community.

/2007/ In 2005, DHSS provided staff support to the Council to assist with 3 projects:

- 1) planning a 1-day leaders' Academy for Healthy Community Development scheduled in May to provide training to assist communities with designing local projects to promote health and physical activity.
- 2) reviewing and approving 20 municipality proposals for mini-grants to develop the workability or bike ability of the community,

3) development and printing of the Council's book "Get Fit New Jersey" .//2007//

/2008/ The Second Annual Leaders' Academy for Healthy Community Development was held on May 18, 2007. //2008//

NJ SOPHE coordinated the NJ Childhood Obesity Roundtable II, held in December 2004, in collaboration with Rutgers State University, the NJ Obesity Group and DHSS. The agenda highlights included a presentation on the current state of childhood obesity by national speaker, Barbara Moore, Ph.D., of Shape Up America!; ten panel presentations on state and local efforts currently in place, and a consensus from the group on next steps. Roundtable recommendations/next steps will be shared with the recently legislated NJ Obesity Prevention Task Force. The NJ Obesity Prevention Task Force is a 27 member, Governor-appointed Task Force charged with the responsibility to study, evaluate and develop recommendations and specific actionable measures to support and enhance obesity prevention among New Jersey residents, particularly children and adolescents.

In addition, NJ SOPHE has been instrumental in getting the KidStrong (Inside & Out), grades 5 & 6 osteoporosis curriculum, revised in consultation with the NJ Interagency Council on Osteoporosis (ICO) Education sub-committee. A marketing plan for KidStrong and the follow-up Jump Start Your Bones grades 7 & 8 curriculum is also being developed in consultation with the ICO Education sub-committee.

NJ AHPERD has made pedometer school kits available to elementary and high schools. In addition, 3 bike safety programs were held with one recreation program for 1st -- 3rd graders, 4th -- 6th graders and 7th --10th graders.

/2007/ In March 2006, a mini-grant application was approved for Isle's, a Trenton-based non-profit community agency, to promote nutrition and physical activity with Trenton youth. The objectives of this grant are to:

- implement community gardens at 2 school sites;
- conduct "Trenton Moves" program with 80 youth at 4 sites;
- coordinate community assets and resources in the Greater Trenton area that address youth obesity, healthy eating and physical activity.

DHSS, represented by staff from Adolescent Health, participates in the Action for Healthy Kids (AFHK) -- NJ State Team and on the Governor's Healthy Choices, Healthy Kids initiative. Six regional Train-the-Trainer programs were implemented by AFHK-NJ to provide training on nutrition and physical activity to school personnel. A comprehensive resource guide was distributed.

In 2005 the Team conducted 3 regional Super Saturday events on fitness and nutrition education for approximately 250 educators, families and children in grades 4 to 6. Workshops on nutrition and physical activity were conducted for both children and adults. The State Team is planning to develop a Super Saturday best practice guide for use by other groups interested in working on improving nutrition and increasing physical activity.//2007//

#### SP #6. Decrease Asthma Hospitalizations

DHSS is a member of the Pediatric/Adult Asthma Coalition of New Jersey (PAC/NJ). PAC/NJ is organized by the American Lung Association of NJ and the NJ Thoracic Society. It has developed the "Pathway to Asthma Control in NJ", that outlines the strategies and initiatives to address the asthma burden. PACNJ has formed Task Forces for each of the Coalition's six (6) implementation areas: Physician, Community, Schools, Child Care, Environment, and Health Insurance Task Forces. The 6 task forces are an integral component to PACNJ's success. With the support of staff and resources from PACNJ and its member organizations, the task forces design and implement the various strategies/activities identified in the implementation plan.

In 2002, the DHSS formed an Interdepartmental Working Group on Asthma. With the

participation of staff from the Departments of Education, Human Services, and Environmental Protection, the working group prepared a strategic plan for the activities of the state government in addressing asthma.

/2008/ Significant accomplishments to date are described under Section F Health Systems Capacity Indicator #1, and include:

- On October 6, 2006 the Second Annual Asthma Summit was held with over 260 professionals attending the half day event.
- NJ is 1 of 6 states participating in the Agency for Healthcare Research and Quality's (AHRQ) "Learning Partnership to Decrease Disparities in Pediatric Asthma" project. • "Asthma in NJ Update 2006" was published in September 2006.
- In November 2006, PACNJ presented their "Asthma Friendly School Award" to 135 schools in NJ serving over 70,600 students.
- The PACNJ Asthma Action Plan and training CD were provided to 3500 school nurses.
- The PACNJ asthma education program, "Asthma Management in the School Setting" has been presented to 1000 school nurses.
- The PACNJ asthma education program, "ABCs of Asthma are All 'Bout Control", has been provided to 2500 school personnel.//2008//

#### SP #7. Improving and Integrating Information Systems

The MCH Epidemiology Program and the NJDHSS are all involved in efforts to improve and integrate public health information systems. Activities are related to NPM #11, 15, 17, 18, SPM #3, 4 and HSCI #5, 9A, 9B, and 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.

#### SP #8. Improving Access to Quality Care for CSHCN

New Jersey will continue to enhance current efforts to improve access to quality of care for CSHCN, as well as provide additional training opportunities for families, case managers, Part C service coordinators and staff of the Child Evaluation Centers, Cleft Lip/Palate Centers, Tertiary Care Centers, and Ryan White Title IV Family Centered HIV grantees in resources and services to support CSHCN in the community. Training will be provided to promote effective involvement of youth and parents in school to work transition, and medical transition to adulthood for the SSI population.

/2007/ In 2005, the Federation of Child Evaluation Centers conducted their first annual seminar for health care providers on the subject of autism. Approximately 60 social workers, nurses and child study team representatives participated. //2007//

/2008/ The members of the Federation continued to meet regularly, to share information and resources, and to collaborate in order to ensure that the continuation of quality care is provided to the children and families served.//2008//

Information, referral, development of an individualized service plan (ISP) and ongoing monitoring to achieve identified needs for CSHCN remains a priority of Family Centered Care grantees. These needs include medical/dental, developmental, rehabilitation, education, socio-economic, and emotional. Parent and professional training on accessing comprehensive services for CSHCN through Medicaid Managed Care, updates on changes in NJ FamilyCare, and access to community based services for CSHCN were conducted in 2004, through quarterly case management meetings, Family Centered HIV programs and collaboration on the development of conferences conducted by community based organizations such as the NJ SSI Alliance, SPAN, and the ARC of New Jersey. Likewise, Family Centered Care Services staff provides ongoing technical assistance to grantees regarding access to care issues, including how to access appropriate community based providers, and how to coordinate services across intergovernmental agencies and programs.

/2007/ The quarterly case management meetings continued in 2005, with additional training in the areas of access to care for CSHCN through NJ FamilyCare, the Catastrophic Illness in Children

Relief Fund Program, charitable organizations, Federally Qualified Health Centers, the Family Support Center of NJ, Inc. and others. As members of the NJ SSI Alliance, SCHEIS contributed to development of the 7th annual conference titled "Changing Times," which focused on Medicare Part D, electronic applications for Social Security and resources for professionals and consumers; over 200 attendees participated. //2007//  
 /2008/ Additional training and updates continued through the SCHS Quarterly Case Management meetings, including topics such as the Children's System of Care Initiative, family support programs, dentistry for CSHCN, transition to adulthood.//2008//

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	99.6	100.0	100.0	100.0
Numerator	113215	111583	110905	110634	112406
Denominator	113215	112051	110905	110634	112406
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	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2007**

Source: Newborn Biochemical Screening Program - The number of initial newborn biochemical screenings as reported by the state's Inborn Errors of Metabolism laboratory.

All newborns with confirmed biochemical disorders receive appropriate follow-up as detailed on Form 6.

See attachment to PM #1 Screens and Confirmed Cases by Individual Disorder, SFY 2007

Final 2007 data will be available in 2009.

**Notes - 2006**

Source: Newborn Biochemical Screening Program - The number of initial newborn biochemical screenings as reported by the state's Inborn Errors of Metabolism laboratory.

All newborns with confirmed biochemical disorders receive appropriate follow-up as detailed on Form 6.

**a. Last Year's Accomplishments**

The Newborn Biochemical Screening Follow-up Program, within Special Child Health and Early Intervention Services (SCHEIS) ensures that babies with out-of-range screening results receive timely follow-up testing, care, treatment and management. The goal is to rule in or rule out a

disorder, initiate prompt medical care and maintenance treatment and provide parents, practitioners and consumers with appropriate educational materials within nationally established time lines.

All newborns with confirmed biochemical disorders received appropriate follow-up - see attached chart.

Currently, newborns receive screening for 20 disorders: phenylketonuria, hypothyroidism, galactosemia, the hemoglobinopathies, including sickle cell disease, maple syrup urine disease, cystic fibrosis, biotinidase deficiency, congenital adrenal hyperplasia, medium chain acyl-CoA dehydrogenase deficiency, short chain acyl-CoA dehydrogenase deficiency, long chain acyl-CoA dehydrogenase deficiency, very long chain acyl-CoA dehydrogenase deficiency, citrullinemia, argininosuccinic acidemia, methylmalonic acidemia, propionic acidemia, glutaric acidemia type I, isovaleric acidemia, 3-hydroxy-3-methylglutaryl CoA lyase deficiency and 3-methylcrotonyl-CoA carboxylase deficiency. The Follow-up Program aggressively follows all presumptively positive results by telephone calls to primary care providers and subspecialists to ensure confirmatory testing and initiation of treatment. Support for treatment services and specialized formula includes 4 regional metabolic centers, 3 cystic fibrosis care centers, 5 pediatric endocrine specialty care centers, 2 biochemical genetics laboratories and 5 sickle cell treatment centers.

In 2005, the American College of Medical Genetics (ACMG), on behalf of HRSA released the report 'Newborn Screening: Towards a Uniform Screening Panel and System' recommending national guidelines that all babies be screened for the same 29 disorders called the "Core Panel". In fall 2005 Newborn Screening Annual Review Committee (NSARC) reviewed this ACMG report and its recommendations. In 2006, NSARC recommended that due to multiplex nature of testing, the newborn screening panel should expand to include all disorders in the Core Panel of the ACMG report, plus the secondary disorders that may be detected as a result of screening for core panel disorders. This increased the number of disorders in the NJ newborn screening panel to 45 disorders. These recommendations were approved by the Commissioner in 2006.

In preparation for the expansion of the newborn screening panel, the Follow-up Program developed the physician education initiative. This initiative consists of 3 educational activities: a web-based CME activity for physicians for expanded panel of disorders as well as other contemporary issues, a series of lectures delivered at "grand rounds" in major hospitals in different regions of NJ and revision of laminated sheets to include the expanded panel of disorders. In 2007, the grand round lecture series went in effect and approximately 30 lectures in more than 15 hospitals were given by various subspecialists. The web-based CME and the revised lamination sheets are finalized and ready for roll-out as soon as a final expansion date is decided. The various consultant groups also 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 information material the program already 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 NJ birthing facilities. The disorder specific brochures are also revised and translated in Spanish to be available at the time of expansion.

In SFY 2008, Newborn Screening and Genetic Services (NSGS) funding for cystic fibrosis services at one hospital for their Affiliate Cystic Fibrosis Center, recognized by the National Cystic Fibrosis Foundation was initiated. The Center provides comprehensive diagnosis, treatment and counseling services for NJ residents with cystic fibrosis. Another grant was initiated to provide partial support for metabolic services at another major hospital. This grant will partially support confirmatory testing, treatment and counseling services for NJ residents with inherited metabolic defects.

***An attachment is included in this section.***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expanded screenings to include 45 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 babies and their families				
4. Ongoing collaboration with specialists and pediatric primary care providers				
5. FHS and Public Health and Environmental Lab staff regularly meet with established specialty consultants				
6. Newborn Screening Annual Review Committee (NSARC) reconvened to advise Newborn Biochemical Screening Program				
7. Physician education initiative, consisting of a series of lectures at "grand rounds", web-based CME activities and laminated sheets with NBS management and emergency guidelines				
8. Improvements in generic NBS parent pamphlets				
9. Follow-up protocols, new parent and physician fact sheets for expanded NBS				
10.				

**b. Current Activities**

In 2002, SCHEIS began funding for the establishment and provision of specialty services in the areas of genetics/metabolic disorders, pediatric pulmonary and endocrine disorders, and specialty laboratory services.

Testing, reporting and follow-up of the additional screening tests will continue to be directly managed by the State. To address technological changes that have the potential for improving sensitivity, specificity and the scope of newborn screening services, the NSARC will continue to assess, evaluate and make recommendations.

For each of the newborn biochemical disorders, semi-annual meetings continue to be held with the respective consultant groups. The purpose of the consultant meetings is 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 2008, the NSGS initiated a program for ongoing internal evaluation which consists of internal chart reviews, procedure reviews and discussions and other internal quality assurance activities. In 2008, the Disorder of the Month lecture series was also initiated to review the medical and programmatic aspects of various disorders screened by the NJ Newborn Screening Program.

**c. Plan for the Coming Year**

- Expansion of the Newborn Screening Panel: Approval for expansion was granted in May, 2006, by the Commissioner of Health and Senior Services. The final implementation date will be determined by the Newborn Screening Laboratory which is undergoing computer system and new mass spectrometer validations.
- Hiring staff for existing positions: The program is working on getting an exempt from the state wide hiring freeze to fill existing positions.

- The NBS software vendor is providing a major upgrade to the current software and hardware environment. This upgrade will take effect once the validation process at the NBS Laboratory is complete.
- The follow-up staff reviewed and prepared the following material regarding new expanded disorders:
  - o Follow-up Protocol Action Sheets for expanded disorders
  - o Disorder Information for Parents
  - o Disorder Information for Health Professionals
  - o Physician and Parent Notification Letters
  - o These materials were reviewed and approved by the Metabolic Consultant Task Force
- Web-base CME will go live and the revised lamination sheets will be distributed once a final date for the NBS expansion is given to the program.
- Spanish version of the disorder specific parent sheets are in the final stages of development and are expected to be ready for distribution in 2008
- Cystic Fibrosis Study: "Possible cases of CF not identified by existing universal newborn screening for Cystic Fibrosis in New Jersey by IRT/DNA single mutation analysis protocol." The Newborn Screening and Genetic Services Follow-up program received an exemption from the IRB to conduct the Cystic Fibrosis Study. This study is expected to start in late March or early April 2008. The objective is to identify any cases of CF missed by this IRT/DNA protocol as well as identify the need to evaluate the possibility of increasing the number of mutations tested for in NJ.
- Disorder of the Month lectures and Quality Assurance meetings will continue on a monthly basis to promote a system of continuous learning and staff development.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	58	59	60	61	62
Annual Indicator	57.7	57.7	57.7	57.7	55.4
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	56	60	63	64	64

**Notes - 2007**

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 - 2006**

The data reported in 2006 are pre-populated with 2002 state estimates from the SLAITS Survey.

**Notes - 2005**

The data reported in 2005 are pre-populated with 2002 state estimates from the SLAITS Survey.

**a. Last Year's Accomplishments**

SCHEIS continues to support through a health service grant with the Statewide Parents Advocacy Network (SPAN) the a Parent-to-Parent Network to further increase the degree to which the State ensures family participation in program and policy activities of the State CSHCN program. The Parent-to-Parent Network links parents of CSHCN to "veteran" parents of children with similar needs for support, information on the disability, and problem solving.

**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 Survey to be done by the 21 county case management units.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In 2005, the supplemental EHCI funding supported targeted additional training of non-English speaking Creole, Haitian and Chinese families of children that are deaf and hard of hearing. To date, over 1,000 matches have been made through Parent to Parent.

In 2005, the Special Child Health Services Case Management Unit (SCHS CMU) Family Satisfaction Survey was piloted in Hunterdon County. The survey was revised in 2006 and distributed statewide. Results are pending. Statewide, results of the 2006 SCHS CMU Family Satisfaction Survey indicated that of the 714 surveys mailed to families that received case management services, 437 responded. The majority of these families reported that they were satisfied with the case management services that they received; 89% would recommend the service to others, 77% were satisfied with the explanation of services that they had received from their case manager, and 78% were satisfied with the information and resources that they had received. Overall, families reported being satisfied or very satisfied with the resources they'd received, availability of case manager, that their child's and family's needs were being addressed, case management was being delivered in a culturally competent manner and that their confidentiality was being maintained. The survey is being reviewed and revised for administration in the upcoming year.

**c. Plan for the Coming Year**

Projections for FFY 2007 estimate an additional 120 parents will be trained and 180 matches made. The Statewide Family Voices Chapter, initiated by SCHEIS in collaboration with Family Voices and SPAN, will continue conducting family leadership development trainings. These trainings provide families with the information and support they need to advocate for their own children, advocate for and support other families, and advocate for improvements in policies, practices, and systems. In addition, Case Management and Specialized Pediatric Services staff will collaborate, provide technical assistance and serve on the SPAN Champions for Progress Advisory Board. The Advisory Board will target medical home and transition to adulthood, and develop a "Road Map" to assist families and CSHCN in planning and decision making. This tool

is anticipated to be presented to CSHCN, families and providers at the 2006 SPAN conference and distributed to families through SCHEIS grantees. The "Road Map" is in final draft and will be incorporated into a transition to adulthood training of Case Management, Specialized Pediatric Services and Ryan White Title IV HIV Family Centered Services grantees in fall 2006.

The 2005 Special Child Health Services Case Management Family Health Satisfaction Survey findings will be finalized and results discussed with the Case Management Unit Coordinators. This process is intended to provide SCHEIS and the Case Management Unit Coordinators with information on family satisfaction with access to case management services, suggestions for improving satisfaction and access, and revisions of the survey which is anticipated to be repeated in 2006.

SCHS Case Management is administering a statewide family satisfaction survey of families served in 2007. The survey has been revised to include a query on transition to adulthood. It has been tested for cultural competence and translated into Spanish. Results remain pending.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	53	54	55	56	57
Annual Indicator	52	52	52	52	40.8
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	42	43	44	45	46

**Notes - 2007**

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 - 2006**

The data reported in 2006 are pre-populated by the CDC with 2002 state estimates from the SLAITS Survey.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**a. Last Year's Accomplishments**

SCHEIS continues to provide enabling services to children with special health care needs (CSHCN) in order to ensure a "medical/health home" (National Performance Measure #3). SCHEIS has promoted the concept of a "medical home" as defined by the American Academy of

Pediatrics through case management services, collaboration with the Statewide Parent Advocacy Network (SPAN), and support of the Child and Adult Special Services Program providers. In 2005, SCHEIS State staff conducted a statewide review of Individual Service Plans for children receiving Special Child Health Services case management to determine status of insurance and whether a primary care physician was identified. Of the 416 charts sampled, the percentage of children with a reported form of health coverage remained at 96% (approximately 46% Medicaid, 50% private, 4% uninsured.) Those without insurance had been screened for eligibility and/or referred for SSI, NJ KidCare, and/or Medicaid. Also, children without a documented primary care provider had been referred for follow-up through Federally Qualified Health Centers, local health department and/or hospital clinics, as well as referral to pediatricians that may be accepting clients without insurance. This informal survey indicated that the majority of children served through the Case Management Units have access to both health care and a primary care provider; however, access to a medical home remains a challenge for some children. This survey will be repeated and extended to include additional Family Centered Care Service providers. In 2006, 470 charts of children receiving SCHS Case Management were reviewed for status of health insurance and primary care provider. In comparison with 2005, a slight improvement was noted; 98% of the individual service plans reviewed indicated insurance and a primary care provider with a slight shift in Medicaid vs. insured/uninsured; 42% Medicaid, 51% private insurance and 7% uninsured.

The 2007 chart review of children receiving SCHS Case Management was comparable to 2006; 98% of the individual service plans reviewed indicated insurance and a primary care provider, 44% Medicaid, 49% private insurance and 7% uninsured.

To assist families in accessing the Medicaid managed care system, SCHEIS County Case Managers continue to provide consultation, advocacy, information and referral to access comprehensive health care coverage. In an effort to assist families of CSHCN in navigating the Medicaid managed care system, a Medicaid Managed Care Alliance was formed in 1999. This Alliance is comprised of parents, advocacy groups, representatives from the DHS Office of Managed Care, NJ FamilyCare, HMO case managers, SCHEIS case managers and others. A brochure entitled "Finding Your Way through Medicaid Managed Care...For Families with Children with Special Needs," was developed through this initiative, and continues to be distributed statewide. In 2004, resources listing both managed care case managers and county case management unit staff were revised and distributed among staff members of both systems. Periodic case conferencing continues as needed. In the Pediatric HIV Family Centered Care Network, each of the Network agencies has entered into linkage agreements with the managed care systems operating within their catchment areas.

In 2004 the CECs organized a formal Federation whose primary goal is to advocate for children with developmental, behavioral and learning disabilities through the promotion of community awareness, collaboration of like organizations, promotion of quality care and education, facilitation of collaborative research and communication with public and private agencies. In 2005, the CEC Federation conducted a Legislative breakfast and poster presentation to increase awareness among NJ Legislators and their aides about the comprehensive services provided to children with special health care needs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Case Management Services		X		
2. Your Voice Counts				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**

SCHEIS continues to provide or subsidize direct specialty and subspecialty services to CSHCN by funding Child and Adult Special Services which includes: 11 Child Evaluation Centers (CEC), 5 Cleft Palate Centers, 3 Tertiary Centers, 6 Genetic Centers, 4 Hemophilia Centers and 5 Sickle Cell Centers. These centers provide a comprehensive array of services with a multidisciplinary approach to assure that CSHCN receive coordinated, ongoing, comprehensive care within a medical home. 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 to advocate for CSHCN. 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.

In collaboration with the Epilepsy Foundation of NJ, SCHEIS staff participated on Project Access, an initiative funded by HRSA, National Initiative for Children's Healthcare Quality, National Epilepsy Foundation, and Jersey Shore Univ. MC. This project targeted awareness across health care systems of needs and services for children with epilepsy/seizure disorder to improve access to a comprehensive medical home. As a result, an epilepsy toolkit was developed for and shared with families and physicians, to facilitate communication and coordination of specialty and primary care among the family, primary provider and neurology.

**c. Plan for the Coming Year**

The SCHS County Case Managers will continue to provide consultation, advocacy, information and referral to access comprehensive health care coverage. Approximately 12,000 children were newly referred to SCHS Case Management in 2007. All are offered case management/care coordination including the development of Individual Service Plans (ISP) that address assessment of and need for comprehensive health, education, social, and rehabilitative services. Included in the ISPs are enabling services such as transportation, economic assistance, service linkages, respite care, and general support in terms of rights and safeguards. Case managers work with these families and their physicians to ensure care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate. It is anticipated that implementation of the autism registry will result in an increase in referrals of children with autism. Additional trainings in autism diagnosis, treatment and family support for the SCHS Case Managers are anticipated. To facilitate linkage with a medical home, SCHEIS redesigned its statewide brochure in a family friendly question and answer format. The brochure was field tested for cultural competency and translated into Spanish.

In the Family Centered HIV Care Network, each of the Network agencies has linkage agreements with the managed care systems operating within their catchment areas. Development of linkage agreements is ongoing, and will ensure the delivery of coordinated primary and specialty care for the HIV affected special needs children and their families.

SCHEIS will continue to provide or subsidize direct specialty and subspecialty services to CSHCN by funding Child and Adult Special Services which includes: eleven Child Evaluation Centers including 6 FAS sites, five Cleft Palate Centers, three Tertiary Centers, six Genetic Centers, four Hemophilia Centers and five Sickle Cell Centers. The CEC Federation will continue to promote community based comprehensive services for CSHCN, as well as the availability of those services in New Jersey. Services will be provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach to advocate for CSHCN. No child is denied service due to the

inability to pay. It is anticipated that implementation of the autism registry will result in an increase in referrals of children suspected to have autism. Training in diagnosis and coordination with primary care providers is anticipated.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	62	63	63	64	64
Annual Indicator	62.1	62.1	62.1	62.1	59.9
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	61	62	63	64	65

**Notes - 2007**

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 - 2006**

The data reported in 2006 are pre-populated with 2002 state estimates from the SLAITS Survey.

**Notes - 2005**

The data reported in 2005 are pre-populated with 2002 state estimates from the SLAITS Survey.

**a. Last Year's Accomplishments**

SCHEIS continues to ensure accessibility of Children with Special Health Care Needs (CSHCN) to primary and specialty care through the support of specialized pediatric services and County Case Management Units. However, challenges remain in access to care for uninsured CSHCN, with a slight increase in the reported number of uninsured served by CSHCN programs in 2004. Health insurance data extrapolated from the combined CSHCN programs in 2005 indicated no significant change in the CSHCN identified as uninsured (should have read un-insured approximately 4%), 4% of the nearly 38,800 CSHCN in 2005 versus 4.5% of the 42,000 CSHCN served in 2004. The rate of uninsured continued fairly consistently at 4% in 2006. Nearly 4% of CSHCN reported Medicaid eligibility in 2006, The County Case Management Units will continue to provide care coordination at no expense to families and to assist in referring families to resources such as Medicaid, New Jersey FamilyCare, the Catastrophic Illness in Children Relief Fund program, and the Charity Care program. The 2006 report of total CSHCN served was 38,500, and remained nearly level as compared to 2005 (38,800.) Likewise, no significant change was noted in CSHCN self-identified as insured, nearly 49% in 2006. The 2007 data for total CSHCN served was comparable to 2006, at 38,500 and 48% insured.

**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.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Despite challenges created by a rapidly changing health care environment, SCHEIS has continued to ensure the availability of specialty and subspecialty services, including care coordination, not otherwise accessible to children with special health care needs (CSHCN). The CSHCN programs in New Jersey have traditionally provided and/or financed specialty and subspecialty care services through a network of specialty clinics. More emphasis continues to be placed on providing care coordination through the County Case Management Units. With many families transitioning to managed care, the care coordination services of County Case Management Units are now even more important to ensure comprehensive care due to potential restrictions created by utilization review, referral requirements, and closed panel networks. Anecdotal experience this past year has proven the benefits of the County Case Management Units who have assisted families in navigating the complicated managed care system to obtain necessary services.

**c. Plan for the Coming Year**

SCHEIS will continue to ensure the availability of specialty and subspecialty services, including care coordination, not otherwise accessible to CSHCN. SCHEIS will continue to collaborate with other Medicaid Managed Care and Medicaid Assistance Advisory Council (MAAC) members to facilitate access to specialty and subspecialty services. Training will continue regarding changes in Medicaid programs including the newly released Advantage program for uninsured children with family incomes above 350% FPL. The County Case Management Units will continue to provide care coordination at no expense to families and to assist in referring families to resources such as Medicaid, New Jersey FamilyCare, the Catastrophic Illness in Children Relief Fund program, and the Charity Care program.

**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	2003	2004	2005	2006	2007
Annual Performance Objective	76	77	78	79	80
Annual Indicator	75.9	75.9	75.9	75.9	88
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	88	90	90	90	90

**Notes - 2007**

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 - 2006**

The data reported in 2006 are pre-populated with 2002 state estimates from the SLAITS Survey.

**Notes - 2005**

The data reported in 2005 are pre-populated with 2002 state estimates from the SLAITS Survey.

**a. Last Year's Accomplishments**

In 2005 SCHEIS and the Statewide Parent Advocacy Network (SPAN) continued collaborative efforts to ensure access to care for CSHCN. Family input is on services through participation at Family Centered Care Services provider meetings, both as attendees and presenters; including transition, advocacy and support. In addition, 2006 SCHS Case Management Unit family satisfaction survey respondents indicated that the majority of respondents were satisfied or very satisfied with the availability of their case manager, child and family's needs were being addressed in a culturally competent manner and their confidentiality was maintained.

**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.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Collaboration between the Statewide Parent Advocacy Network (SPAN) and SCHEIS, which began eleven years ago, has enhanced the provision of accessible family-centered care. SPAN is the only federally funded parent training and information center for parents of children with disabilities and special health care needs in New Jersey. During 2004, ten Case Management Units housed 14 SPAN Resource Parents who provided 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. The Resource Parents documented nearly 6800 contacts with families and professionals during that time. In addition, SCHEIS provided funding in 2002 for a project enabling volunteer parents trained through SPAN to provide statewide coverage for the New Jersey Parent-to-Parent Program. As another statewide initiative, SCHEIS continues to collaborate and partially support a Family Voices chapter, whose

mission is to provide parents with training in family leadership, policy making, and advocacy in health care.

In addition, the Case Management units have collaborated and developed a standardized Family Satisfaction Survey intended to assess the family's experience with case management services, responsiveness to needs and effectiveness of referrals. The Family Satisfaction Survey was piloted and will become standardized for use statewide in 2006.

**c. Plan for the Coming Year**

Collaboration between the SPAN and SCHEIS 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.

Contingent upon the availability of funding, an additional five Parent Resource Specialists have been trained and will be housed this spring at five southern counties; Cape May, Cumberland, Burlington, Salem and Gloucester. Funding to support this expansion of family support resources at the SCHS Case Management Units was identified by SPAN through a parent training grant. This collaborative initiative will bring the total number of case management units with onsite part-time family support up to 15 counties.

The 2005 SCHS Case Management Family Satisfaction Survey was conducted by mail. Families were randomly surveyed, and 437 out of 715 (61%) indicated that overall families were satisfied with their case management services; 89% would recommend the service to others, and 77% received a clear explanation of services for their CSHCN. Likewise, most respondents indicated that they were satisfied or very satisfied with: resources, availability of case manager, their child's needs were addressed, family's concerns were addressed, services were culturally sensitive and confidentiality was maintained. A 2007 family satisfaction survey is underway. SCHEIS will continue to participate in quarterly MAAC meetings to facilitate access to specialty services for CSHCN, as well as the DHS Aged, Blind and Disabled sub-group targeting the transition from fee-for-service Medicaid to Medicaid Managed Care.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	6	7	8	10	12
Annual Indicator	5.8	5.8	5.8	5.8	37.9
Numerator					
Denominator					
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

	2008	2009	2010	2011	2012
Annual Performance Objective	40	42	44	45	45

**Notes - 2007**

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 - 2006**

The data reported in 2006 are pre-populated with 2002 state estimates from the SLAITS Survey.

**Notes - 2005**

The data reported in 2005 are pre-populated with 2002 state estimates from the SLAITS Survey.

**a. Last Year's Accomplishments**

In addition to ongoing transition to adulthood information, referral, counseling and support provided by Family Centered Care grantee's case managers, SPAN Resource Specialists, social work and medical staff, multiple transition trainings were conducted in 2005, through parent and provider organization collaborations. As members of the ARC of New Jersey's Mainstreaming Medical Care Executive Committee, Family Centered Care staff assisted in developing and conducting a training for parents of CSHCN at the ARC of New Jersey's 16th Annual Mainstreaming Medical Care Conference. Presentation topics included accessing care for the developmentally disabled, dental care, and medications for dual eligibles. Representation continued on the ARC's Mainstreaming Medical Care Advisory Board, and the 17th Annual Conference included break-out sessions on the importance of the prevention of lead exposure, screening, treatment, and follow-up for the lead burdened child as well as community based supports. Likewise, parent and professional training was provided through collaboration with the NJ SSI Alliance, an association of SSI stakeholders including consumers, State agencies, and advocacy groups. Approximately 250 attendees participated in the 7th Annual NJ SSI Alliance Conference. Targeting SSI and SSDI enrollees, the 2005 conference included topics such as how to access SSI benefits, medical and school to work transition, Ticket to Work, PASS, NJ Workability and other benefits available to persons eligible for Medicaid and/or Medicare. Planning for the 8th Annual NJ SSI Alliance Conference began and will focus on transition.

Enabling transition to adulthood for CSHCN is approached through several ongoing collaborative efforts between Family Centered Care Services staff, intergovernmental agencies, and parent advocacy groups. Since 1993, Family Centered Care Services (FCCS) staff collaborated with staff from the Social Security Administration, New Jersey Epilepsy Foundation, Department of Labor Vocational Rehabilitation and Disability Determination units, Department of Human Services Medicaid and Mental Health units, advocacy groups such as SPAN, Community Health Law Project, Family Voices New Jersey, Legal Services of New Jersey and others, on the development of the New Jersey SSI Alliance. The SSI Alliance meets quarterly to share information, promote awareness and provide training and technical assistance related to SSI benefits and supports, which are invaluable to youth transitioning to adulthood. In addition, FCCS staff participated with the Epilepsy Foundation of NJ in the development of a Toolkit on Epilepsy which included information to assist youth with Epilepsy to access resources.

In addition, a draft transition to adulthood packet has been developed through a pilot project conducted in collaboration with SPAN and the Essex Healthcare Foundation, at the Essex County SCHS case management unit. The packet targets families with CSHCN and includes information on Department of Education Section 504 basic rights, Individual Health Plan development, SPAN, SCHS, and a description of the New Jersey Catastrophic Illness in Children Relief Fund financial assistance program. Distribution of the packet to CSHCN age 13 and older served through the

county case management units is underway. Likewise, during 2004, a statewide training about transition to adulthood was conducted by SPAN for parents of CSHCN, and staff of the SCHS Case Management Units, Child Evaluation Centers, Cleft Lip/Palate Centers, Tertiary Centers, Family Centered HIV Centers, and HMO case managers.

In 2005, a Transition to Adulthood committee was convened by State SCHEIS staff including representation from the SCHS Case Management Units and SPAN to expand transition packet. Plans to standardize a statewide transition resource tool for SCHS Case Management Units, including the Roadmap for Transition is targeted for development in 2006, followed by a statewide training on transition.

**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 CSHCN in SCHS Case Management		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Enabling transition to adulthood for CSHCN continues through several ongoing collaborative efforts between Family Centered Care Services staff, intergovernmental agencies, and parent advocacy groups. The SSI Alliance meets quarterly to share information, promote awareness and provide training and technical assistance related to SSI benefits and supports, which are invaluable to youth transitioning to adulthood. Distribution of the transition to adulthood packet to CSHCN age 13 and older served through the county case management units is underway. Plans to standardize a statewide transition resource tool for SCHS Case Management Units, including the Roadmap for Transition will be followed by a statewide training on transition.

**c. Plan for the Coming Year**

The SSI Alliance will continue to meet quarterly to share information, promote awareness and provide training and technical assistance related to SSI benefits and support, which are invaluable to youth transitioning to adulthood. Plans for the upcoming annual NJ SSI Alliance conference are being developed for the next year. Transition to adulthood packets with state, local and federal resources will continue to be disseminated to CSHCN through their SCHS CMU at or about age 13.

As a result of a collaboration between Title V, the Academy of Pediatrics, SPAN and the Epilepsy Foundation of New Jersey (EFNJ) a statewide needs assessment targeting transition to adulthood for children and youth with special health care needs is proposed for 2005. Rutgers University researchers will be contracted to analyze New Jersey specific SLAITS data, and collaborate SPAN and/or EFNJ's efforts to conduct focus groups, and survey health care providers to determine transition to adulthood needs for New Jersey youth.

A transition to adulthood needs assessment was conducted by Rutgers University which included a New Jersey specific analysis of 2000-2002 SLAIT data, pediatric specialist and adult medical

provider interviews and interviews of families of children with special needs aged 16-26 years with one of the following diagnoses: Cleft Palate, Spina Bifida, Diabetes or Sickle Cell. The needs assessment was intended to determine a better understanding of the factors and issues that facilitated successful transitions as well as those barriers which prohibit the transition process. Although the sample sizes were small, the findings suggested several resources that may be helpful in facilitating transition, including family supports in the form of educational resources, workshops and tools such as lists of providers. These families would also benefit from more assistance from social service providers about their specific adult services and involvement of their pediatricians and adult doctors throughout the transition process. Physicians would also benefit from more assistance from specific providers and information on special needs, such as having a case manager to help adolescents moving toward adulthood, parent support resources and creating a "transition time."

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	75	76	79	82	83
Annual Indicator	75	82.7	78.2	78.8	80.3
Numerator					
Denominator					
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	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	83	84	84	85	85

**Notes - 2007**

The most current data available (Q3/2006-Q2/2007) from the CDC is entered as provisional 2007 data.

[http://www.cdc.gov/vaccines/stats-surv/nis/tables/0607/tab03\\_antigen\\_state.xls](http://www.cdc.gov/vaccines/stats-surv/nis/tables/0607/tab03_antigen_state.xls)

Reported as 80.3 % +- 5.7%.

Final 2007 data will be available from the CDC in 2009.

**Notes - 2006**

Data is from the National Immunization Survey at the CDC. The data is reported as 78.8 ± 6.1

[http://www.cdc.gov/vaccines/stats-surv/nis/tables/06/tab02\\_antigen\\_iap.xls](http://www.cdc.gov/vaccines/stats-surv/nis/tables/06/tab02_antigen_iap.xls)

No numerators or denominators are available.

**Notes - 2005**

Data is from the National Immunization Survey at the CDC

<http://www.cdc.gov/nip/coverage/NIS/>

No numerators or denominators are available.

**a. Last Year's Accomplishments**

New Jersey has achieved a 78.9% age appropriate immunization rate in 2006, according to the CDC National Immunization Program. To address age appropriate immunizations (National Performance Measure #7), the Immunization Program in the Division of Communicable Diseases continues to support immunization at clinics in local health departments, Federally Qualified Health Centers (FQHCs), and other pediatric clinics. The State's Vaccines for Children Program became available to private practitioners 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.

**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.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The New Jersey Department of Health and Senior Services began the "rolling-out" of a re-designed, web based, statewide universal childhood Immunization Registry in April 2003, through a series of introductory efforts sponsored by the seven regional maternal child health consortia. All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate. Interfaces with private insurance carriers have been completed and they will be able to populate the registry as well via physicians accounting entries once the enabling legislation completes its way through the State Legislature. A new, nationally sponsored program, NICHQ, has been joined by DHSS and the New Jersey Chapter of the American Academy of Pediatrics to facilitate the introduction of the Immunization Registry into practice sites in targeted areas of particular need. Similar efforts are on going with the Academy of Family Practice of New Jersey as well. The Registry interfaces with the programmatic requirements of WIC and Medicaid.

**c. Plan for the Coming Year**

FHS continues to work collaboratively with the Immunization 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 record sharing. Interfaces with private insurance carriers and physician offices will also contribute to populating the registry.

**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	2003	2004	2005	2006	2007
Annual Performance Objective	16.5	16	12.5	12.4	12.3

Annual Indicator	15.4	12.5	12.3	12.0	12.3
Numerator	2424	2216	2216	2184	2233
Denominator	157765	176780	179456	181696	181696
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	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	12.2	12	11.8	11.6	11.4

**Notes - 2007**

Source: Provisional Electronic Birth Certificate file as of 5/17/2008.  
Denominator for 2007 is based on estimate from 2006 from  
<http://www.wnjpin.net/OneStopCareerCenter/LaborMarketInformation/lmi02/index.html#state>

Final 2007 data will be available in 2009.

**Notes - 2006**

Source: Provisional Electronic Birth Certificate file as of 6/15/2007.  
Denominator from  
<http://www.wnjpin.net/OneStopCareerCenter/LaborMarketInformation/lmi02/index.html#state>

**Notes - 2005**

Provisional 2005 data is from a provisional EBC file as of 7/12/2006. Census estimate for females 15-17 is from the Population Division, U.S. Census Bureau.

**a. Last Year's Accomplishments**

Seventeen family planning agencies with 57 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 Family Planning Program of the Reproductive & Perinatal Health Services held the 9th Annual Adolescent Health Institute. The Adolescent Puzzle: Supporting and Nurturing All Of the

Pieces, on Friday, November 16, 2007 at the Holiday Inn in East Windsor, New Jersey. There were 130 registered participants including individuals working in Family Planning agencies, schools and community-based agencies. The conference focused on the essential elements of healthy adolescent development and provided participants with a holistic view of the many components of this crucial period. Adolescence is a time of experimentation, excitement and emergence into adulthood and this conference examined elements of this entire process.

The Family Planning coordinator serves on the Region II Male Advisory Committee (MAC). The document "Guidelines for Male Sexual and Reproductive Health Services," a tool for family planning providers, was compiled in English and translated into Spanish and then distributed to all Region II Family Planning agencies. The MAC recommends that the guide be used as a tool by an agency to develop an organizing structure, outlining the male services to be included in their program.

**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. Adolescent Pregnancy Prevention Advisory Council				X
4. Community Partnership for Healthy Adolescents Grants				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In addressing NPM # 8 Teen (15-17) Birth Rate, collaboration with the Department of Human Services, the Department of Education, 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 and events for Teen Pregnancy Prevention Month (May).

Additionally, this interdepartmental workgroup continues to facilitate cohesive, integrated statewide systems that provide comprehensive pregnancy, prevention services for young people. Presently, the 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. As a result, this program is now referred to as the Teen Prevention and Education Program (Teen PEP), 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 with 57 clinical sites will continue to provide comprehensive reproductive health services to over 131,756 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. MCH resources also continue to support a Young Fathers Program in Newark.

Annually, the interdepartmental workgroup co-sponsors an Adolescent Health Institute in November. This one-day program was established for the purpose of bringing together adolescent stakeholders from throughout the state who are given an opportunity to participate in a forum that will provide up-to-date information and resources as they pertain to the many issues and challenges facing NJ youth.

Three of 8 Community Partnership for Healthy Adolescents Grants address Pregnancy Prevention including STIs and HIV/AIDS through planned community-based activities, youth forums, and in-school educational workshops.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	43	43	44	44	45
Annual Indicator	42.6	40	40	42	42
Numerator	803				
Denominator	1883				
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	45	46	46	47	47

**Notes - 2007**

During the 2006-2007 dental sealant survey, two additional parent/guardian recall questions were asked as follows: "Has your child ever had a cavity?" Data revealed that 52% of third grade students had a cavity during their lifetime. The other question asked, "Did your child have a dental checkup in the last year?" Data revealed that 87% of third grade students had a dental checkup during the last year.

**Notes - 2006**

2006 data is based on the NJ Dental Sealant Survey conducted during the 2006-2007 school year which gave a provisional statewide estimate of 42% of third grade students with sealants.

**Notes - 2005**

2005 data is based on the NJ Dental Sealant Survey conducted during the 2004-2005 school year which gave a statewide estimate of 40% of third grade students with sealants.

**a. Last Year's Accomplishments**

In the area of oral/dental health, support continues for two regional programs that employ dental hygienists who act as the Regional Oral Health Coordinators providing oral health education to school students through a variety of age appropriate teaching programs. During the 2006-2007

school year over 28,500 students participated in "Save Our Smiles", The weekly fluoride mouth rinse program.

A survey of third grade children in a sample of 46 elementary schools conducted in January 2001, found that 42% of parents reported their child had protective sealants on at least one permanent molar tooth. The dental sealant survey of third grade children was repeated in 2003 and found the similar result that 42.6% of parents reported their child had protective sealants on at least one permanent molar. During the 2004-2005 school year, a random sample of 40 schools statewide were surveyed and found a statewide estimate of sealants present in 42% of third grade students. These results were similar to the surveys conducted in 2001 and 2003. Education efforts related to the importance of dental sealants have been strengthened through parent education Efforts via the school setting. The dental sealant survey was conducted during the 2006-2007 school year and the survey found that statewide 42% of third grade students had a dental sealant. The data is consistent from surveys conducted during previous school years.

**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", Fluoride Mouthrinse Program			X	X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Federally Qualified Health Centers (FQHC) Expansion program continues to provide financial support of dental health services.

**c. Plan for the Coming Year**

To improve pediatric oral/dental health, the "Cavity Free Kids" program, the "Save Our Smiles" program and other age appropriate oral health programs will continue to provide oral health education to school age students. The FQHC Expansion program will continue to provide financial support of dental health services and the Physician/Dentist Loan Redemption Program will work to place more dentists in underserved areas of the State. Collaboration continues with the New Jersey Dental School and the New Jersey Dental Association to promote "Give Kids a Smile Day" which was held in February, 2007. The state supported FQHC capacity building effort will work to increase access to dental services.

In support of the ECCS grant goals and objectives for early childhood systems building, a collaboration with the Head Start-State Collaboration Project, a federal grant was submitted and awarded to convene an Early Childhood Oral Health Forum. The forum was held May 10, 2007 to address the oral health needs of underserved children in Head Start, Early Head Start, and children in child care settings. Approximately 75 health and oral health participants in and provided input for the development of an oral health action plan for New Jersey's children from birth to six.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	1.9	1.7	1.6	1.6	1.5
Annual Indicator	2.0	1.6	1.3	1.3	1.3
Numerator	34	28	23	23	23
Denominator	1738140	1788012	1737386	1737386	1737386
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	1.3	1.3	1.2	1.2	1.2

**Notes - 2007**

Most recent data available (2005) from the CDC is provided as an estimate for 2006  
 Data source - CDC National Center for Injury Prevention and Control  
<http://www.cdc.gov/ncipc/wisqars/>

**Notes - 2006**

Most recent data available (2005) from the CDC is provided as an estimate for 2006  
 Data source - CDC National Center for Injury Prevention and Control  
<http://www.cdc.gov/ncipc/wisqars/>  
 Final 2006 data will be available from the CDC in 2009.  
 Final 2007 data will be available from the CDC in 2010.

**Notes - 2005**

Data source - CDC National Center for Injury Prevention and Control  
<http://www.cdc.gov/ncipc/wisqars/>

**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.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Healthy Child Care Initiative safety focus			X	
2. Childhood Lead Poisoning Prevention Project's safety focus				X
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Although not specifically focused on deaths due to motor vehicle crashes, progress has been made on unintentional injury prevention activities. The Childhood Lead Poisoning Prevention Projects, in addition to providing lead-focused case management, instruct families in child safety including use of infant car seats and child restraint systems. Safety at home and in the child care center is one of the major focuses of the Healthy Child Care New Jersey Initiative.

**c. Plan for the Coming Year**

The Healthy Child Care New Jersey Initiative will continue to emphasize safety at home and in the child care center, and has collaborated with the state's Emergency Medical Services for Children program to develop a training curriculum entitled "Anticipating the Unexpected in Child Care Settings". This curriculum has been provided to child care providers in a variety of venues, including the inclusion of related articles in the quarterly Early Childhood Health Link newsletter.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				30	42
Annual Indicator			29	37.3	37.3
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	46	47	48	49	50

**Notes - 2007**

Source: National Immunization Survey, 2005 Births, Centers for Disease Control and Prevention, US Department of Health and Human Services  
[http://www.cdc.gov/breastfeeding/data/NIS\\_data/2005/state\\_any.htm](http://www.cdc.gov/breastfeeding/data/NIS_data/2005/state_any.htm)

New Jersey 37.3±7.4

Final 2007 data may be available from the CDC in 2010.

**Notes - 2006**

Source: National Immunization Survey, 2005 Births, Centers for Disease Control and Prevention, US Department of Health and Human Services  
[http://www.cdc.gov/breastfeeding/data/NIS\\_data/2005/state\\_any.htm](http://www.cdc.gov/breastfeeding/data/NIS_data/2005/state_any.htm)

New Jersey 37.3±7.4

Final 2006 data may be available from the CDC in 2009.

**Notes - 2005**

Estimate based on 2004 data.

Prior years data from Ross

[http://www.ross.com/images/library/bf\\_trends\\_2003.pdf](http://www.ross.com/images/library/bf_trends_2003.pdf)

2001 - 32.1 %

2002 - 31.3 %

2003 - 31.0 %

2004 - 29.0 %

**a. Last Year's Accomplishments**

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, and for 25% to breastfeed until one year.

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 2004 (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 2004, exclusive breastfeeding at hospital discharge statewide was 37.4% while any breastfeeding (exclusive and combination feeding) was 67.8%.

Breastfeeding rates on discharge varied with the minority composition of mothers. Asian non-Hispanic women were most likely to breastfeed (84.0%) while Black non-Hispanic women were least likely to breastfeed (49.3%). White non-Hispanic and Hispanic women initiated breastfeeding at 68.8% and 70.2% respectively.

The exclusive rates were 48.6% for White non-Hispanic women, 39.2% for Asian non-Hispanic women, 22.7% for Hispanic women, and 21.3% 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.

Closer collaboration between Maternal, Child, and Community Health Services (MCCH) and WIC Services (WIC) has begun. Both programs have an interest in breastfeeding protection, promotion and support and have similar constituencies. The programs looked at how breastfeeding is addressed in delivery hospitals by medical staff, clerks, and educators. The CDC Guide to Breastfeeding Interventions was sent to all the delivery hospitals in the State.

**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 applied research projects			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.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Many hospitals employed International Board Certified Lactation Consultants who identify early signs of breastfeeding difficulties and suggest appropriate options to the patients and medical staff. WIC Services funds breastfeeding promotion and support services for WIC participants through grants to five local WIC agencies and four MCH Consortia. 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 and education to healthcare providers who serve WIC participants.

**c. Plan for the Coming Year**

MCCH and WIC plan to partner with the MCH Consortia to hold a conference for maternity care providers in two locations. New Jersey hospital policy makers will be encouraged to use the CDC Guide to Breastfeeding Interventions to select evidence-based interventions and implement changes that are consistent with the "Ten steps to successful breastfeeding." Other appropriate resources will be provided. The activities and accomplishments of hospitals that have implemented appropriate policies and protocols and increased their breastfeeding rates will be highlighted.

Dissemination of surveillance information on breastfeeding will be expanded using birth certificate and PRAMS survey data. Efforts will also be made to improve the accuracy and collection of this data.

**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	2003	2004	2005	2006	2007
Annual Performance Objective	98	99	99	99	99
Annual Indicator	98.1	98.8	98.8	99.2	99.1
Numerator	108690	109060	108561	109181	108354
Denominator	110843	110401	109902	110054	109312
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	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	99.2	99.2	99.2	99.2	99.2

**Notes - 2007**

Provisional 2007 data from the Newborn Hearing Screening Program based on the EBC (as of 6/2008) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Final 2007 data will be available in 2009.

**Notes - 2006**

Final 2006 data from the Newborn Hearing Screening Program based on the EBC (as of 6/2008) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

**Notes - 2005**

Source: Newborn Hearing Screening Program, SCHEIS, FHS.

**a. Last Year's Accomplishments**

Current data indicates that for 2007, 99.1% of infants were screened prior to discharge.

During 2007, over 100 new users were trained on the EHDI reporting interface in the New Jersey Immunization Information System (IIS). The total EHDI user of the IIS now exceeds 200 individuals. Over 75% of outpatient forms are submitted by providers directly through the IIS interface.

The EHDI program co-sponsored Family Learning Day on May 19, 2007. This second biennial event was designed to provide an opportunity for families to come together and share information on a variety of topics related to raising and advocating for their children who have been diagnosed with hearing loss.

Also in May 2007, the EHDI program held a panel discussion for audiologists and other professionals who provide services to children with hearing loss. Speakers included representatives from the Case Management program, the Department of Education, the Division of the Deaf and Hard of Hearing, and parent support agencies. The panel was held at three locations in the northern, central and southern part of the state.

The program attended Pediatric Department business meetings at 5 hospitals, and had an exhibit table at the 2007 annual meeting of the New Jersey chapter of the American Academy of Pediatrics (AAP) in order to educate pediatricians about their role in the EHDI process. The program also collaborated with the Biochemical Screening program and the New Jersey AAP EHDI chapter champion in the development of a web-based educational program for pediatricians which will be released in 2008.

Site visits to all 59 active birthing facilities in the State were made during 2007 by the EHDI staff, focusing this year on compliance of hospital policies to state regulations and on the role of the pediatrician in the EHDI process. Quarterly reports were distributed to all hospitals comparing hospital performance to statewide averages and detailing children still needing follow-up. Annual visits by the EHDI audiologist to audiology facilities throughout the State were also continued in 2007. The audiologist visited 24 facilities and discussed the EHDI process with over 50 individuals at these facilities. Additionally, the EHDI Audiologist visited 18 SCHS Case

Management Units this year, educating nearly 150 case managers on the management of hearing loss.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activities Outreach to private practitioners				X
2. Amended regulation for universal screening				X
3. Hospital level surveillance reports			X	
4. Increase in follow up and diagnostic reporting for those who fail screening		X		
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

EHDI staff will conduct educational presentations to pediatrician groups and pediatric clinics during 2007 to emphasize the physician's role in the EHDI process and will discuss the importance of early screening and diagnosis. EHDI staff will review the importance of prompt follow-up so families can initiate appropriate intervention by the infant's six month.

The program's two parent education brochures (Can Your Baby Hear? and Your Baby Needs Another Test) have been translated into four additional languages -- Arabic, Korean, Polish and Portuguese. Printing is currently underway for these to be distributed during 2008.

The program is currently working on a quality assurance initiative to determine why children with hearing loss may fail to be enrolled in early intervention services in a timely manner.

The New Jersey Pediatric Hearing Health Care Directory will be updated in spring 2008 and annually or semi-annually thereafter. Over 120 facilities were listed in the Fall 2007 Edition.

**c. Plan for the Coming Year**

Ongoing activities to be continued for the coming year include hospital and audiology site visits. Quarterly reports continue to be sent to all hospitals to track success and progress. The EHDI program will continue to focus on improving rates of outpatient follow-up for children who do not pass their initial screening. The program will also focus on continued education of physicians, audiologists and hospital personnel involved in identification of hearing loss in newborns.

Educational visits to pediatrician offices will continue to be conducted, as will visits to private audiology offices. The AAP Chapter Champion for hearing screening plans to present several grand rounds on newborn hearing screening this year.

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

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	10.5	10	9.5	9	10
Annual Indicator	11.5	11.7	11.3	13.1	13.1
Numerator	264614	269256	258536	299274	299274
Denominator	2291296	2299330	2292031	2292031	2292031
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	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	12	11	10	9	9

**Notes - 2007**

Data for 2006 is entered as an estimate for 2007.

Final 2007 data will be available in Spring 2009.

**Notes - 2006**

Source: the Annual Social and Economic Supplement (ASEC) of the Current population Survey (CPS), which is conducted by the Bureau of the Census for the Bureau of Labor Statistics. The age group is children 0-18 years old.

[http://www.state.nj.us/health/chs/documents/hic00\\_07.pdf](http://www.state.nj.us/health/chs/documents/hic00_07.pdf)

**Notes - 2005**

Source: Source: Current Population Survey: Annual Demographic File, 2003-6, Bureau of the Census

[http://www.state.nj.us/health/chs/hic0106/hic00\\_06.pdf#Tab2](http://www.state.nj.us/health/chs/hic0106/hic00_06.pdf#Tab2)

Uninsured by age (0 - 18) = 11.3

estimated numerator based on weighted data = 258536

**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, New Jersey and the Federal government have joined as partners in NJ FamilyCare (formerly New Jersey KidCare). NJ FamilyCare, administered by the New Jersey Department of Human Services, started in 1998. As of January 2008 there were 109,410 children enrolled in the expanded NJ FamilyCare initiative and 104,410 adults 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 13.1% in 2006.

**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.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

To reduce the number of uninsured children in New Jersey (National Performance Measure #13), Reproductive and Perinatal Health Services continues to work with the Healthy Mothers, Healthy Babies (HMHB) Coalitions, Healthy Start Projects and Black Infant Mortality Reduction projects to facilitate enrollment of children whose mothers are served by the projects.

Atlantic City, Paterson, and Essex County HMHB coalitions have made FamilyCare enrollment one of their priority areas as an access to care issue. Outreach staff assists clients with accessing the system and completing the enrollment process.

**c. Plan for the Coming Year**

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	2003	2004	2005	2006	2007
Annual Performance Objective				39	40
Annual Indicator			39.8	39.1	39.1
Numerator			60981	61327	61327
Denominator			153155	157001	157001
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	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	39	39	38	38	37

**Notes - 2007**

Data for 2007 is not available as of 7/1/2008. Data from 2006 is entered as an estimate for 2007. Final 2007 data may be available from CDC in Spring 2009.

**Notes - 2006**

Data from the 2006 WIC Pediatric Nutrition Surveillance System Table 12C

- 2002 - 33.9%
- 2003 - 34.9%
- 2004 - 34.5%
- 2005 - 35.4%
- 2006 - 35.6%

**Notes - 2005**

Data from the 2004 WIC Pediatric Nutrition Surveillance System Table 2C and 10C

Data for 2005 is estimated from 2004 data.

- 2000 - 39.0%
- 2001 - 37.9%
- 2002 - 38.3%
- 2003 - 38.8%
- 2004 - 39.8%

**a. Last Year's Accomplishments**

The New Jersey Obesity Prevention Action Plan was approved by Governor Corzine in July 2006.

The PLAY (Physical Lifestyles of Active Youth) Task Force and the Interagency Council on Osteoporosis collaborated on a pre-school healthy eating and physical movement curriculum project. With materials from National Dairy Council, the curriculum was updated to include current content and pilot trainings were conducted at statewide conferences in the spring and the fall of 2007. Funding from the Robert Wood Johnson Foundation was applied for but not approved.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing collection and reporting of weight and height in the NJ Child Weight Status Report				X
2. Development of recommendations by the New Jersey Obesity Prevention Task Force				X
3. Three Community Partnership for Healthy Adolescents grantees are exploring the feasibility of collecting and analyzing height and weight data from their respective school systems				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The New Jersey Obesity Prevention Task Force was reconvened in fall 2007 and discussion about pending recommendations for next steps took place. OPTF is creating a volunteer speaker's bureau and developing a marketing plan to maintain the impetus of the obesity awareness campaign.

Two Child Health Regional Network meetings on "Nutrition and Physical Activity Strategies for the Early Childhood Population" utilizing the program: I am Moving, I am Learning (IMIL); Color Me Healthy (CMH); and PLAY Plus were held with public health nurses, Head Start, child care and LHD staff, and county Child Care Health Consultant Coordinators.

An application for CDC's 5 year competitive cooperative agreement is being submitted for the Nutrition, Physical Activity and Obesity Program. The application is due March 17, 2008. If approved, funding is anticipated to begin July 1, 2008.

**c. Plan for the Coming Year**

Collect and evaluate NAPSACC data submitted preschools implementing PLAY PLUS.

The New Jersey Obesity Prevention Action Plan (OPAP) will be reviewed and revised to meet CDC milestones. The first milestone is that the current plan be revised by partners who are engaged to contribute or leverage their resources toward the development and implementation of the plan rather than a legislated Task Force. Second a process for establishing priorities and responsible entities (agencies or organization) for implementation of activities and delineation of timelines needs to be completed. Third, measurable program objectives, indicators to measure progress available data sources and methods for determining success have to be determined. Fourth, the OPAP needs to target six areas; physical activity, fruit and vegetables consumption, sugar sweetened beverages, energy dense foods, television viewing and breastfeeding. CDC's State Plan Index (SPI) can be utilized to evaluate the planning process, stakeholder participation, goals and objectives and the methods to implement the strategies; and, ensure that the original OPAP document is enhanced to be aligned with meeting CDC milestones for a NPAO state plan. The state plan will be evaluated at least annually, thereafter.

Other than reviewing and revising OPAP, the plan for the coming year is dependent upon approval of DHSS's funding request to CDC. Notification of approval is anticipated by June 2008.

**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	2003	2004	2005	2006	2007
Annual Performance Objective				8	8
Annual Indicator			8.1	8.1	8.1
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	7.8	7.7	7.6	7.5	7.4

**Notes - 2007**

2006 data is estimated from the NJ PRAMS 2002-2004 sample.

**Notes - 2006**

2006 data is estimated from the NJ PRAMS 2002-2004 sample.

**Notes - 2005**

2005 data is estimated from the NJ PRAMS 2002-2004 sample.

See NJ PRAMS Brief on Smoking and Pregnancy in New Jersey at [http://www.state.nj.us/health/fhs/documents/brief\\_smoking\\_prevalence.pdf](http://www.state.nj.us/health/fhs/documents/brief_smoking_prevalence.pdf)

**a. Last Year's Accomplishments**

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

New Jersey has formed a partnership with ACOG and continues to participate as needed. This is a statewide, interdisciplinary committee.

Mom's Quit Connection (MQC), a grant funded project that offers phone counseling to pregnant women, MQC teaches the 5 A's approach to quit smoking to professionals to use with their clients.

**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**

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 Maternal, Child and Community Health 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 Post Partum Depression Initiative will focus on development and implementation of increased treatment options for woman who suffer with PPD.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	3.5	3.5	3	2.9	2.8
Annual Indicator	3.1	5.6	4.4	4.4	4.4
Numerator	18	33	26	26	26
Denominator	573100	587620	585572	585572	585572
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	4.2	4	3.6	3.3	3

**Notes - 2007**

Provisional 2007 data estimated from final 2005 data. Final 2007 data may be available from NCHS in Spring 2010.

**Notes - 2006**

Provisional 2006 data estimated from final 2005 data. Final 2006 data may be available from NCHS in Spring 2009.

**Notes - 2005**

Source: CDCP - National Center for Injury Prevention and Control  
[http://webappa.cdc.gov/sasweb/ncipc/mortrate10\\_sy.html](http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html)

**a. Last Year's Accomplishments**

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. Since FY 2001 state funds have been budgeted to replicate this coalition in the other 20 counties in New Jersey.

An inter-agency, inter-disciplinary team was convened by Deputy Commissioner Dr. Eddy Bresnitz with the task of developing a New Jersey State Plan for Suicide Prevention. They met May 23rd and 24th, 2006 to review the progress to date in New Jersey in this field and to adapt the National Strategy for Suicide Prevention: Goals and Objectives for Action to suit the needs of New Jersey. The meeting was facilitated by Dr. Ramya Sundararaman, Coordinator from the Suicide Prevention Resource Center, in Newton, Massachusetts. A draft of the New Jersey State Suicide Prevention Plan was sent to Celeste Andriot Wood through channels for approval.

Through collaboration with Department of Human Services and University of Medicine and Dentistry of New Jersey the following trainings were provided:

- Traumatic Loss Trainers provided 44 Suicide Awareness Training Workshop for Educators throughout the State. These workshops provided information on mental health disorders that put youth at higher risk for suicide as well as risk factors, protective factors and warning signs for suicide to 7,168 educators and other school personnel
- There were 672 attendees at the 5th Annual Suicide Prevention Conference on May 10, 2007.
- Traumatic Loss County Coordinators provided or co-sponsored suicide prevention workshops and trainings in their respective counties for a total of 6,557 attendees.

**Table 4a, National Performance Measures Summary Sheet**

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

**b. Current Activities**

"Managing Sudden Traumatic Loss in the Schools" (revised edition) is made available to schools and other youth serving organizations upon request. The document outlines a model for responding to the needs of the general school population after a suicide, homicide or sudden accidental death.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	88	88	85	85	80
Annual Indicator	84.5	83.9	80.5	77.6	76.7
Numerator	1501	1438	1398	1379	1315
Denominator	1776	1713	1737	1776	1714
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	80	80	80	80	80

### Notes - 2007

Provisional 2007 data from the Electronic Birth Certificate file as of 6/15/2008. Final 2007 data may be available in Spring 2010.

### Notes - 2006

Provisional 2006 data from the Electronic Birth Certificate file as of 6/15/2008. Final 2006 data may be available in Spring 2009.

### Notes - 2005

Facilities for high risk deliveries defined as Intensive and Regional Perinatal Centers. Provisional 2005 data from EBC as of 7/11/2006.

### a. Last Year's Accomplishments

The state has made consistent progress on NPM #17. However, despite improvements in Neonatal Intensive Care Units (NICU) and community-base efforts that focus on early admissions to prenatal care and comprehensive services, we have not observed 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 rapid 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 FHS/Perinatal Services coordinates regional continuous quality improvement activities within each of the 6 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 Consortia

monitor the accuracy of data entered into the EBC and provide training and technical assistance as needed. Data collected by each Consortium through the EBC reflects births that occur in each Consortium's member hospitals only. The MCH Consortia recommend, implement, and monitor corrective action, based upon the data collected. A multidisciplinary committee that includes representation from member hospitals and the community oversees the total quality improvement process within the Consortium. Data collected through the EBC and the NJ Maternal Mortality Review and NJ Fetal-Infant Mortality Review are presented to the Consortium TQI Committee. 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. Data and information gleaned from regional TQI activities is forwarded to the FHS/Perinatal Services, which will be included in a combined database used for planning on a statewide level.

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 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 Chief of Neonatal Medicine from the Regional Perinatal Centers and the Executive Director of each of the regional MCH Consortia attended a series of meetings in 2007 to develop this total quality improvement project.

**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. MCH Task Force on Hospital-based perinatal and pediatric services				X
4. Development of the New Jersey VON Collaborative				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

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

The Directors of Neonatology of the RPCs have been meeting to develop the NJ VON Collaborative. To date, 12 of the 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 Neonatal Intensive Care Units (NICU) performance data submitted to the Vermont Oxford Network, Inc.

The participants acknowledge that the goal of the Collaborative is to improve the quality and outcomes of perinatal health care in NJ through the adoption of VON's mission - to improve the quality and safety of medical care for newborns and their families through a coordinated program of research, education and quality improvement project. The purpose of the Collaborative is 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.

**c. Plan for the Coming Year**

The NJ VON Collaborative will be meeting to plan the review of the data indicators for the next year. Preliminary plans include review of data indicators chosen by the Directors of Neonatology. Outcome data on specific indicators will be compared among the participating facilities. Facilities with documented "best practices" will provide opportunities for site visits by teams from other neonatal units.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	79	79	79	79	79.2
Annual Indicator	79.2	78.6	77.9	77.1	76.6
Numerator	89022	88136	86278	86158	86363
Denominator	112350	112117	110697	111727	112715
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	79.2	79.4	79.6	79.8	80

**Notes - 2007**

Source: 2007 provisional data from the Electronic Birth Certificate file as of 6/15/2008. Final data will be available in 2010.

**Notes - 2006**

Source: 2006 provisional data from the Electronic Birth Certificate file as of 5/17/2008. Final data will be available in 2009.

**a. Last Year's Accomplishments**

Through the Healthy Mothers Healthy Babies HM/HB Coalition program, the enabling services of outreach, supportive services, and education are provided to improve maternal and infant care (National Performance Measures #18, #5, #17, and Health Status Indicators #2, #3, #4, #5). The percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester and the percentage of infants born to pregnant women receiving adequate prenatal care (Kotelchuck Index) have slowly increased over the last decade.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Mothers Healthy Babies coalition activities				X
2. MCH Consortia outreach and education activities				X
3. HealthyStart				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Prenatal Care Task Force was convened in February 2008 will the following charge: Review current data on first trimester prenatal care access, racial and ethnic disparities in first trimester prenatal care access, contributing factors to women not accessing first trimester care, adequacy of the provider network, and identify and regional or geographic barriers to care: Review best practices and identify successful programs to increase first trimester prenatal care; Review current support for improved pregnancy outcome activities; and make recommendations to improve access to first trimester prenatal care in New Jersey.

The enabling services of outreach, supportive services, and education will continue to be provided to improve prenatal care through the Healthy Mothers/Healthy Babies (HM,HB) Coalition program.

**c. Plan for the Coming Year**

The HM,HB programs will provide the following services.

The Atlantic City HM,HB Coalition will: conduct outreach to identify 50 women in need of prenatal or postpartum care, educate them and provide follow-up to ensure continued receipt of care; educate 500 women on the importance of preconception care; and sponsor a Mother Daughter Day of Health.

The Camden HM,HB Coalition will: provide case management for 75 high risk pregnant women; reconnect 150 pregnant women "lost to care"; educate them and provide follow-up to ensure continued receipt of care; identify 75 pregnant women in their first trimester who are not receiving care, educate them and connect them to services; and sponsor a Fatherhood event.

In East Orange, Irvington, Newark and Orange, the Essex HM,HB Coalition and 5 subgrantees will: sponsor a conference for outreach workers; identify 40 pregnant women not receiving prenatal care, educate them, refer them for services and follow-up to ensure continued receipt of care; conduct outreach activities to educate 7,000 residents on perinatal health issues; reconnect 150 pregnant women "lost to care," educate them and follow-up to ensure continued receipt of care and provide case management to 3,500 pregnant or post-partum women.

The Jersey City HM,HB Coalition will: identify 60 pregnant women not receiving prenatal care, educate them, refer them for services and follow-up to ensure continued receipt of care; conduct prenatal education workshop for 25 high school students; sponsor a conference on infant mortality reduction for 50 professionals and 25 consumers; conduct workshops for 4,000 women on infant mortality reduction and provide preconception health information to 6,000 women.

The New Brunswick HM,HB Coalition will: sponsor 2 outreach workers trainings and participate in 12 community events. The Coalition awarded a subgrant to provide parenting/baby care classes for 600 parents and identify women "lost to care," educate them on the importance of care, reconnect them to services and follow-up to ensure continued care.

The Paterson HM,HB Coalition will: identify 100 pregnant women "lost to care", educate them on the importance of care, reconnect them to services and follow-up to ensure continued receipt of care, and educate 3,000 high school and 100 grammar school students on the risks associated with teenage pregnancy.

The Plainfield HM,HB Coalition will: sponsor a "Game of Life" and participants in 12 community events. The Coalition awarded a subgrant to assure prenatal care for 25 women not receiving services and to assure continued services for 125 women or children 0-1 year of age "lost to care."

The Trenton HM,HB Coalition will: provide case management for 125 high-risk mothers; and assure prenatal care for 25 pregnant women not receiving services. The Coalition awarded a subgrant to provide preconception, prenatal, and post-partum information in English and Spanish and prenatal classes and support groups for 40 Latina women.

## 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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	13.3	13.2	13.2	13.1	13
Annual Indicator	13.4	11.6	11.5	12.1	11.3
Numerator	2256	1912	1866	2039	1945
Denominator	16872	16447	16221	16864	17256
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	13	13	13	12	12

### Notes - 2007

Provisional 2007 data from the Electronic Birth Certificate file as of 6/15/2008. Final 2007 data will be available in 2010.

### Notes - 2006

2006 data from the Electronic Birth Certificate file as of 5/7/2008.

### Notes - 2005

Source of provisional 2005 data is the Electronic Birth Certificate file as of 7/11/2006 which include births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

### a. Last Year's Accomplishments

Maternal, Child and Community Health chose the percent of black preterm births in New Jersey as State Performance Measure #1. Previous sections concerning the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign and MCH activities demonstrate the department's commitment to reduce black infant mortality. 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.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Mothers /Healthy Babies Coalitions			X	X
2. Healthy Start		X		X
3. Preconceptual health counseling/training				X
4. HealthStart				X
5. MCH Consortia outreach and education activities			X	X
6.				
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**

Seven health service grants were awarded to a variety of health service agencies to implement innovative approaches to reduce the high incidence of black infant mortality. These strategies include outreach and education, case management, prenatal and postnatal healthcare prevention and social service support, community awareness activities on the issue of black infant mortality and multifaceted communication programs via websites.

**State Performance Measure 2:** *The percentage of Regional MCH Consortia implementing community-based Fetal and Infant Mortality Review (FIMR) Teams.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	7	6	6	6	6
Denominator	7	6	6	6	6
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2007**

Source: Maternal Child & Community Health Service Unit

**Notes - 2006**

Source: Maternal Child & Community Health Service Unit

**Notes - 2005**

Source: Maternal Child & Community Health Service Unit

**a. Last Year's Accomplishments**

State Performance Measure #2 was selected to monitor progress toward the implementation of community-based Fetal and Infant Mortality Review Teams (FIMR). 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.

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 2003 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 year 1991-2001 was released in August, 2006.

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 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 3:** *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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	0.4	0.4	0.3	0.3	0.2
Annual Indicator	0.5	0.3	0.4	0.3	0.2
Numerator	832	543	628	450	350
Denominator	172932	167018	173141	179158	161776
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	0.2	0.2	0.2	0.2	0.2

**Notes - 2007**

Source: Childhood Lead Prevention Program Database, MCCH, FHS. for Federal Fiscal Year 2007.) Final 2007 data will be available in Spring 2009.

**Notes - 2006**

Source: Childhood Lead Prevention Program Database, MCCH, FHS. for calender year.

**Notes - 2005**

Source: Childhood Lead Prevention Program Database, MCCH, FHS.  
For Federal Fiscal Year 2005 (not calendar year).

**a. Last Year's Accomplishments**

The percent 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 than the national average. In State FY 2006, 1.8% of children tested for lead poisoning in New Jersey had elevated (> 10 ug/dL) blood lead levels. Children with elevated blood lead levels are at increased risk for behavioral, physiological and learning problems. Increased childhood morbidity will result from undetected and untreated lead poisoning.

Significant progress was made toward SPM # 3 regarding childhood lead poisoning prevention. During calendar year 2007, more than 205,000 blood lead tests were reported on 193,284 children. Of the children tested during calendar year 2007, 83.7% were under the age of 6 years. Among these children, 1.3% had results > 10 ug/dl and 0.2% had results > 20 ug/dl. Of all the children tested, 93,118 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 42.8% of all children in that age group. Looking at all blood lead tests reported since 1999, it is estimated that 76% 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.

A new web-based data and surveillance system (LeadTrax) containing medical and environmental case management modules has been customized and implemented as of July 1, 2006. This surveillance system is accessible to local health departments 24 hours a day, 7 days a week, by means of the internet. The new system is able to track non-paint based lead sources, share data with other data systems (such as New Jersey Immunization Information System), and enhance communication between child health program staff and local health departments. The new data system has tools for improved de-duplication of records and cleaning of data, electronically exporting quarterly surveillance extracts to the CDC, and generating summary reports. The new surveillance system is CDC compliant.

During calendar year 2007, because of ongoing efforts the percentage of electronic reporting increased to 96% from the calendar year 2006 rate of 92%. This surpasses the rate that was originally anticipated by the end of State Fiscal Year 2008 (95%). Child Health program staff is in the process of helping outstanding laboratories to make a transition from hard copy to electronic reporting. With the new web based surveillance system, more laboratories will be able to report electronically because of the system's capability to accept HL7 and Microsoft Excel format reports.

**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. Medicaid collaboration on pilot screening projects				X
4. Regional Childhood Lead Poisoning Prevention Coalitions			X	X
5. Plan for Elimination of Childhood Lead Poisoning in New Jersey			X	X
6. Nurse case management and environmental investigation protocol enhancements for highest risk jurisdictions (>=15 ug/dl)			X	X
7. Targeted screening enhancements (children exposed to			X	X

parental occupational exposure, refugee children to age 16 years)				
8.				
9.				
10.				

**b. Current Activities**

The project of expanding LeadTrax use by more local health departments will be launched in the calendar year 2008.

In 2008, the DHSS will publish the FY 2006 Annual Report on Childhood Lead Poisoning in New Jersey for dissemination of this data to local health departments and the public. These efforts have involved child care as access points for lead poisoning prevention education and screening in collaboration with local health departments and other community agencies.

The project to create maps using childhood lead poisoning data and housing data, exhibiting lead poisoning and screening distribution, along with the distribution of pre-1950 houses, in the State, will be launched in March 2008. This project will be in partnership with Center for Cancer Initiatives of New Jersey in the Department of Health & Senior Services. The maps will be shared with the grantee agencies to help them design their targeted screening and education plans. This project will be expanded further to create census tract level (zoomed-in) maps for high risk jurisdictions in the State.

**c. Plan for the Coming Year**

Continue to collaborate with the State's Immunization Program to populate the lead screening module for the Immunization Registry. Collaborative efforts with Medicaid and its contracted managed care providers will continue in order to increase the number of Medicaid-enrolled children screened for lead poisoning.

Screening is an integral component of a lead poisoning prevention program. A NJ specific targeted screening and case management plan was implemented in 2006. In January 2006, a team comprised of DHSS, CDC, and Harvard School of Public Health developed a plan to evaluate the implementation and outcomes of the case management component. The evaluation process should be completed in 2009.

The Child Health unit will continue to place a greater focus on implementing primary prevention initiatives and strengthening strategic partnerships at all levels. State partners include Department of Community Affairs which is responsible for the development and enforcement of state housing codes and standards, Department of Human Services (Medicaid), and Department of Children and Families. Local health departments and local and regional coalitions will continue to expand their efforts with their local housing authorities to identify and address lead hazards prior to a young child moving into a home, 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 will be coordinated by DHSS to assure that the state is collectively making progress to eliminate childhood lead poisoning (0 cases  $\geq$ 10 ug/dL by 2010).

In the highest risk city, Newark, the CLPP Program will continue to partner with the Newark Department of Health and Human Services (DHHS) to sustain the Newark Partnership for Lead Safe Children. The partnership has been designed to empower the city and participating organizations to "take charge" of the lead problem in Newark. Newark DHHS has implemented a citywide lead poisoning prevention education initiative: "Lead Free is Best for Me". A small passenger van donated to the partnership by one of its members has been converted into "Leadie Eddie" - a mobile lead poisoning prevention exhibit that travels to childcare centers and community sites to do education programs. In addition, CDC issued a contract to the National

Center for Healthy Housing in March 2008 to provide technical assistance, for all areas of the Newark DHHS' local CLPP program, focusing on strategies that will assure progress toward the goal of eliminating childhood lead poisoning.

All children in target areas with elevated blood lead levels that require public health intervention are eligible for Childhood Lead Poisoning Prevention Project services (described earlier in this section) Children in other areas of the State with elevated blood lead levels are served by their local health department as required by the State Sanitary Code (Chapter XIII).

**State Performance Measure 4:** *The percentage of repeat pregnancies among adolescents 15 - 19 years of age.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	6.3	6	5.8	5.7	5.6
Annual Indicator	5.8	5.8	5.9	6.3	5.7
Numerator	406	404	408	448	411
Denominator	7032	6917	6865	7139	7258
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	5.5	5.5	5.4	5.4	5.3

**Notes - 2007**

Provisional 2007 data from the Electronic Birth Certificate file as of 5/7/2008. Final 2007 data will be available in Spring 2009.

**Notes - 2006**

2006 data from the Electronic Birth Certificate file as of 5/7/2008.

**Notes - 2005**

Source of provisional 2005 data is the Electronic Birth Certificate file as of 7/12/2006 which include births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

**a. Last Year's Accomplishments**

The percentage of repeat pregnancies among adolescent mothers 15-19 years of age (State Performance Measure # 4) was chosen because teen parents are more likely to have another child within two years, often leading to increased hardship and economic dependency. This state performance measure will also impact on National Performance Measure # 8. The percentage of repeat pregnancies among adolescent mothers 15-19 has decreased from 8.2% in 1998 to 5.8% in 2004.

The Adolescent Parenting Project (APP) serving Cumberland County continues to use a case management/home visiting model in order to reduce the rate of repeat pregnancy within 24 months of a first birth. It also promotes the physical and psychosocial health of low-income pregnant or parenting adolescents and their infants. Cumberland County is a rural area in the state and has the highest rate (37.3%) of teen (ages 10-19) births per County population in New Jersey (NJ Health Statistics 2004). During 2007, the percent of parenting moms in the APP having a repeat pregnancy within 24 months following delivery of a first baby was 6%. Out of a total of 69 pregnant and/or parenting adolescents who participated in the APP, 41% were Hispanic as compared to 47% in 2004 and 53% in 2005.

While the APP appears to have demonstrated success in reducing a repeat pregnancy, several

caveats need to be acknowledged. A control group is critical to scientifically proving the effectiveness of the APP program. Without a comparison of the APP repeat pregnancy rate with a control group pregnancy rate, the true impact of the APP program cannot be estimated. In addition, the APP caseload consisted of a self-selected group of teens who elected to participate in the APP and many clients did not remain in the program for a full two year period for complete follow-up.

During 2007, 88% of enrolled teens had primary care providers. 90% of their babies were enrolled with pediatricians, and 96% of babies were age appropriately immunized. The birthweights of 81% of the babies born to the teens were at 2,500 grams or above and none were less than 1500grams. 70% of pregnant teens were admitted to the program during the first trimester; however, all the pregnant teens received prenatal care. The program has never had any substantiated cases of child abuse.

In the spring of 2007, FamCare applied and was approved, by the Department of Children and Families, to implement the Parents as Teachers (PAT) model. Staff were sent for training on this evidenced-based model.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive services for teens through Family Planning sites	X			X
2. Adolescent parenting project (AAP)		X		X
3. Advisory Council on Adolescent Pregnancy Prevention completion of a three-year strategic plan				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The APP at FamCare is in the process of transitioning their program from APP to the PAT model. This transition will be completed by June 30, 2008 at which time FamCare will be fully funded by the Department of Children and Families for implementation of this model.

**c. Plan for the Coming Year**

There will not be any funded initiatives in Adolescent Health addressing this measure since the APP at FamCare was the only grantee.

**State Performance Measure 5:** *The percentage of State supported initiatives implemented for improving the nutrition and physical activity of children and adolescents*

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				100	100
Annual Indicator		100.0	100.0	100.0	100.0
Numerator		7	12	12	12
Denominator		7	12	12	12
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2007**

Source: Child & Adolescent Health Programs, FHS.

**Notes - 2006**

Source: Child & Adolescent Health Programs, FHS.

**Notes - 2005**

Source: Child & Adolescent Health Programs, FHS.

**a. Last Year's Accomplishments**

A multi-year Memorandum of Agreement (MOA) between DHSS and Rutgers Cooperative Extension (RCE) was signed in March 2007 to collaborate on a statewide obesity prevention campaign 'Get Moving, Get Healthy NJ! (GMGH NJ!)

DHSS supported the Department of Agriculture's regulatory policy that requires each school district to have developed and, by September 2007, implemented a policy consistent with the NJ Department of Agriculture's Model School Nutrition Policy.

Stakeholders on the Obesity Prevention Task Force Report and recommendations for next steps were discussed.

Thirteen applications were submitted by local health department and YMCA teams for ACHIEVE (Action Communities for Health, Innovation and EnVironmental Change) grants. DHSS ranked and submitted these applications to the national sponsoring agencies: National Association of Chronic Disease Directors (NACDD) and Y-USA (YMCA of the USA). ACHIEVE grants will bring together local stakeholders to build healthier communities by promoting policy and environmental change strategies. However, NJ's application submission was not approved.

Adolescent Health staff met with the NJ After 3 Executive Director and staff about potential areas (childhood obesity and school health) of collaboration. NJ After 3 funds 108 programs and serves 15,000 youth a year.

In December 2007, DHSS and NJ Dietetic Association (NJDA) hosted a meeting with Commissioner Jacobs and 125 Registered Dietitians (RDs), Dietetic Technicians Registered (DTRs) and students and encouraged collaboration and the use of state resources: County Health Improvement Plans, Mayors Wellness Campaign, NJ Fruit and Vegetable Program and Rutgers Cooperative Extension Get Moving, Get Healthy NJ! Campaign.

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Revision of the Obesity Prevention Action Plan to determine priorities				X
2. Two Community Partnership for Healthy Adolescents grantees				X

are continuing efforts to address nutrition and physical activity with 10-17 year old youth				
3. Collaboration with PLAY Task Force and the legislated Interagency Council on Osteoporosis (ICO) on a statewide pre-school education initiative for providers, families and pre-school aged children				X
4. Healthy Community Development mini grants		X		X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The NJCPFS funded 22 mini-grants from throughout NJ for promoting health and physical activity in their communities.

As part of the MOA with Rutgers Cooperative Extension the Get Moving, Get Healthy NJ! Website ([www.getmovinggethealthynj.org](http://www.getmovinggethealthynj.org)) aimed at increasing youth and family access to nutrition was launched. In addition, the 9th Childhood Obesity Summit was held in Morris County on November 2nd and 180 stakeholders attended this event aimed at encouraging the community to participate in activities to assist youth and families. A second Child Health Summit is pending as are 8 Family Fun Night events.

Child and Adolescent Health staff and the Office of Local Health are exploring ideas of how MAPP teams and their CHIPs (most reflect obesity as a priority) might be used, as the umbrella for county coalitions (infrastructure), to address nutrition and physical activity, obesity and 5-A-Day initiatives. Training for the obesity sub-committee of MAPP team members is being proposed for the OPTF statewide conference.

The Osteoporosis Awareness and Education Act became law in 1997 but does not include a state appropriation. Osteoporosis activities are coordinated with the Division of Senior Affairs, in consultation with the Interagency Council on Osteoporosis (ICO). Currently, the KidStrong (Inside & Out) curriculum will be reviewed and revised by Rutgers Cooperative Extension and consideration will be given to its use as both an osteoporosis and obesity prevention strategy.

**c. Plan for the Coming Year**

The New Jersey Obesity Prevention Action Plan (OPAP) will likely be reviewed to meet CDC milestones. The first milestone is that the current plan be revised by partners, rather than a legislated Task Force, who are engaged to contribute or leverage their resources toward the implementation of the plan. Second, a process for establishing priorities, responsibilities for implementation of activities and delineation of timeliness, needs to be completed. Third, measurable program objectives, indicators to measure progress available data sources and methods for determining success have to be determined. Fourth, the OPAP needs to focus on six areas: physical activity, fruit and vegetable consumption, sugar sweetened beverages, energy dense foods, television viewing and breastfeeding. CDC's State plan Index (SPI) is a tool that can be utilized to evaluate the planning process, stakeholder participation, goals and objectives and the methods to implement the strategies; and, ensure that the original OPAP document is enhanced to be aligned with meeting CDC milestones for a NPAO state plan. The state plan will be evaluated at least annually, thereafter.

Other than reviewing and revising OPAP, the plan for the coming year is dependent upon

approval of DHSS's funding request to CDC. Notification of approval is anticipated by June 2008.

**State Performance Measure 6:** *The percentage of children with birth defects who are appropriately reported to the New Jersey Birth Defects Registry.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	86	87	87	88	88
Annual Indicator	87.2	86.6	88.8	88.9	89.0
Numerator	1310	1289	1359	1437	1377
Denominator	1503	1488	1531	1616	1547
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	89	90	90	91	92

**Notes - 2007**

There are several changes due to data recording errors and further refinement/reconciliation of data from previous audit periods. 2006 and 2007 data is provisional pending further reconciliation of data from the hospital medical chart audits. Final 2006 and 2007 data may be available in 2009.

**Notes - 2006**

2006 data is provisional pending further reconciliation of data from the hospital medical chart audits.

**Notes - 2005**

2005 data is provisional pending further hospital medical chart audits.

**a. Last Year's Accomplishments**

SPM #6 was chosen to improve the quality of the Birth Defects Registry (BDR) which has been an invaluable tool for surveillance, needs assessment, service planning and research. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928. Since 1985, NJ has maintained a population-based BDR of children with all defects. In 2003, the SCHS Registry received a 5-year cooperative agreement from CDC for the development and implementation of a web-based data reporting and tracking system. In 2007 NJ legislation passed legislation mandating the reporting of Autism. As a result of this legislation, the BDR will add autism as a reportable diagnosis to the BDR. Legislative rules have been drafted detailing the mechanics of reporting Autism to the BDR. The proposed rules include expanding the mandatory reporting age from birth through age 1 to birth through age 5 and adds severe hyperbilirubinemia as a reportable condition. This expansion was mandated by an amendment to the BDR law enacted in 2005.

In FY 2008, the CDC continued to fund the BDR through this cooperative agreement for improvements in the BDR system. Rutgers, the State University - Bloustein School of Planning and Public Policy (Bloustein SPPP) continued development of the new BDR System (BDRS) by developing a preliminary electronic registration form. They conducted extensive interviews with staff from the SCHS county-based Case Management Units. As a result of these interviews, BDR staff developed electronic forms for routine case management activities, including the Individual Family Service Plan (IFSP), child-specific case manager activities, and State and federally required reports. Separately, discussions were held with EIS's staff to identify the information needed to include children diagnosed with autism into the BDR and to identify any modifications to existing procedures to meet the new legislation requirements.

The web-based BDRS will facilitate improvements in reporting from hospitals and medical providers as well as the information transfer between NJDHSS and the county-based Case Management Units through a secure and HIPAA-compliant Virtual Private Network (VPN). In parallel to the development of the BDRS, a new 2-page hard copy registration form was designed and implemented.

In 2007, the SCHS Registry:

- Processed nearly 12,000 registrations
- Identified over 8,500 new children with birth defects and other special health needs
- Updated about 1,500 records of previously registered children
- Referred over 8,000 families to the SCHS County-based Case Management Units
- ? Received over 260 autism-related registrations

In addition to identifying children through the formal registration process, the Program has implemented quality assurance measures to assure children are properly reported to the BDR. BDR staff identify non-reported children by cooperatively working with birthing hospitals, Early Hearing Detection and Intervention (EHDI) Program, and NJEIS. The Program conducted their annual audit at all birthing hospitals and one children's specialty hospital to identify children who were not registered. During the audits, education was provided on the use of the new registration forms, which included providing a detailed instruction manual. A quarterly report, which lists all children registered by the hospital, was sent to each birthing hospital to ensure that all children with mandated birth defects are reported to the SCHS Registry. The Program also worked with the EHDI Program and NJEIS to register children having any level of hearing loss, who were known to these programs, but had not been registered with the SCHS Registry. Additional quality assurance measures include matching BDR data files to the NJ Birth data file, the NJ infant birth-death file, and the Universal Billing data files.

In FY 2008 BDR staff have been collaborating with staff from the Family Centered Care Program (FCCP) to develop a case management module for the electronic BDRS. Registry staff held extensive meetings with FCCP staff to determine their needs for a case management component for the new BDRS. During these discussions, a standardized approach to collecting, using, and presenting case-related information was developed. This information was provided to Bloustein SPPP for the development of required data elements, forms, and the electronic processing of the information.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Annual Audits				X
2. Collaboration of 1 of 8 National Centers for Birth Defects Research and Prevention Quarterly reports to hospitals				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Annual audits performed by the SCHEIS staff are necessary to identify children with birth defects that would otherwise not be entered into the Registry. The audits, performed at every maternity

hospital and facility with pediatric beds, provide an opportunity for Registry staff to present reporting performance back to each facility. This year, registry staff audited each of the 60 birthing facilities in NJ and each of the 21 County Case Management Units. While birth defects affect 3-5% of all newborns and are a leading cause of infant mortality, the cause of 67% of birth defects is unknown. Improving the infrastructure and quality of surveillance data is a prerequisite for developing better programs and advancing research toward prevention. Provisional data from the most recent audit shows that hospitals accurately reported 90% of newborns having birth defects.

Staff from the BDR conducted site visits and education session on the registration process to NJ Early Intervention System providers.

**c. Plan for the Coming Year**

In FY-2009, it is anticipated that the CDC will continue to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance System. Rutgers, the State University -- Bloustein School of Planning and Public Policy will continue the development of the new Birth Defects Registry System (BDRS) which will include a special module for registering children with autism. It is expected that the BDRS will be beta tested in several hospitals as well as several Case Management Units in FY-2009, with full roll-out of the system in the beginning of FY-2010. The BDRS will improve reporting from hospitals and medical providers as well as improve the information transfer between the Department and the County-based Case Management Units through a secure and HIPAA-compliant virtual private network.

BDR Staff will continue to provide assistance to the Case Management Units and the birthing facilities with the transition from the paper-based system to the electronic system. Staff will continue to monitor the implementation of the two-page reporting form and will assist reporting agencies with concerns.

Audits will again be conducted in each of New Jersey's birthing facilities. Audits will also be conducted in each of the 21 County Case Management Units.

Facilities having the lowest levels of appropriate reporting, based upon results of the hospital audit conducted during FY-2008, will receive remedial assistance from staff of the Birth Defects Registry.

Due to the passing of NJ legislation mandating an Autism Registry, the Registry staff have been meeting to identify the process to be utilized to add autism to the Birth Defects Registry. Staff have modified the Birth Defects Reporting rules and have sent a draft of the proposed rules for review and ultimately adoption. They have met to discuss the data elements which will be needed for complete ascertainment of Autism, and are making design changes in both the hard copy and electronic reporting forms to fully incorporate autism into the existing registration process. A Memorandum of Agreement with Rutgers, The State University -- Bloustein School of Planning and Public Policy has been executed to incorporate an Autism Registry into the new BDRS.

**State Performance Measure 7: *Percent of children reported to the NJ Birth Defects Registry by three months of age.***

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				80	80

Annual Indicator	60.8	60.2	63.6	59.6	60.8
Numerator	2918	3421	3385	3432	3541
Denominator	4799	5687	5320	5757	5822
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	80	80	80	80	80

**Notes - 2007**

Data for 2007 entered as estimate pending verification of completeness of 2007 data file. Final 2007 data will be available in 2009.

**a. Last Year's Accomplishments**

The percentage of children reported to the State Registry by three months of age will be a new state performance measure. Because of our link to SCHS Case Management services, it is important that children are reported to the registry in a timely fashion. Current data indicate that 61% of children are reported to the Registry by their third month of life.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Audits of charts for a three month period on a yearly basis				X
2. Hospital education				X
3. Collaboration with the NJ Hospital Association				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Again this year, staff from BDR visited each of the birthing facilities in New Jersey this year. In attendance from the facilities included representatives of all pediatric disciplines, nursing, medical records and hospital administration. Included in the presentations by BDR staff included discussion of the importance of registering children as quickly as possible to facilitate the linkage of children with SCHS Case Management Units. Quarterly reports were provided to each birthing facility listing all children registered by their institution. Institutions were instructed to promptly review their quarterly reports and verify that all children diagnosed in their facility for the quarter were properly reported. Staff attended quarterly meetings of the SCHS Case Management Units, and stressed the importance of the registration process.

**c. Plan for the Coming Year**

Staff will continue to stress the importance of quickly reporting children diagnosed as having birth defects. Facilities with untimely reporting to the Registry will be contacted and reminded of the mandate to report and of the importance of the linkage to SCHS Case Management Units. Quarterly reports and a summary table detailing age at time of registration will continue to be provided. During the annual Birth Defects Reporting audit, birthing facilities having reporting times exceeding three months of age for over 25% of their reported children will receive additional training on the importance of the registration process. Hospital staff will be educated as to their importance in the registration process and how faster reports will enable children and families to more quickly obtain services through the SCHS Case Management Units.

**State Performance Measure 8:** *The percentage of HIV exposed newborns receiving appropriate antiviral treatment to reduce the perinatal transmission of HIV.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	72	73	74	75	76
Annual Indicator	84.2	91.7	82.9	97.0	97.0
Numerator	192	176	136	128	128
Denominator	228	192	164	132	132
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	77	77	78	78	78

**Notes - 2007**

Data for 2007 is not currently available (may be available Fall 2008). Data for 2006 entered as provisional 2007 data.

**a. Last Year's Accomplishments**

The percentage of HIV exposed newborns receiving appropriate antiviral treatment, was selected to focus efforts on reducing the perinatal transmission of HIV. Please note that the data above has been revised to reflect results from the Survey of Resident Childbearing Women from Division of HIV/AIDS Services, as opposed to previous submissions which have utilized surveillance data from the Division of HIV/AIDS Services.

Early identification and AZT treatment of pregnant women identified as HIV infected appears to be reducing perinatal transmission to newborns. Accurately monitoring the identification and early management of pregnant women and at-risk infants should have a significant impact on reducing the perinatal transmission of HIV. The number of reported cases of HIV/AIDS babies born in NJ dropped from 71 in 1993 to 6 in 2006. Each of NJ's seven Ryan White Title IV Family Centered HIV Care Network Centers has a dedicated perinatal care coordinator responsible for targeting outreach, counseling, testing and long-term follow-up of high-risk adolescents and women of child-bearing age. Pregnant women identified as HIV positive are referred to specialty clinics within the network. AZT treatment is provided during pregnancy, delivery and to newborns according to the CDC protocol. All newborns are referred and managed within the network. Co-located mother-child or family clinics have been established in each site to facilitate long term maintenance of mother and child in care.

Data from the 2006 Survey of Child Bearing Women (SCBW) indicated that 97% of the mothers/newborns received AZT at the time of labor/delivery. This is a marked increase from 13% in 1994, the first year SCBW specimens were tested for AZT. In conjunction with the Division of HIV/AIDS Services, the Network established a Perinatal HIV Advisory Committee in 2000 to develop a statewide policy for rapid testing and short course therapy to reduce the risk of perinatal HIV transmission in women who present in labor with an unknown HIV serostatus. In 2001 the Standard of Care for Women Who Present in Labor with Unknown HIV Sero status was developed. The intent of the Standard of Care is to provide HIV counseling and voluntary rapid or expedited testing of mothers in labor or delivery, or newborns in nursery units, if there is no documentation of prior HIV testing. The Standard of Care is currently under review, and may be updated to reflect the new 2006 CDC guidelines for HIV testing.

A hospital policy survey designed to assess the institution's ability to comply with the Standard of Care was implemented in 2005. Of particular note, survey responses indicated that the majority of obstetrical hospitals in the state had policies for documenting HIV status in labor and delivery (L&D). Policies for the provision of HIV counseling and rapid testing in L&D, three quarters of hospitals had point-of-care HIV testing in L&D, and two-thirds of hospitals provided anti-retroviral

agents to the mother during labor and to the newborn.

As a result of both targeted intervention to pregnant HIV positive women, and administration of appropriate antiretroviral therapy at birth and in subsequent years, the Network has witnessed an aging trend in its population. The trend table , Trends in HIV Infection in NJ (attached to this section), demonstrates fewer babies born in New Jersey with HIV infection, and a growing HIV+ adolescent population.

In 2007, Bill S2704 was signed into law; requiring health providers to test pregnant women for HIV (Human Immunodeficiency Virus) as part of routine prenatal care unless the woman refused testing. It also requires testing of newborns whose mother's HIV status is either positive or undocumented at the time of delivery. The Ryan White Part D Network sites are already fielding questions from hospitals in regards to the implementation of these new requirements. The Division of HIV/AIDS Services is currently writing the new regulations, and Network staff will participate in providing technical assistance when they are finalized.

***An attachment is included in this section.***

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing outreach and education targeting pregnant women		X		
2. Ongoing collaboration with Division of AIDS Prevention and Control				X
3. Transition education for HIV+ youth		X		
4. Development of formal medical and social service transition care plans for adolescents approaching adulthood		X		
5. Ongoing formal Continuous Quality Improvement activities to assess the level of compliance with established health care standards.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The NJDHSS and the seven Ryan White Part D Network are currently engaged in a patient satisfaction survey. Three hundred and fifty patients have been interviewed, and their responses to questions on 16 health care issues are being aggregated and analyzed.

The Network offered a caregivers retreat to HIV+ women to help them address the loss of loved ones and cope with the grieving process. An additional retreat was held for adolescents to provide education on HIV and sexuality. Two Case Study Days are offered to providers of HIV+ women annually. This year's topics include the new HPV vaccine, and HIV/TB comorbidity.

The annual Quality Improvement study was completed for 2007. In total, 275 charts were reviewed across three age groups, for receipt of medical and social services. Since the inception of a statewide total quality improvement effort in 2001, the pap rate for HIV positive women receiving care at a Network site has increased from 40% to 72%. Another significant change has been the number of children with an undetectable viral load. This number had steadily increased from 26% to 68% in 2007.

**c. Plan for the Coming Year**

The seven Ryan White Part D Family Centered HIV Care Network Centers in New Jersey will continue in the coming year to target outreach, counseling, testing and long-term follow-up of high risk adolescents and women of child bearing age.

## **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.

Health Status Indicators contribute to your State V agency's ability to assess the MCH needs of the state by providing demographic information on State residents, functioning as evaluative measures, and serving as additional surveillance measures for MCH health. Below are summaries of selected individual Health Status Indicators as they are reported on forms 20 to 21.

Health Status Indicator # 01A (Low Birth Weight - the percent of live births weighing less than 2,500 grams) as displayed in the attachment IIIA graph has been very slowly increasing since 1990. Racial disparities persist between white non-Hispanics and black non-Hispanics. Activities addressing this indicator are discussed in sections related to Health Systems Capacity Indicator 05A and State Performance Measure 1.

Health Status Indicator # 01B (Low Birth Weight - Singleton Births - the percent of live singleton births weighing less than 2,500 grams) has remained level since 1990. With the effect of the large increase in low-birthweight multiple births removed, HSI #01B has remained level. The racial disparity between white non-Hispanics and black non-Hispanics remains unchanged.

Health Status Indicator # 02A (Very Low Birth Weight - the percent of live births weighing less than 1,500 grams) as displayed in the attachment IIIA graph has been very slowly increasing since 1990 like HSI #01A. Racial disparity between white non-Hispanics and black non-Hispanics for HIS #02A is even greater than the racial disparity for HSI # 01A.

Health Status Indicator # 02B (Very Low Birth Weight - Singleton Births - the percent of live singleton births weighing less than 1,500 grams) has remained level since 1990. With the effect of the large increase in very low-birthweight multiple births removed, HSI #02B has remained level.

Health Status Indicator # 03A (Fatal Unintentional Injuries - the death rate per 100,000 due to unintentional injuries among children aged 14 years and younger) remains the leading cause of death for among children aged 1 to 14 years old. The number per year of specific types of fatal unintentional injuries in New Jersey is small and does not display recent trends.

Motor vehicle crashes remain the leading cause of death for children 1 to 14 years old. Health Status Indicator # 03B (Fatal Unintentional Injuries - the death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes) does not appear to be decreasing.

Health Status Indicator # 03C (Fatal Unintentional Injuries - the death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years) may have decreased recently. Motor vehicle crash fatalities remain a leading cause of death for 15 to 24 year olds.

Health Status Indicator # 04A (Non-fatal Unintentional Injuries - the rate per 100,000 of all nonfatal injuries among children aged 14 years and younger) appears to be decreasing based on the reported data from hospital discharge records.

Health Status Indicator # 04B (Non-fatal Unintentional Injuries - the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger) appears to be decreasing based on the reported data from hospital discharge records.

Health Status Indicator # 04C (Non-fatal Unintentional Injuries - the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years) does not display a clear trend based on recent hospital discharge data.

Health Status Indicator # 05A (Sexually Transmitted Disease (Chlamydia) - the rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia) and Health Status Indicator # 05B (Sexually Transmitted Disease (Chlamydia) - the rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia) are based on data from the Sexually Transmitted Disease Program in the DHSS. The increase in HSI #05A and HSI #05B may represent an increase in the reporting of cases to the DHSS, and increase in the screening for cases or a true increase in the incidence of cases.

An overview of demographic trends including HSI #06A & B (Demographics -Total Population) and HSI #07A & B (Demographics -Total live births) are provided in section III. A. State Overview. 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.

## **F. Other Program Activities**

During the grant Year 2006-07, the Family Health Line received and assisted 12,372 calls, and made 13,763 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 program coordinates quarterly staff trainings for the agency with an emphasis on current family health initiatives. The trainings covered the Federally Qualified Health Center (FQHC) Project, The Governor's Mammography Campaign, the Lead Screening Initiative, Diabetes Prevention and Prematurity/Folic Acid topics. 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.

***An attachment is included in this section.***

## **G. Technical Assistance**

The technical assistance needs of the State are reported on Form 15 and will likely be updated after submission of the MCH Block Grant Annual Report/Application.

## V. Budget Narrative

### 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 maintained and increased 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 2009 budget programs and services are maintained at the SFY 2008 levels with slight increases due to cost of living increases. There is one exception, an increase of \$5 million for early intervention services was included to provide the needed resources to accommodate the growth in enrollment. There is continued commitment on the part of the State to support to the best of its ability services to the most vulnerable populations. Since the State budget will not be finalized until June 30, 2008, the following are the proposed funding levels for programs and services for FFY 2009 that reach maternal and child health populations in New Jersey:

Birth Defects Registry	\$563,000
Cleft lip and palate projects	\$ 707,000
Family Planning Services	\$ 7,749,000
Infant mortality reduction including a new project focused on reduction of black infant mortality	\$ 2,500,000
Sudden Infant Death Syndrome	\$ 214,000
Newborn screening (revenue)	\$ 3,306,000
Postpartum Depression education	\$ 2,500,000
Postpartum Depression screening and referral	\$ 2,000,000
Early intervention for developmental delay/disabilities	\$105,104,000
Childhood lead poisoning prevention	\$ 957,000
Hemophilia services	\$ 1,208,000
Catastrophic illness in children relief fund	\$ 1,606,877
Handicapped children's fund, which is used to support subspecialty care and case management services	\$ 2,441,000
Fetal Alcohol Syndrome	\$ 570,000
MCH Services	\$ 5,930,000
Council Physical Fitness and Sports	\$ 50,000
Tourettes Syndrome	\$ 1,250,000
Autism Registry	\$ 500,000
Governor's Council on Autism Research	\$ 500,000

Federally supported programs included in our federal state partnership for maternal and child health for FFY 2009 are as follows:

From the Centers for Disease Control and Prevention:

Childhood Lead Poisoning Prevention	\$ 1,200,000
Preventive Health and Health Services Block Grant	\$ 557,209
Asthma Surveillance	\$ 350,000
Early Hearing Detection and Intervention	\$ 189,269
PRAMS	\$ 133,519
Birth Defects Surveillance	\$ 194,713

From the Maternal and Child Health Bureau	
State System Development Initiative	\$ 94,644
Mortality Review Coordination	\$ 72,000
Universal Newborn Hearing Screening	\$ 157,453
Healthy Start	\$ 500,000

From Other Federal Sources	
Ryan White Pediatric AIDS	\$ 2,260,049
Family Planning	\$ 2,895,000
Primary Care Cooperative Agreement	\$ 215,737
Social Service Block Grant	\$ 1,922,000
US Dept of Education- Part C-Early Intervention	\$ 11,049,668
USDA -- WIC Administrative	\$ 23,885,700

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. State appropriations have included cost of living increases that are passed on to the service providers. New Jersey has undertaken several new or expanded initiatives over the past few years, which may in some cases, result in slight variations in allocations or expenditures. The annual Title V budget is summarized below. The following federal and state programs are targeted to meet performance measures and goals in the areas of maternal and child health for Year 2009 proposed or projected (the funding sources listed is not all inclusive):

Reproductive and Perinatal Health Services - State:	
Fetal Alcohol Syndrome	\$ 450,000
Healthy Mothers / Healthy Babies	\$ 2,000,000
Black Infant Mortality Reduction	\$ 500,000
SIDS Resource and Counseling	\$ 214,000

Reproductive and Perinatal Health Services -- Federal:	
Healthy Start -- East Orange	\$ 500,000

Child and Adolescent Health - State:	
Childhood lead poisoning prevention activities	\$ 957,000
Reproductive Health Family Planning	\$ 7,749,000

Child and Adolescent Health -- Federal:	
CDC Childhood Lead Poisoning Prevention	\$ 1,021,436
State System Development Initiative	\$ 737,598
Preventive Health and Health Services Block Grant	\$ 692,603

Federal-State MCH Block Grant Partnership Budgeted FY 2008	
Pregnant Women	\$ 7,898,588
Infants < 1 year old	\$ 6,690,410
Children 1 to 22 years old	\$ 10,022,400
CSHCN	\$ 73,718,902
Administration	\$ 727,175
SUB-TOTAL	\$ 99,057,475

II. Other Federal MCH Related Funds

WIC	\$ 23,885,700	
AIDS		\$ 2,260,049
Healthy Start		\$ 500,000
CISS		\$ 100,000
CDC		\$ 2,288,757
SSDI		\$ 94,644
Social Security BG		\$ 1,922,000
Family Planning		\$ 2,283,000
Early Intervention		\$ 11,049,668
Others		\$ 220,000
SUB-TOTAL		\$ 44,603,818

## **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.