



MATERNITY **ACTION** PLAN



NEW JERSEY
HEALTH CARE
**QUALITY
INSTITUTE**

Sustainable Policy Change
to **Strengthen** and **Accelerate**
the Nurture NJ Strategic Plan



AUTHOR'S NOTE: HOW TO MAKE THE MOST OF THIS REPORT

The Nurture NJ strategic plan, released in January 2021, set forward a strong vision: Make New Jersey the safest, most equitable state in the nation to deliver and raise a baby.

This clear, achievable destination requires effort, collaboration, and dedication of individuals, organizations, advocates, communities, and state government to plan and act together. The work is essential, given that longstanding systemic racism has perpetuated unsafe and inequitable care for birthing people of color in New Jersey.

The New Jersey Health Quality Institute (Quality Institute) created this Maternity Action Plan (MAP) as a complement to the Nurture NJ strategic plan. It aligns with and elevates aspects of Nurture NJ to build sustainable policy change in the state. To provide direction, it draws from the impact of many existing programs, innovative pilots, grant-funded initiatives, and regional activities. The MAP represents the research, findings, and views of the Quality Institute. We are grateful to the State of New Jersey, our members, board, community, and expert partners for their input and to the Robert Wood Johnson Foundation for funding this work.

This report contains 11 recommendations in four key areas plus supporting material, all of which are aimed at helping to implement regulatory and policy changes needed to operationalize Nurture NJ. In that regard, the report is for community members, stakeholders, policymakers, regulators, and public and private funders looking to support and accelerate the Nurture NJ Strategic Plan. We hope the MAP helps provide a path to achieving the vision of the Nurture NJ Strategic Plan and end intolerable disparities in maternal and infant health.

About the New Jersey Health Care Quality

Institute: The New Jersey Health Care Quality Institute (Quality Institute) is a multi-stakeholder nonprofit organization founded in 1997. Our mission is to improve the safety, quality, and affordability of health care for everyone. To support healthy communities and individuals, we believe that health care should be:

1. Safe and of high quality;
2. Accessible and affordable;
3. Equitable, respecting individual dignity; and
4. Transparent, to promote accountability and quality improvement.

For 25 years, the Quality Institute has informed our research and policy work with the front-line experiences of our diverse membership of providers, purchasers, health plans, associations, consumer groups, and health care companies.

About the Robert Wood Johnson Foundation:

The Robert Wood Johnson Foundation (RWJF) is the nation's largest philanthropy dedicated solely to health. Since our founding in 1972, RWJF has worked to improve health and health care in the United States. We support efforts to build a national Culture of Health rooted in equity that provides every individual with a fair and just opportunity for health and well-being, no matter who they are, where they live, or how much money they have. In our home state, we work in collaboration with others to secure the promise of a healthier, more equitable New Jersey.

Acknowledgements: The Quality Institute would like to thank those that contributed to the development of the Maternity Action Plan, including staff members Linda Schwimmer, Kate Shamszad, Brittany Stapelfeld Lee, Adelisa Perez, and Armonie Pierre-Jacques. Many stakeholders, advocates, and experts contributed to the MAP, greatly shaping the recommendations. A full list of contributors is available at the end of the document. Additionally, the Quality Institute thanks the Robert Wood Johnson Foundation for its generous funding for the MAP and for ongoing dedication and support for birth equity and advancing maternal infant health in New Jersey.

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INTRODUCTION

The Nurture NJ (NNJ) Strategic Plan expresses a vision and outlines a plan for New Jersey to be a leader in healthy, equitable care for pregnant individuals and children. It calls upon all interested parties in New Jersey to apply their experiences, expertise, and efforts toward achieving the Plan's goals. A foundational part of this work is addressing racism at all levels from an individual, organizational, and systemic perspective to achieve the changes needed for New Jersey to be the safest, most equitable state in the nation to deliver and raise a baby.

Through funding and support from the Robert Wood Johnson Foundation, the New Jersey Health Care Quality Institute (Quality Institute) used its expertise in policy, quality measurement, and payment reform to create the Maternity Action Plan (MAP). The MAP is designed to be, literally, a map to navigate the journey to our mutual goals of improving quality and birth equity in Maternal Infant Health (MIH) — particularly for birthing people of color, to whom systemic racism and consistently inequitable care have done the most harm.¹

The Quality Institute worked closely with organizations and advocates — conducting research, market scans, and interviews to include their personal, community-based, social service, and clinical experience to inform the MAP. The MAP also includes suggestions on how to scale and sustain existing resources and programs that further many of the goals in the Strategic Plan and are directly aligned with the recommendations outlined in the Strategic Plan.²

A lot of work on the NNJ Strategic Plan is well underway. We want to highlight that work and accelerate the already impressive pace of change.

The Quality Institute, like many entities working in New Jersey, has been focused on improving MIH quality for many years. The MAP provides specific steps to assess existing MIH work and needs and creates a guide to achieving many of the goals outlined in the NNJ Strategic Plan. A central part of the MAP is its focus on

how to incorporate and scale proven, community-led, evidence-based work already occurring in New Jersey and nationally. In some cases, this means modifying the work or acknowledging what resources and investments have been lacking and providing steps to address those issues.

The MAP is intended for all interested community members, stakeholders, policymakers, regulators, and public and private funders looking to support and accelerate the Nurture NJ Strategic Plan.

In developing the recommendations in the MAP, we focused on how each one can be achieved through action in four fundamental policy-focused areas. Racial equity and community engagement serve as the foundation for which to focus on policy-driven solutions, and are essential within each of the four areas of focus:

- >> Build the workforce needed to achieve birth equity and quality**
- >> Collect and use data to improve equity and quality**
- >> Reform payment systems to drive high-quality holistic maternal infant health**
- >> Improve community-based social supports**

The MAP discusses each of these areas, with recommendations and references to how these areas and steps align with — and will accelerate — achieving the recommendations in the NNJ Strategic Plan. Where possible, there is also a description of existing programs and policies in New Jersey or elsewhere that show a path to reaching our destination.



SECTION 1: BUILD THE WORKFORCE NEEDED TO ACHIEVE BIRTH EQUITY AND QUALITY

Together, public and private sectors must redesign and support today's MIH workforce through changes to training, education, licensing and registration, recruitment, retention, and reimbursement systems. These reforms must focus on expanding the workforce to include professionals and other staff and caregivers with more diverse backgrounds and experience than today's workforce — who are trained to have cultural humility and congruency and to acknowledge and address racism within the health care system and the other societal systems.³

National accrediting organizations and the US Health Resources and Services Administration (HRSA) recognize the benefits of funding measures that create or expand increased diversity of historically marginalized individuals in health careers and medicine. While it is not the only answer to addressing inequities in MIH, researchers recognize the value of culturally congruent care, especially when it comes to matters of trust, communication, and safety.⁴

Creating a more diverse, culturally congruent, and respectful MIH workforce requires defining what types of MIH services are needed and the types of providers to deliver them in a patient-centered, trauma-informed

way. Patients from marginalized communities and organizations serving them should lead the way in defining the community's needs. Listening to patients' experiences is essential to eliminating racism within the systems that contribute to inequitable MIH outcomes. Community input received in creating the MAP pointed to the value of investing in, supporting, and reforming regulatory barriers for midwives, doulas, lactation consultants and lactation support professionals, and community health workers.

Reforming ongoing education, recruitment, and retention efforts to include a focus on addressing racism and teaching culturally respectful, patient-centered, trauma-informed care should be a priority across public and private institutions. In addition, the state must collect data to inform funding decisions and prioritize job program development to increase diversity and increase access to care in historically marginalized areas. Efforts must be made to engage and inform marginalized communities of MIH education, jobs, and funding opportunities. Finally, reimbursement rates and models must be improved to retain trained workers and enable them to earn a livable wage and thrive in their roles to advance equitable MIH in New Jersey.



SECTION 1: BUILD THE WORKFORCE NEEDED TO ACHIEVE BIRTH EQUITY AND QUALITY

WORKFORCE POLICY RECOMMENDATION 1

Promote reforms to educate, recruit, and retain a more diverse MIH workforce, including ongoing anti-racism education and training.

Educational reforms should include changes that address individual, organizational, and structural racism — for health professional and allied professional programs from secondary schools through post-graduate studies — and as part of continuing education post-licensure.

CONSIDERATIONS



>> A diverse MIH workforce, trained in the importance of addressing bias and racism, is essential to eliminating MIH inequities. Training must be ongoing, infused within educational, organizational, and societal systems, and take a multi-sector focus and commitment.

>> These reforms will need to include education and repeated training within traditional health care settings not only for licensed clinical staff, such as physicians, nurses, physician assistants, and midwives, but also for all staff— from the Chief Executive Officer to receptionist, scheduler, and biller. It must include other community-based caregivers like mental health providers, doulas, and community health workers. Change will not occur without attention and training, and reinforcement for shifts in practice for all staff levels from the top down.

>> Every organization must have a strategy to recruit, educate, mentor, and retain a diverse workforce that reflects the communities and individuals it serves.

>> Organizations leading this educational design change must deploy well-defined programs with assigned accountability for addressing racism and promoting cultural respect and should have systems in place to help participants understand the effectiveness of the training.

>> Organizations should collect demographic data and use it to stratify patient health outcomes with a focus on eliminating disparities and achieving birth equity. Data can be used for quality improvement, reimbursement, and public reporting. These programs will drive accountability for improving MIH equity.



SECTION 1: BUILD THE WORKFORCE NEEDED TO ACHIEVE BIRTH EQUITY AND QUALITY

WORKFORCE POLICY RECOMMENDATION 2

Use community input and data to enhance health care workforce training, recruitment, and retention programs, and workforce sustainability to improve MIH.

This community input and data should be used to identify the state's MIH workforce needs; make targeted investments in training, recruitment, and retention programs; and increase reimbursement to sustain a diverse MIH workforce.

CONSIDERATIONS



- >> The state must invest in technology and personnel to develop and maintain a Health Care Workforce Reporting System to track workforce supply and needs. There are nine health workforce research centers in the US that operate this type of system, sponsored by the Health Resources and Services Administration (HRSA), dedicated to providing health care workforce data and information to inform decision making.⁵
- >> The state must collect and use health care workforce demographic data to learn where gaps exist, assess current and future needs, and design a diverse MIH workforce positioned to improve MIH outcomes.
- >> Private and public sectors must consult with community-based organizations for input on the MIH workforce needs and barriers to recruitment and retention of a diverse MIH workforce, and respond in a meaningful way.
- >> The private and public sectors should fund community-based organizations serving historically marginalized individuals to design and provide training programs and outreach materials to recruit a more diverse workforce.
- >> Federal and state funding should be increased to support loan repayment programs to encourage health care workers to work in underserved areas. Such programs must be targeted to increase diversity and access to care.
- >> Government loan redemption programs should expand the types of health care workers eligible to participate.
- >> The private sector should be encouraged to establish and fund training programs for high-need positions and create direct job referrals to employers.
- >> Collaboration among professional organizations, licensing boards, and educational institutions is needed to make anti-racism and implicit bias-mitigation recruitment and retention strategies part of admissions, education, and training programs.
- >> Employers should work with secondary schools, vocational and technical schools, 2- and 4-year colleges, and graduate schools to align educational programs with workforce needs. Financial incentives are needed, such as reimbursement for student loans or paying trainees, especially for commitments to work in under-resourced communities or high-need roles.
- >> Revise state and insurer reimbursement policies and programs to provide livable wages for key MIH workforce roles, including community health workers and community doulas.



SECTION 1: BUILD THE WORKFORCE NEEDED TO ACHIEVE BIRTH EQUITY AND QUALITY

A PATH TO CONSIDER: GREATER FLEXIBILITY IN STATE LOAN REPAYMENT PROGRAMS FOR HEALTH CARE PROVIDERS

In addition to the federal government's National Health Service Corps, many states offer opportunities for health care providers to receive additional payments toward qualified student loan debt in exchange for commitments to work in certain underserved areas or with specific populations. The goal of these programs is to reduce the burden of student loans on new health care providers — encouraging more people, including those with lesser economic means, to enter the field and increase the availability of providers in underserved communities.

In New Jersey, the Higher Education Student Assistance Authority administers several loan-redemption programs, including the Primary Care Practitioner Loan Redemption Program (NJLRP).⁶ This program enables primary care physicians, dentists, certified nurse midwives, certified nurse practitioners, and certified physician assistants to receive up to \$120,000 toward student loans in exchange for 2 to 4 years of practicing under contract at approved sites in underserved areas. Programs also exist for licensed providers focused on substance use disorder and for students training for

advanced degrees in nursing to support Schools of Nursing. New Jersey is also making historic investments in community college grants and loan programs through the Community College Opportunity Grant program, which will service thousands of residents, though better public awareness would build even greater scope.

While New Jersey's health care provider loan redemption programs resemble those in other states in terms of the time frame of the service commitment and amount of payment toward loans, they are limited in the types of professionals that are eligible to participate.⁷ Greater flexibility in these programs would be helpful. For instance, in Oregon's Health Care Provider Incentive Loan Repayment, unlicensed mental health providers who have completed a master's program are eligible to participate before receiving their license, which helps to address shortages in mental health providers.⁸

As budgets allow, especially with receipt of federal recovery funding, the state should increase redemption amounts and adjust program requirements to support a broader array of health care workers.

WORKFORCE POLICY RECOMMENDATION 3

Increase support for these key MIH workforce roles: community health workers, community doulas, lactation consultants and lactation support professionals, and midwives.



SECTION 1: BUILD THE WORKFORCE NEEDED TO ACHIEVE BIRTH EQUITY AND QUALITY

CONSIDERATIONS FOR COMMUNITY HEALTH WORKERS (CHWs)

>> Community Health Workers (CHWs) fill an important need for addressing social determinants of health by acting as intermediaries between the community and health care and social service systems, helping community members access services that meet their needs.

>> With their understanding of the culture, languages, and challenges of their neighborhoods, CHWs are trusted by the people who live there and are equipped to complement the health care system and improve MIH.

>> There is no single best model for training CHWs. Input from the community on the MAP focused on the need for training from both the state and community-based organizations led by historically marginalized groups.

>> CHWs must be paid a livable wage (\$15/hour or more) and be given a manageable caseload to increase retention.

>> NJ FamilyCare's recent Demonstration Renewal, which sets forth a five-year plan for much of its Medicaid activity, included supporting and expanding the role of CHWs within the Medicaid program.⁹ This is an opportunity to embed the role of CHWs into Medicaid Managed Care Organizations and health care models, and to improve data, accountability, and reimbursement for these roles.

>> The ability of CHWs to improve MIH in New Jersey is limited by the small number of established CHW training and employment programs in the state, lack of clarity as to registration and reimbursement models, and lack of awareness of the role and employment paths and options. These are areas of opportunity for improvement and direct investment by the state, private industry, and foundations.

>> The NJ Department of Health (NJDOH) established the Colette Lamothe-Galette Community Health Worker (CLG) Institute through a NJ Department of Labor (NJDOLE) Apprenticeship program. The goal of the Institute is to create a robust CHW workforce through a standardized training and certification program. This would help establish career pipelines for CHWs, enhance the workers' skills, and lead sustainable efforts to support this indispensable workforce. The CLG Institute training, which is free to participants, consists of 144 hours of classroom instruction and 1,000 to 2,000 hours of on-the-job-training, depending on prior experience as a CHW. The CHWs will complete classroom instruction with one of the participating academic partners: Camden, Ocean, Essex, and Mercer County Colleges. The on-the-job training will be completed by a NJDOH Employer Partner site, which will be assigned upon acceptance to the program.

>> Among the many core CLG Institute training competencies are effective communication, outreach methods and strategies, cultural responsiveness and mediation, advocacy and community capacity building, and supporting Adverse Childhood Experiences.





SECTION 1: BUILD THE WORKFORCE NEEDED TO ACHIEVE BIRTH EQUITY AND QUALITY

CONSIDERATIONS FOR COMMUNITY DOULAS

>> Community doulas provide pregnant people emotional support as well as education, in their homes and communities. Doulas help clients navigate the health and social service systems and help connect what their clients need for a healthy perinatal experience.

>> Doulas may accompany their clients to provider visits and are present continuously through labor and delivery. During the postpartum period, they offer support for lactation, parent and child wellbeing, and bonding. Doulas are trained in the core competencies of doula care as well as culturally congruent care. The benefits of partnering with a community doula during the perinatal period are significant, including lower rates of maternal and infant health complications, preterm birth, low-birth weight infants, and lower c-section rates, as well as higher rates of breastfeeding and reduced rates of postpartum depression.

>> Starting with a series of successful doula pilots run by community-based organizations, New Jersey has recently taken steps to make community doula care available to more women. Under the 2018 Healthy Women, Healthy Families initiative, NJDOH implemented a doula program in municipalities with high Black infant mortality rates. Under the initiative, 79 community doulas were trained using the Uzazi Village model, which prepares doulas to serve women of color in the communities where they both live.¹⁰

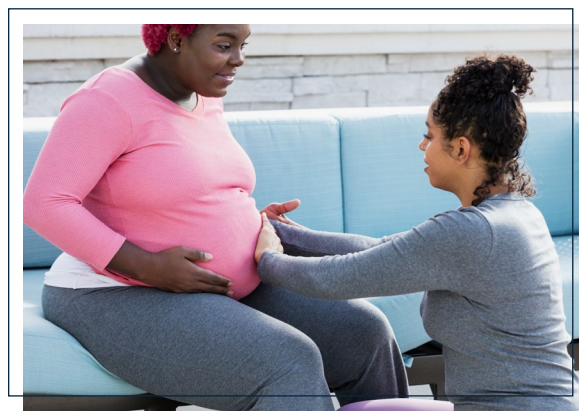
>> The AMAR Community Doula Program, part of the Children's Home Society of New Jersey, uses the HealthConnect One Community Doula training model and has over 23 community doulas working within the greater Trenton area.¹¹

>> In 2021, NJ FamilyCare implemented a covered doula benefit for pregnant people enrolled in Medicaid. To participate, doulas

must become credentialed providers under Medicaid and may then credential and contract with each of the five Medicaid Managed Care Organizations (MCOs) and bill them fixed reimbursement amounts. NJ FamilyCare also created Doula Guides, who are state designees trained to help doulas navigate the system.¹²

>> While supportive of the NJ FamilyCare coverage requirement, community members providing input on MAP feel the credentialing system should be uniform and less cumbersome, and that reimbursement rates are too low to support existing doulas with a livable wage and to attract more doulas. These suggestions provide an opportunity for improvement within the state, the MCOs, and for further investments in this valuable MIH role.

>> NJDOH engaged a contractor, HealthConnect One, to establish a Doula Learning Collaborative to increase the number of trained community doulas in the state, support doulas in engaging with hospital systems to improve understanding of the role and benefits of a doula and engage MCOs to foster doulas' network participation and contracting. Based on community and doula feedback, there is a need for improvement in participation by health care systems and MCOs in streamlining the credentialing and billing process for doulas.





SECTION 1: BUILD THE WORKFORCE NEEDED TO ACHIEVE BIRTH EQUITY AND QUALITY

CONSIDERATIONS FOR LACTATION CONSULTANTS AND LACTATION SUPPORT PROFESSIONALS IN THE COMMUNITY

>> Lactation is an integral part of the reproductive process, with important implications for the health of the lactating person and the baby. Research shows that 60% of US parents discontinue breastfeeding before they desire to for several reasons, including the perception of inadequate milk supply, latching difficulties, and painful breasts or clogged milk ducts. These concerns could be addressed by preventive, coordinated, community-based, skilled lactation support.¹³

>> As maternal and pediatric care is often not centralized, families receive direct and indirect support in various settings during infancy and early childhood. Ensuring comprehensive lactation support services during this period of transition requires coordination and access to board-certified lactation consultants (IBCLCs), breastfeeding educators, lactation counselors, doulas, and breastfeeding peer counselors. IBCLCs are certified in the clinical management of breastfeeding and lactation. Breastfeeding peer counselors, lactation counselors, and other trained peer-to-peer lactation supporters provide non-clinical care, education, and support to birthing families. Breastfeeding physicians with specialized lactation training and members of the Academy of Breastfeeding Medicine, also play an important role.

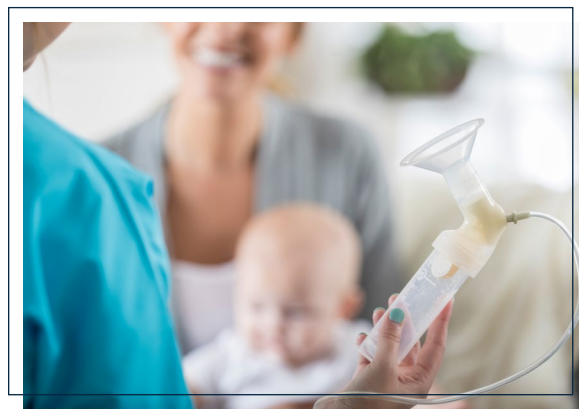
>> Planning how to expand this workforce — particularly in communities where systemic racism and inadequate resources and support make it difficult for breastfeeding people of color to access and receive the support needed — requires coordination along the spectrum of lactation support providers and others who interact with families across various community settings in both prenatal and postpartum periods. This includes ensuring cultural congruency in

the care provided and establishing a trusted, community-based workforce.¹⁴

>> New Jersey law requires insurance, including Medicaid, to cover lactation consultations and counseling in many circumstances. That coverage can fund skilled lactation support and education in health care settings that include physician practices, federally qualified health centers, and other points of health care access.

>> There is opportunity to identify and enhance existing community programs serving diverse populations and to expand resources to build capacity for sustainable and equitable breastfeeding services beyond a provider's office. This can be done by integrating lactation education and support curriculum and training into the community-based health care workforce.

>> This expansion should include creation of workforce development programs and clinical training opportunities to increase and diversify the pool of lactation consultants and lactation counselors to ensure availability of skilled lactation support and inclusion of lactation care in all health care and community settings that serve birthing families.





SECTION 1: BUILD THE WORKFORCE NEEDED TO ACHIEVE BIRTH EQUITY AND QUALITY

CONSIDERATIONS FOR MIDWIVES¹⁵

>> In 2019, 8.95% of all births in New Jersey were attended by Certified Nurse Midwives (CNMs) or Certified Midwives (CMs), and less than 0.2% of births in New Jersey were attended by “other” midwives, including Certified Professional Midwives (CPMs).

>> The benefits midwives provide to MIH would increase by supporting growth in the size and diversity of the profession. Increasing the percentage of midwife-attended births in the US from 8.9% to 20% over the next 10 years could save over \$4 billion, according to an analysis by the University of Minnesota School of Public Health. It would also result in 30,000 fewer preterm births and 120,000 fewer episiotomies.

>> In New Jersey, the state Board of Medical Examiners oversees the regulatory framework for midwives in New Jersey. This arrangement is unusual, as most states have either an independent Board of Midwifery or provide oversight via the Board of Nursing.¹⁶ New Jersey’s oversight framework creates unnecessary barriers to midwives practicing to the full extent of their training. This can be alleviated by transitioning to an independent Board of Midwifery in New Jersey and allowing for greater practice autonomy.

>> Medicaid reimbursement should be expanded to allow insurance reimbursement to midwives regardless of the site of care, which would give patients increased decision-making and ownership over their birthing experiences. Reimbursement by Medicaid should be increased from 95% to 100% of the physician rate for the same services and care provided. Managed Care Organizations should be required to credential and reimburse midwives at non-hospital sites, such as birthing centers or for home births.

>> Increased reimbursement rates as well as changes to payment structures are needed to support the sustainability and growth of birthing centers in underserved areas. Reimbursement for care in birth centers does not usually cover the full cost of care provided and many Medicaid Managed Care Organizations and commercial providers do not have birth centers as in-network or covered providers. This limits midwife-attended births primarily to hospitals. A Medicaid-focused study of freestanding birth centers found that reimbursing for midwifery care at birthing centers could save an average of \$1,163 per birth (2008 constant dollars) nationally, or \$11.6 million per 10,000 births per year. This could yield a lower total cost of care across Medicaid-covered deliveries. Staffing resources within the NJDOH and Division of Consumer Affairs are also needed to support increased licensing of birthing centers.

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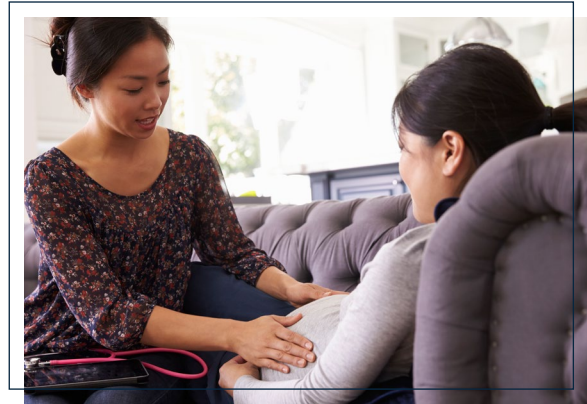
SECTION 1: BUILD THE WORKFORCE NEEDED TO ACHIEVE BIRTH EQUITY AND QUALITY

CONSIDERATIONS FOR MIDWIVES (cont'd)

>> According to the American Midwifery Certification Board, most CNMs and CMs identify as white (86%) and women (99%) and speak English as their primary language (96%). Approximately 7% of midwives identify as Black or African American, and only 5% of midwives identify as Hispanic or Latino. Incentives, such as scholarships and loan forgiveness programs, should prioritize supporting people of color interested in pursuing careers in midwifery to help promote diversity in the profession.

>> There are also significant challenges related to training opportunities for midwifery students. The lack of midwifery preceptors is a barrier to expanding the midwifery workforce. Increased access to midwifery training programs and investment is needed to expand clinical training opportunities and the availability of preceptors. Building a diverse pipeline of midwives can be bolstered by promoting all available nurse midwifery programs, including master's level programs that are available virtually or through distance-learning to augment the sole Doctorate program now available in state.¹⁷

>> One barrier to increasing both the midwifery workforce and access to midwifery care is a lack of knowledge (or inaccurate knowledge) about midwifery care and midwifery as a profession. Public and private sector funders, educators, and MIH organizations should create public health messaging and raise awareness about the profession of midwifery — including who midwives are and how and when they provide care.

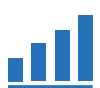




SECTION 2: COLLECT AND USE DATA TO IMPROVE EQUITY AND QUALITY

New Jersey is ranked 47th in the United States for maternal health outcomes.¹⁸ Black women in the state are 7 times more likely to die from a pregnancy-related complication than are white women.¹⁹ These unacceptable statistics and the ability to effectively collect and use MIH data on quality, equity, and outcomes will drive action, funding, and ultimately the change called for in the NNJ Strategic Plan.

BENEFITS OF MIH DATA COLLECTION AND REPORTING INCLUDE:



Enabling providers and health plans to benchmark their results and be held accountable for their performance.



Using demographic data to enable providers and health plans to identify and work to reduce disparities.



Transparency of MIH data that empowers consumers, providers, health plans, purchasers, and policymakers to make informed decisions and quality improvements.

Unfortunately, today, relevant MIH data is spread across and siloed within too many different organizations across the state, which limits its use.²⁰ Better alignment and sharing of the data would reap tremendous rewards. The various departments and entities that collect or hold these data will be more successful and efficient if they improve access to and sharing of aggregated data.

The NJDOH is committed to improving and expanding its Maternal Data Center (MDC) to collect, analyze, and report on much of this data to advise users of how to improve MIH in the state.²¹ This step is critical to successful implementation of the NNJ Strategic Plan.

Background on the NJDOH Maternal Care Quality Collaborative (MCQC)'s Role on Quality and Data

The NJDOH, with HRSA funding, created the NJ Maternal Care Quality Collaborative (MCQC) to drive policy change needed to improve MIH, including implementing much of the NNJ Strategic Plan. The MCQC's work will be informed by the MDC. The NJ Maternal Mortality Review Committee (MMRC) was recently reconstituted by law and is receiving additional focus and funding. Its work will also inform MCQC's work.

The MCQC, informed by MDC data and MMRC findings, is responsible for guiding NJDOH's MIH policy change. This work will include partnerships with the Perinatal Quality Collaborative (PQC), led by the New Jersey Hospital Association (NJHA) and funded by the CDC, the maternal and child health consortia, the individuals and organizations on the MCQC's 34-member steering committee, and the individuals and organizations working on the NNJ Strategic Plan.

All of work of the MDC and MCQC will be critically important to supporting the Maternal and Infant Health Innovation Center in Trenton, outlined in the NNJ Strategic Plan's Recommendation 3.3. This work and the data will be vital to actions to make New Jersey a safer, more equitable place to give birth.



DATA COLLECTION AND USE POLICY RECOMMENDATION 1

Improve data collection and reporting.

New Jersey MIH data is found on a variety of state and federal dashboards. Additional data is collected but not reported. The NJDOH MDC is taking steps to improve data access and usability and to integrate it into one site, connecting all disparate MIH data, improve the user experience, and improve timeliness. This work is foundational to implementing the NNJ Strategic Plan and will need funding and staffing.

CONSIDERATIONS



>> Align and publicly define quality measures so clear, consistent information is available for providers, purchasers, consumers, and policymakers to achieve quality and equity goals.

>> Definitions for MIH quality measures and goals for MIH outcomes should align across all state run or funded programs so that providers and health plans are working together to tackle specific issues and treating their members and patients equitably.

>> MIH quality measures should align with those established and used by national organizations, including the Joint Commission, a group that accredits health care organizations and programs, and the Leapfrog Group, a nonprofit watchdog that serves as a voice for health care consumers and purchasers, to reduce administrative burden, increase purchaser and consumer usability, and enable public reporting of more recent data.

>> More timely MIH data is needed to analyze program effectiveness.

>> Publicly reported data on quality should include self-reported and verified demographic information to catalyze action at all levels to achieve birth equity.

>> Consumer/patient experience reports are needed to further actions to achieve birth equity. Community leaders report wanting this work to engage organizations led by researchers from historically marginalized groups and express the need for tools that are free of bias.²²



SECTION 2: COLLECT AND USE DATA TO IMPROVE EQUITY AND QUALITY

A PATH TO CONSIDER: PARTNER WITH THE LEAPFROG GROUP TO ACCESS AND SHARE DATA



Every labor and delivery hospital in New Jersey voluntarily reports on its quality and safety through The Leapfrog Group Hospital Safety Survey, which has a section on maternity care using measures based on those used by The Joint Commission.²³ Definitions for these measures are regularly updated and the data is generally reported for the previous 12-month period. The definitions are used nationally, enabling states, health plans, and hospital systems to compare data both locally and nationally. The Leapfrog website is created for consumer use with clear graphics and explanations.



New Jersey's MDC could enter into an agreement with Leapfrog and The Joint Commission in the same manner as the California Maternal Quality Care Collaborative and Data Center has done. By doing so, the state could reduce resources spent collecting information that is already available and reported. This step would reduce the reporting burden for hospitals and assist the MDC to further its capacity.



Partnerships across public and private sectors are essential for data sharing, analysis, and use. The MDC must be funded and staffed to enable it to collect and receive data to support the work of the MCQC, MMRC, PQC, three maternal consortia, NJ FamilyCare, and five MCOs, hospital systems, other birthing facilities, and purchasers.



DATA COLLECTION AND USE POLICY RECOMMENDATION 2

Use maternal health data in quality improvement, payment models, and public reporting to improve equity and quality.

- >> Increase public reporting of data to show status on addressing disparities.
- >> Ensure that patient-reported data is collected, and the public understands how it is used to improve care.
- >> Use improved, timelier, and robust data in quality improvement work, payment models, and public reporting.

CONSIDERATIONS

>> All New Jersey birthing hospitals should commit to using maternal health data to reduce maternal morbidity and mortality rates and to attaining rates lower than the national target for NTSV cesarean births, early elective deliveries, and episiotomies established by Healthy People 2030.



>> Facilities must collect demographic data and stratify quality outcomes on these measures to track and address racial or other disparities. NJDOH and MCQC should work with hospitals, providers, and other stakeholders — including patients — to achieve the quality and equity goals. These goals should be tied to reporting and payments. The California Perinatal Quality Collaborative and Maternal Data Center are examples of how the focused use of public health data can make a difference.²⁴

>> With support from the MDC, MCQC, PQC, and others, all New Jersey birthing hospitals should commit to participating and successfully implementing at least some of the safety bundles listed below, based on their needs as shown in the data. The bundles were developed as part of the Alliance for Innovation on Maternal Health (AIM) Program and funded by HRSA.

>> Several of these bundles are being implemented throughout the state. They are core building blocks of the AIM program's efforts to address the leading known causes of preventable severe maternal morbidity and mortality in the US.²⁵

>> The bundles are:

- | | |
|---|---|
| > Obstetric Care for Women with Opioid Use Disorder | > Cardiac Conditions in Obstetrical Care |
| > Obstetric Hemorrhage | > Postpartum Discharge Transition |
| > Safe Reduction of Primary Cesarean Birth | > Care for Pregnant and Postpartum People with Substance Use Disorder |
| > Severe Hypertension in Pregnancy | |

cont'd



CONSIDERATIONS (cont'd)



>> All state-funded and regulated health plans or programs should use data and reimbursement models for perinatal care to improve reproductive health, pregnancy, and the post-partum and inter-partum periods.

>> Supporting birthing facilities and providers for vaginal births after cesarean (VBACs) can help increase access to this type of delivery, based on best evidence on shared decision making, patient-centered care, and safe practices.

>> Cesarean sections, episiotomies, and early elective deliveries can do serious harm to pregnant individuals and infants. There is significant variation in their use by race. The Leapfrog Group's survey asks hospitals to report how they collect, verify, and use demographic data to identify and address inequities. Hospital efforts to accurately collect and use demographic data to identify inequitable treatment and outcomes, now in their early stages, must be encouraged and accelerated, especially regarding MIH to address birth equity and reduce Black maternal morbidity and mortality.

>> NJ FamilyCare pays for over 40% of the births in New Jersey. Most individuals are enrolled in an MCO for coverage and coordination of care. Unfortunately, the MCOs perform below the national average on timeliness of prenatal care and postpartum care, based on 2019 data. The MCO contract should include performance penalties and incentives — enforced to improve access to perinatal care and increase accountability for timeliness of care.

>> The National Committee for Quality Assurance (NCQA) is the steward of the quality measures that health plans and purchasers use to compare plan performance. NCQA is creating methods to collect and report performance by demographics, which has significant value for improving MIH quality and equity. New Jersey should require the MCOs and other insurers it contracts with to adopt these new data fields in their reporting.

>> Aligning contract terms, payment models, and targeted quality outcomes can further promote joint accountability, improved care coordination and access, and improved quality and equity outcomes.

>> It will be essential to involve many entities in implementing a data strategy that aligns with payment reforms, including perinatal providers, health purchasers/plans, birthing facilities (including hospitals, birthing centers, and those facilitating home births), NJDOH, NJ FamilyCare/Medicaid, DCF, Treasury, Division of Consumer Affairs, DOBI, MCQC, PQC, MDC, the maternal and child health consortia, and the Regional Health Hubs.



A PATH TO CONSIDER: INCLUDE PATIENT-REPORTED EXPERIENCES AND OUTCOMES

>> The Northern and Southern maternal and child health consortia, in partnership with NAACP Black Infant Morbidity and Mortality Taskforce, are piloting a Maternal Experience Survey throughout the state.²⁶ The Survey enables women to share their perinatal experience, including their birthing experience. Unlike standard hospital surveys, it allows for open-ended text so respondents can fully share their feelings and thoughts on the care they received. The Survey includes questions focused on inequity in care, particularly for individuals of color.

>> This and other qualitative surveys will increase interpretation and understanding of the patient experience at sites of care and could assist in formulating focused actions to reduce facility-level bias and inequity. Collaboration with county-based advisory boards to review the survey input and provide aggregate, anonymous data to hospitals and community organizations will be used to improve the birthing experience for people of color across the state.

>> The Survey's qualitative data, gleaned from patient stories and responses in their own words, and the quantitative quality metrics could help improve MIH through quality improvement and payment changes.

>> Patient-centered outcomes research (PCOR), like this survey, focus on metrics and outcomes most important to patients. This can help providers, hospitals, birthing centers, and pregnant individuals make better-informed decisions about their care.²⁷ PCOR also provides the ability to include a diverse group of participants and better understand what high-quality care looks like to individuals and across the population.



SECTION 3: REFORM PAYMENT SYSTEMS TO DRIVE HIGH QUALITY HOLISTIC MATERNAL INFANT HEALTH CARE

Payment reform and incentives offer opportunity to drive higher-quality, holistic MIH care. An array of pilots and projects in MIH have been launched or funded by specific health plans or foundations. This work should be identified, aligned, and — as proven — expanded at the state level to increase the pace of change. A review of existing programs funded by the state or the federal budget, or through combined funding should also be conducted.

These steps are important so funders and stakeholders can see where additional support — through increased financial resources, workforce enhancement, or public awareness — can be used to increase the impact of these programs before shifting focus to new pilots that may have the same goals or impact.

To drive significant change, focus should be given to payment structures that expand integrated care to include physical and mental health during the perinatal period, when pregnant people are more susceptible to mood

disorders and mental health concerns and during the early years of a child's life. This will promote and support early foundational relationships between young children and their caregivers to advance physical health and development, social well-being, and resilience.

Addressing pregnant and postpartum individuals' social needs to ensure holistic health quality and birth equity also should be a priority. Tools, payment strategies, and services that use the Perinatal Risk Assessment (PRA) form, which includes the demographic, medical, and psychosocial factors considered for the care of pregnant people, should be employed to connect and deliver resources essential to achieve NNJ's goals. In addition, payments and expansion of these services will be needed and consideration should be given to incorporating these social services into payment models — including expanded use of Medicaid to cover integrated services and supports and to link those in postpartum to reproductive services to promote health and wellbeing during the interpartum period.



PAYMENT REFORM POLICY RECOMMENDATION 1

Support and sustain existing MIH programs and as needed, launch and leverage payment reforms and pilots to further MIH quality and equity.

New pilots and programs that meet a gap in existing models should be launched and leveraged through the MCQC's HRSA grant and innovation models, and within NJ FamilyCare through its ability to test innovative payment models that deliver high-quality care and preserve resources. Existing models should be built upon and scaled to expand services that provide integrated care to further MIH quality and equity.

CONSIDERATIONS

Many state-based pilots and programs that align with the NNJ Strategic Plan or the MCQC grant are in early stages or yet to launch, including:

>> Perinatal Episode of Care (EOC) for Medicaid beneficiaries: This restructuring of payment models to increase provider incentives is a priority under NJ FamilyCare's three-year pilot launched in spring 2022 — an important step into outcome-based payments.²⁸ The pilot, involving the five MCOs, is a voluntary payment arrangement for perinatal providers that rewards providers for achieving certain quality targets. The pilot will provide an opportunity to collect data and assess strategies to improve the quality of patient care. These models must be designed to encourage and reward participation and not unintentionally penalize providers for improving quality of care over the entire period of the birth and a fixed period thereafter.

>> Community doula benefit for Medicaid participants: Beginning in 2021, community doulas were able to enroll with NJ FamilyCare as fee-for-service providers and then contract with MCOs to bill for their services at amounts fixed by the state.

>> Universal home visiting post-partum: Under state law, mothers and families can choose to have a registered or advanced practice nurse provide a home visit after delivery to assist or educate them in their care or the care of their infant. This program is currently being operationalized by DCF.

>> TeamBirth NJ: This evidence-based model promotes shared decision making between the pregnant individual and birth team. It empowers patients throughout the birthing process and supports the birth team by establishing a familiar process. Now being tested and supported by the MCQC through HRSA funding, the model could be scaled and included in quality and payment programs for birthing facilities.

Many of these programs and pilots offer promising outcomes but are time-limited in their design. It is essential to include evaluation plans to assess each model and build sustainability into payment systems beyond the pilot periods.

Private sector payers and stakeholders should consider whether new payment and care delivery models align with services already offered, like home visitation programs, so consumers, communities, and providers better understand the various models and how to access them.





PAYMENT REFORM POLICY RECOMMENDATION 2

Improve the Perinatal Risk Assessment (PRA) form and use it to connect pregnant individuals to social and clinical services.

Improvements are needed in the efficiency, accuracy, and usability of the PRA to provide necessary social and clinical services to pregnant people and for timely referrals for services during the prenatal period.

CONSIDERATIONS



>> The PRA is a set of forms developed to promote early identification of prenatal risk factors and refer eligible individuals to community support, including evidence-based home visitation programs, housing and food programs, and other social services.

>> Providers submit completed forms to Family Health Initiatives (FHI), a subsidiary of the Southern New Jersey Perinatal Cooperative, one of the maternal and child health consortia in the state.²⁹ Data from the PRA is submitted to Connecting NJ (formerly Central Intake) offices in each county to facilitate patient referrals to needed services. PRA forms must also be submitted by a provider to the patient's MCO for the provider to be reimbursed for the prenatal care.

>> State law mandates these forms be completed for all uninsured, Medicaid presumptively eligible, and Medicaid enrolled pregnant individuals. Medicaid currently requires that providers complete a PRA form to be reimbursed for prenatal care, however, payment is not linked to any follow-up or referrals on the risk factors identified on the PRA.³⁰

>> The PRA forms do not integrate with clinical electronic health records. Clinicians need to reinput clinical data into the PRA, which is time-consuming. Based on provider community feedback, the PRA is lengthy, contains outdated questions and terminology, and — because it takes so long to fill out — is often not completed as intended at the time of a patient's or caregiver's appointment. Forms often contain missing and/or incorrect information. This prevents patients from receiving the education and support they need while they are in the office and hinders timely referrals to necessary clinical and social services.

>> The state must commit to creating a PRA form that can be used with electronic health records to reduce provider and practice burden and enable timely referrals to services. The PRA/SPECT database could also be enhanced to better communicate with, and track referrals made to Connecting NJ.

cont'd



CONSIDERATIONS (cont'd)



>> The PRA forms should be updated, simplified, and connected to electronic health records to increase usability, accuracy, and likelihood of completion during the patient's visits. NJDOH, through the NJ Health Information Network, contracted with FHI to undertake some of these changes and to connect the PRA to the NJHIN. More public information is needed on the progress of these changes.

>> There is value in using the PRA for all pregnant people, not just those in Medicaid, but there are no current stipulations about form completion for those who are covered by state health benefits, individually insured, or part of a commercial plan. This sets up different standards of care for patients based on their insurer, leading to inequity in practice and potential stigma for Medicaid participants.

>> The state, through Treasury, NJDOH, Division of Consumer Affairs, and NJ FamilyCare, should ensure that the PRA forms are used by all entities receiving funds to insure or care for pregnant individuals and that staff receive regular training on the PRA form's purpose, the process of sharing the data, and enabling the patient to receive services. This includes:

- > All prenatal providers and office staff likely to assist in completing the forms
- > All Medicaid MCO and insurance staff that communicate with perinatal members
- > Community-based organizations that provide mental health and social services to pregnant individuals

>> Successful use of PRA forms, including the rate of access to identified needed services, should be tracked and reported annually by county and by specific Connecting NJ entities. This data should be provided to the MDC and MCQC. Data regarding social services referrals, needs, usage will inform other investments to improve MIH.



PAYMENT REFORM POLICY RECOMMENDATION 3

Build upon and scale existing care models that focus on the continuum of integrated care across the full perinatal period.

Greater focus should be put on consistent, timely behavioral health screening throughout the perinatal period and early childhood and increased referral to mental health support before and after delivery.

CONSIDERATIONS



>> Though mental health conditions are the most common cause of complications during the perinatal period, screening, referral, and treatment are inconsistent.³¹

>> State law requires postpartum depression screening before discharge from a hospital, but the follow-up process falls short, and few providers embed behavioral health counseling and support into their model of care.

>> More focus must be devoted to prevention. The United States Preventative Services Task Force recommends that those at increased risk for perinatal depression should be referred to behavioral health counseling support.³² Expanded screening during well-person and prenatal visits in addition to postpartum care is needed to better identify risk factors and concerns.

>> Additional training and education about mental health risks, indicators, and interventions should be offered to all providers who interact with and support birthing people. For example, the state or other funders could provide Mental Health First Aid training for all community-level and home-visiting practitioners.

>> Better communication and coordination of care is needed — including more co-location of services, regulatory and payment options for fully integrated practices, expanded high-quality telehealth, and better coordination with community behavioral health service providers.

>> An emphasis on communication and coordination between maternal and infant health care providers is critical. Pediatricians — usually the providers most regularly interacting with caregivers postpartum — should evaluate maternal health during infant visits to identify the need for behavioral health support.



A PATH TO CONSIDER: THREE MODELS OF INTEGRATED CARE

Several successful proven evidence-based integrated care models can be incorporated into New Jersey's payment landscape through amendments to contracts, guidance, and policy. These include CenteringPregnancy, CenteringParenting, and HealthySteps. Cross-sector work groups should align on how to effectively scale these models within the state and ensure adequate reimbursement.

CENTERINGPREGNANCY

>> The initial CenteringPregnancy pilot was launched through Central Jersey Family Health Consortium as part of the Start Smarter project funded through a four-year grant from the US Department of Health and Human Services for approximately \$425,000 a year.

>> Under the Healthy Women, Healthy Families initiative, NJDOH identified three grantee organizations who selected the evidence-based CenteringPregnancy model of group prenatal care as their preferred choice of program for implementation. The grantees were: Partnership for Maternal and Child Health of Northern New Jersey, Greater Newark Healthcare Coalition, and Central Jersey Family Health Consortium. NJDOH funding was directed toward implementation costs and covering a portion of the Centering Coordinator's salary.

>> The Nicholson Foundation, the Henry and Marilyn Taub Foundation, and the Burke Foundation awarded \$445,000 to the Centering Healthcare Institute for training and support services, startup, and implementation support for five expansion sites, Centering facilitation training workshops, and salary for the state program manager and implementation consultant. The initial program ran from April 2019 through March 2021.

>> Expansion of CenteringPregnancy is underway, following such documented successes as reducing preterm births and sharply narrowing racial disparity among Black women relative to white and Hispanic women in New Jersey.

>> Some Centering programs offer additional behavioral health and substance use disorder support as part of an integrated mental and physical model supporting holistic care during the perinatal period.

>> Centering group health care visits follow nationally recognized guidelines and are billable. NJ FamilyCare covers CenteringPregnancy as a benefit and reimburses an additional \$7 per Centering visit, for up to 10 visits per pregnancy beyond what practices can bill for traditional prenatal care.³³ During the pandemic, Centering programs were able to pivot to a virtual model, which helped reduce the burden on medical practices of altering their physical spaces and on patients who would have had difficulty attending an in-person session due to child care, work, or transportation issues.

>> Besides New Jersey, four states provide enhanced reimbursement for CenteringPregnancy statewide through Medicaid: Ohio, \$45 per visit; South Carolina, \$30 per visit plus a one-time \$175 retention payment; Texas \$5.80 to \$9.51; and Maryland, whose payment amount is yet to be determined

>> Centering Healthcare Institute recommends an increased visit rate of \$45 per patient per visit (an increase of \$38 over New Jersey's present rate), plus a one-time \$250 retention payment to providers when patients complete five CenteringPregnancy visits. Adequate pay for this service, as recommended by the Centering Healthcare Institute, would incentivize more practices to offer Centering.





SECTION 3: REFORM PAYMENT SYSTEMS TO DRIVE HIGH QUALITY HOLISTIC MATERNAL INFANT HEALTH CARE

CENTERINGPARENTING

>> CenteringParenting brings together small groups of parents and partners/spouses who have newborns that are around the same age with support people for family-centered pediatric care. They meet, learn, and connect with each other and their health care providers.

>> Parents participating in CenteringParenting have a higher rate of attendance for postpartum visits and more opportunities to screen for maternal mental health. Their babies breastfeed longer, more regularly attend well-child visits, and experience higher immunization rates.

>> Philanthropic support has provided training and help with implementation for medical practices to launch CenteringParenting. To build sustainability and long-term success of this effective group pediatric model, however, it must be covered by insurance and reimbursed at a rate that encourages more practices and facilities to implement the model, like the CenteringPregnancy payment levels recommended by the Centering Healthcare Institute.

>> CenteringParenting programs can be linked or co-located with CenteringPregnancy programs, enabling continuity of care and seamless transition between pregnancy and the postpartum period.



HEALTHYSTEPS

>> A program of ZERO TO THREE, HealthySteps provides early developmental support to families as part of the care they receive at their pediatric primary care office. HealthySteps Specialists join the care team and, to help foster healthy child development, work closely with caregivers, provide brief interventions, connect families to additional services, and answer caregivers' questions about child development, social-emotional health, and well-being so all babies and toddlers have a strong start in life.

>> HealthySteps has significant benefits for children, their families, and the physicians and practices that serve them. Demonstrated outcomes include timely and complete well-child visits and immunizations,³⁴⁻³⁷ improved social-emotional development,³⁸ early identification of child and family needs, connection to services,³⁹ higher rates of continued breastfeeding,⁴⁰⁻⁴¹ improved maternal depression screening and follow up,⁴² and high parent and patient satisfaction.⁴³

>> HealthySteps, supported in New Jersey through philanthropic partnerships, operates at three Hackensack Meridian Health pediatric primary care sites.

>> Promising approaches to scale and expand the program are being followed across the country and could be implemented in New Jersey through such changes to the NJ FamilyCare benefits and MCO contracts as developing value-based purchasing arrangements focused on pediatric populations and quality measures as well as dyadic services; allowing billing and reimbursement for individual and family therapy with an "at-risk" diagnosis, to support preventive behavioral health services; and allowing billing and reimbursement for behavioral health team-based well-child visits provided by licensed behavioral health specialists.



SECTION 4: IMPROVE COMMUNITY-BASED SOCIAL SUPPORTS

Additional supports outside the medical system are needed as part of a multi-sector approach to address the social determinants of health and reduce maternal and infant mortality in New Jersey. Healthy food, a safe living environment, affordable childcare, quality education,

and viable employment with a livable wage contribute to better health yet are often unaddressed in health care policy initiatives. This requires public investments and partnerships to solve immediate problems and build collaborative systems for long-term change.

COMMUNITY-BASED SOCIAL SUPPORTS RECOMMENDATION 1

Make a safe, secure place to live available to all New Jersey families.

This must involve increasing the amount of affordable housing in New Jersey, with a focus on greater availability for pregnant people and families with young children. Supportive housing incorporates resources including integrated behavioral health and substance use disorder treatment into affordable housing so families can live together while receiving care and is essential to embedding support in a family's primary home.



SECTION 4: IMPROVE COMMUNITY-BASED SOCIAL SUPPORTS

CONSIDERATIONS



>> Research shows significant association between lack of secure housing during pregnancy and poor maternal health, low birth weight, and pre-term birth.⁴⁴

>> Lack of affordable housing is a problem across New Jersey and even more pressing for pregnant individuals and children because it can worsen health during a vulnerable time.

>> Addressing the lack of affordable housing requires significant financial investment as well as connecting people to educational opportunities, nutrition support, and other community-based services that can improve health and overall well-being during and after pregnancy. Supportive housing models should be scaled up to make available facilities that allow women to live with their children and provide embedded substance use treatment.⁴⁵

>> Because housing is an immediate need with significant impact on health outcomes, additional rental assistance and work needed to develop new housing units should begin as soon as possible because of the lag time before residents can be served. Strategies to increase the amount of affordable housing in New Jersey for pregnant people and families with young children should include additional funds to the State Rental Assistance Program (SRAP) to pilot project-based housing, which may include collaborations with the Department of Children and Families (DCF) and may include other special populations and increasing the income threshold for eligibility for SRAP funds for pregnant individuals.⁴⁶

>> State and local policymakers can dedicate a portion of state funds in each budget year to increase affordable housing units in New Jersey for pregnant people and families with young children, with a focus on geographical areas with the highest need and proximity to such support as affordable childcare, health care, and educational centers. Priority consideration should be given to housing services that have integrated behavioral support for mental health needs and substance use treatment.

>> NJ FamilyCare's recent Demonstration Waiver renewal included increased housing support services to connect those with identified needs, including pregnant individuals on Medicaid, with housing services through collaboration with MCOs, community-based partners, and HUD.⁴⁷ Many key players are involved in this strategy, including NJDOH, NJDHS, Department of Community Affairs, Housing Mortgage and Finance Agency, Housing & Community Development Network of New Jersey, Affordable Housing Alliance, and the New Jersey Head Start Association.

>> State and federal funds will be needed to support increased rental assistance to eligible individuals. State and federal funds, as well as support from private corporations, nonprofits, and municipalities, will be needed to support infrastructure development to build more affordable housing units. Collaboration with community-based organizations will support the integration of wraparound services centralized in affordable housing centers.



COMMUNITY-BASED SOCIAL SUPPORTS RECOMMENDATION 2

Maximize financial support to families for high-quality childcare.

This should involve increasing awareness and use of childcare tax credits, paid family leave, Earned Income Tax Credits, and childcare subsidies to support financial security and access to high-quality, affordable childcare.⁴⁸

CONSIDERATIONS



- >> Financial support for childcare as well as paid family leave programs aid in the healthy development of children by reducing poverty and enabling continued involvement in the workforce to promote economic security.
- >> In recent years, New Jersey has made significant advancements to paid family leave programs, invested in making childcare programs more available to families that struggle to get by, and broadened eligibility for the Earned Income Tax Credit (EITC).
- >> The impact of New Jersey's changes to the state EITC and financial assistance for childcare should be studied because the findings will likely inform future policy decisions on social investments to improve health and wellbeing.
- >> At the same time, more needs to be done to increase the impact of such programs by increasing participation. Inadequate communication to potential participants, confusion about programs, and difficulty navigating the bureaucratic process prevent participation from reaching the highest possible levels, depriving many families of benefits that would improve MIH and overall wellbeing.
- >> Much was done during the pandemic to address the upheaval to the state's childcare industry, including increasing subsidies for families and support for childcare workers. As these temporary measures come to an end, the struggle to find reliable and affordable childcare continues for those returning to the workforce. Attention must be paid to the childcare workforce's wage issues, accessibility of resources, and retention in the field.
- >> To support greater access to childcare, the state should consider maintaining pandemic-linked childcare affordability allowances that made high-quality childcare accessible for families and make permanent childcare subsidies based on enrollment, not attendance.^{49–50}
- >> A statewide communication campaign, in partnership and collaboration with state agencies and community organizations, is essential to increase awareness of and utilization of these benefits.



COMMUNITY-BASED SOCIAL SUPPORTS RECOMMENDATION 3

Enhance and build awareness of Connecting NJ to support Title V Block Grant and other community programs.

CONSIDERATIONS

>> Title V funding is one of the largest federal block grants awarded to states. It supports promoting and improving maternal and child health and well-being.⁵¹

>> There are three priority areas for the Title V program in New Jersey: Increase the delivery of culturally congruent services through a well-trained workforce; improve access to health services through partnerships and collaboration; and reduce disparities in health outcomes.⁵²

>> Title V funds are used to support many essential MCH programs in the state, including the Maternal Mortality Review Committee, Fetal Infant Mortality Review, Healthy Women, Healthy Families initiatives, and Maternal Infant Early Childhood Home Visiting (MIECHV) evidence-based home visitation programs.

>> Connecting NJ, a network of partners and agencies (formally Central Intake hubs) are a single point of entry for screening and referral of birthing people and their families to many of the services and supports funded by the Title V block grant. The hubs are county-specific and make referrals based on need and location of the individual. However, there is a lack of public awareness about the role and purpose of Connecting NJ, as well as inconsistent closed-loop referral with the referring provider or professional to verify service uptake or whether needs have been met.⁵³

>> Because each Connecting NJ hub is run on the county level, operations and processes are not standardized. Aligning oversight into one agency would produce the opportunity to create a single point of entry — for example, one toll-free phone number — and to prioritize community outreach as well as build a system for ensuring closed-loop referrals.

>> Creating a “no wrong door” option for families accessing services would enable better connections. While the primary path for families to access services is via the Perinatal Risk Assessment (PRA) or newly added self-referral, pathways to allow for direct referrals from managed care organizations (MCOs), community health workers, and doulas to Central Intake to meet an identified need would be much more effective with a confirmation of services received and program uptake by the family, a closed-loop system.

>> Financial resources and state department collaboration will be essential for this recommendation, including enhancing both the technology and operations of the system to build consistency across hubs, create easy and accessible referral pathways, and enable closed-loop referrals.





A PATH TO CONSIDER: EVIDENCE-BASED HOME VISITING PROGRAMS

>> New Jersey has three established, evidence-based home visitation programs from pregnancy through early childhood. A fourth, the universal home visiting program, is being operationalized for launch soon.⁵⁴

>> The three existing programs are supported by the federal Maternal Infant Early Childhood Home Visiting (MIECHV) program. Flat funding and fixed budgets for the programs create problems, including the inability to increase program budgets, inadequate staff wages — leading to difficulty recruiting and retaining staff — and limiting outreach efforts.

>> The three home visitation programs in New Jersey are:⁵⁵

> **Nurse-Family Partnership (NFP)**, for first-time pregnant people who enroll in the service by their 28th week of pregnancy. During home visits, registered nurses provide education and support and make connections to community services and health care as needed. Visits begin weekly and then may become less frequent. Visits occur until the child reaches age two.

> **Parents as Teachers (PAT)** provides family support and school readiness, serving families from pregnancy until a child starts kindergarten. Certified Parent Educators make home visits or, in some cases, meet with small groups in the community. Parent Educators make connections to community services as needed.

> **Healthy Families America** provides education and support for new and expectant parents, usually during pregnancy or in the first few weeks after birth. Family Support Workers conduct home visits focused on connecting the family to social services and health care and promoting positive parenting and healthy growth and development.

>> There is often a lack of understanding about who is eligible for each program and how to enroll. Greater funding is needed for increased wages to fully staff the programs, recruit, and retain medical and non-medical staff, and conduct marketing and outreach efforts to raise awareness about how to participate.

>> These programs should be better publicized within state government, MCOs, and to providers to increase participation and make timely closed-loop referrals during the prenatal period via Connecting NJ.



CONCLUSION

The MAP is an implementation guide. We invite you to use the MAP to further your work and engage with others to advance the goals of the Nurture NJ Strategic Plan and make New Jersey the safest, most equitable state in the nation to deliver and raise a baby.

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APPENDIX

ALIGNMENT BETWEEN THE NURTURE NJ STRATEGIC PLAN AND THE MATERNITY ACTION PLAN

Each section of the MAP aligns with specific recommendations in the Nurture NJ Strategic Plan. The matrix shows how each section of MAP aligns and all specific Nurture NJ Strategic Plan recommendations are listed below by MAP section.

NURTURE NJ STRATEGIC PLAN GOALS									
	Build racial equity infrastructure and capacity	Support community infrastructures for power-building & engagement in decision-making	Engage multiple sectors to achieve collective impact on health	Shift ideology and mindsets to increase support for transformative action	Strengthen and expand public policy to support conditions for health in NJ	Generate and disseminate information for improved decision-making	Change institutional structures to accommodate innovation	Address the social determinants of health	Improve the quality of care and service delivery to individuals
MATERNITY ACTION PLAN RECOMMENDATIONS		✓	✓	✓	✓	✓			✓
		✓	✓		✓	✓	✓	✓	
					✓	✓	✓		✓
						✓	✓	✓	✓

BUILD THE WORKFORCE NEEDED TO ACHIEVE BIRTH EQUITY AND QUALITY

WORKFORCE POLICY

RECOMMENDATION 1

Promote educational reforms to educate, recruit, and retain a more diverse MIH workforce, including ongoing anti-racism education and training.

RECOMMENDATION 2

Use community input and data to enhance health care workforce training, recruitment, and retention programs and sustainability to improve MIH.

RECOMMENDATION 3

Increase support for key MIH workforce roles: community health workers, community doulas, lactation consultants and lactation support professionals, and midwives.

1.1 All state departments and agencies should be required to implement a plan for increasing and maintaining capacity to promote racial equity in all systems and structures.

1.2 Declare racism a public health crisis.

1.3 Establish an Office for State Diversity, Equity, and Inclusion to reflect the increased priority, enable a greater level of collaboration, and address the state's equity needs.

1.4 Create a state-led accrediting body empowered to award a "racial equity designation" for the public and private sectors.

1.5 The state should convene the private sector to incentivize and engage them in action on racial equity.

2.1 State departments and agencies, in partnership with the private sector, nonprofits, community leaders, and funders, should develop infrastructure for community-level power and knowledge building in communities with high Black maternal and infant mortality.

2.3 Develop permanent structures to integrate community partnerships into state, county, and local decision-making processes.

3.1 Develop public-private partnerships to implement place-based, community partner change models in areas with the highest Black maternal and infant morbidity and mortality and then expand to every community across New Jersey.

4.3 Develop a communications plan to promote benefits of midwifery and community doula models of care.

4.4 Develop a communications plan to encourage mindset shifts regarding the connection of behavioral and physical health services.

5.9 The Division of Consumer Affairs should examine standards of care related to maternal and infant health.

5.11 The Department of Health, the Office of the Secretary of Higher Education, and the Department of Labor should promote workforce development and retention in communities of color.

5.12 The Office of the Attorney General, through the Division of Consumer Affairs, should develop pre and post licensure education for New Jersey's health professions.

5.13 The Department of Human Services and Department of Health should support a representative, effective community workforce serving pregnant individuals and babies.

7.4 Strengthen and expand practice of the midwifery model of care in New Jersey by building a more robust workforce pipeline.

7.11 The Department of Health and Department of Human Services and other relevant departments or agencies should collaborate on a plan to develop community-based providers, including birthing centers, in underserved areas.

7.15 The Department of Health and Department of Human Services should continue to strengthen the community health worker workforce.

7.16 State departments and agencies and health care providers should incorporate community-based perinatal health workers in an interdisciplinary care approach to support pregnant women and caregivers through the postnatal period.

9.2 Secure a commitment to action from the CEOs of all health care systems and leadership of health professional societies in New Jersey, which should include action steps to reduce maternal and infant mortality and morbidity.

9.8 Ensure all parents receive community-based peer support for postpartum health, breastfeeding, and social support.

COLLECT AND USE DATA TO IMPROVE EQUITY AND QUALITY

DATA COLLECTION AND USE POLICY

RECOMMENDATION 1

Improve data collection
and reporting

RECOMMENDATION 2

Use maternal health data in quality
improvement, payment models, and public
reporting to improve equity and quality.

1.1 All state departments and agencies should be required to implement a plan for increasing and maintaining capacity to promote racial equity in all systems and structures.

1.6 Build upon the Nurture NJ interdepartmental working group to break down internal silos and share possibilities for collaboration.

2.3 Develop permanent structures to integrate community partnership into state, county, and local decision-making processes.

4.7 Private sector businesses and/or their associations should fund, conduct, and disseminate a business case for racial equity analysis specific to New Jersey.

4.8 Reframe the statewide targets in Healthy NJ 2030 to eliminate disparities in Black versus white rates.

5.10 The Department of Health should implement a system of community-designed, real-time maternal feedback on quality of care.

6.2 Improve the process for quality and usage of state maternal mortality data through significant reinvestment in the Maternal Mortality Review Committee (MMRC).

6.3 The Department of Human Services and Department of Health should work together to improve accountability to women of color through data transparency.

6.4 The Department of Health, in collaboration with academic partners, should develop a data-based approach to racial inequity surveillance able to identify health and social disparities and focus approaches.

6.5 The academic community in New Jersey should commit to conducting research to monitor and evaluate changes in community engagement, perceptions (mindsets, narrative change), changes in community-supportive policy, and resultant health impacts in populations of color in New Jersey.

7.5 All 49 birthing hospitals and birthing facilities in New Jersey should meet or attain rates lower than the national target for NTSV surgical/cesarean births

7.7 New Jersey hospitals should institute systemic changes to accommodate doulas and safe birth practices.

7.12 The Department of Health should work with New Jersey health care providers to increase accountability on racial equity initiatives.

8.1 Regional Health Hubs should work collaboratively with state departments and agencies, private funders, community and grassroots groups, and academic leaders on a landscape analysis in the state's Black maternal and infant health hotspots.

REFORM PAYMENT SYSTEMS TO DRIVE HIGH-QUALITY HOLISTIC MATERNAL INFANT HEALTH CARE

PAYMENT REFORM POLICY

RECOMMENDATION 1

Launch and leverage payment reforms and pilots to further MIH quality and equity.

RECOMMENDATION 2

Improve Perinatal Risk Assessment (PRA) form and use to connect pregnant individuals to social and clinical services.

RECOMMENDATION 3

Build upon and scale existing care models in New Jersey that focus on the continuum of integrated care across the full perinatal period.

4.4 Develop a communications plan to encourage mindset shifts regarding the connection of behavioral and physical health services.

4.5 Actively shift public and private sector mindsets on benefits of shared decision-making with community.

4.6 Ensure understanding of the importance of human-centered and trauma-informed care practices and expand use among all program planners and providers.

5.7 New Jersey should affirmatively provide for comprehensive family planning services and reproductive autonomy through policy and in funding.

5.8 The Department of Human Services should strengthen efforts to make the health system accountable to women of color through reliable coverage and evidence-based care.

5.9 The Division of Consumer Affairs should examine standards of care related to maternal and infant health.

5.14 The Department of Human Services should continue to ensure comprehensive access to health care for women through the Medicaid program by seeking funding and federal approval to expand Medicaid to 365 days postpartum.

5.15 Assess models for value-based care to ensure they do not penalize health providers that disproportionately serve communities with high social needs.

5.18 The Department of Health should work with state leaders to provide breastfeeding support in communities for both mothers, fathers, and other partners.

5.19 The Department of Children and Families should continue to expand and universally offer evidence-based home visiting programs with focus on those models proven to reduce maternal and infant mortality.

5.21 State leaders should increase the state contribution to the childcare block grant to ensure that, at a minimum, all families within the income limits are able to receive care.

7.2 The Department of Human Services and the Department of Health should ensure access to affordable, equitable, integrated behavioral health care at all times over the life-course.

7.3 Provide access to the full range of family planning services, including all safe and effective contraception methods and abortion care, through stronger provider relationships.

7.5 All 49 birthing hospitals and birthing facilities in New Jersey should meet or attain rates lower than the national target for NTSV surgical/cesarean births.

7.6 The Department of Health and the Department of Human Services should expand the use and improve the utility of the Perinatal Risk Assessment.

7.7 New Jersey hospitals should institute systemic changes to accommodate doulas and safe birth practices.

7.8 To promote access to comprehensive, continuous, high quality maternal care services, the state should design tools to promote shared decision-making with patients.

7.9 The New Jersey Perinatal Quality Collaborative (NJPQC), the organization responsible for improving the quality of perinatal care throughout the state, should lead implementation of prenatal and postpartum Alliance for Innovation in Maternal health (AIM) bundles across the state.

7.10 All persons who give birth in New Jersey should be cared for at a birthing hospital or facility that provides the appropriate level of maternal care by the end of 2022.

7.12 The Department of Health should work with New Jersey health care providers to increase the accountability on racial equity initiatives.

cont'd

7.18 Continue to improve and transform Central Intake.

9.2 Secure a Commitment to Action from the CEOs of all health care systems and leadership of health professional societies in New Jersey, which should include action steps to reduce maternal and infant mortality and morbidity

9.3 Increase access to CenteringPregnancy.

9.4 The Department of Human Services should ensure access to comprehensive evidence-based childbirth education for all Medicaid beneficiaries as standard practice of prenatal care.

9.5 Increase the number of Baby-Friendly designated hospitals in New Jersey to at least one hospital in all infant mortality hotspot areas.

9.7 The Department of Banking and Insurance should continue outreach to pregnant women.

9.8 Ensure all parents receive community-based peer support for postpartum health, breastfeeding, and social support.

IMPROVE COMMUNITY-BASED SOCIAL SUPPORTS

COMMUNITY-BASED SOCIAL SUPPORTS POLICY

RECOMMENDATION 1

Make a safe, secure place to live available to all New Jersey families.

RECOMMENDATION 2

Maximize financial support to families for high-quality childcare.

RECOMMENDATION 3

Enhance and build awareness of Connecting NJ to support Title V Block Grant and other community programs.

5.1 The State should continue to invest in opportunities for safe, decent, toxin-free affordable housing.

5.3 The Department of Treasury should increase uptake of the Earned Income Tax Credit.

5.4 The Department of Labor should continue their efforts with employees and employers to expand utilization of paid family leave benefits.

5.19 the Department of Children and families should continue to expand and universally offer evidence based home visiting programs with focus on those models proven to reduce maternal and infant mortality.

5.20 The Department of Education should continue to prioritize access to high quality childcare through Early Head Start.

5.21 State leaders should increase the state contribution to the childcare block grant to ensure that, at a minimum, all families within the income limits are able to receive care.

5.22 The New Jersey Economic Development Authority should provide targeted support to childcare providers as a critical industry in the state.

7.18 Continue to improve and transform Central Intake.

8.3 Develop multisector efforts to specifically address the impact of environmental factors on maternal and infant health.

8.5 New Jersey's housing developers, funders, advocates, and stakeholders should develop multisector efforts to increase the availability of quality, affordable housing for pregnant individuals and women with young children

9.8 Ensure all parents received community-based peer support for postpartum health breastfeeding and social support.

9.9 Health care providers, social service providers, and health insurers should promote alternative models of early childhood care to expand care for the infant.



FOOTNOTES

¹ Systemic Racism and Health Equity. <https://www.rwjf.org/en/library/research/2021/12/systemic-racism-and-health-equity.html>

² See Appendix 1 for alignment between NNJ Strategic Plan and MAP recommendations

³ Hassen, N., Lofters, A., Michael, S., Mall, A., Pinto, A. D., & Rackal, J. (2021). Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review. *International journal of environmental research and public health*, 18(6), 2993. <https://doi.org/10.3390/ijerph18062993>

⁴ Racially Concordant Care. 2021. <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/infant-mortality/meetings/20210921/4.%20Racially%20Concordant%20Care%20-%20William%20McDade%2C%20MD%2C%20PhD.pdf>

⁵ Find a Health Workforce Research Center. <https://bhw.hrsa.gov/data-research/health-workforce-research-centers>

⁶ Higher Education Student Assistance Authority: Loan Redemption Program. <https://www.hesaa.org/Pages/LoanRedemptionPrograms.aspx>

⁷ The State of New Jersey Budget in Brief Fiscal Year 2022. <https://www.state.nj.us/treasury/omb/publications/22bib/BIB.pdf>

⁸ Oregon Office of Rural Health: Oregon Health Care Provider Loan Repayment. <https://www.ohsu.edu/oregon-office-of-rural-health/oregon-health-care-provider-loan-repayment>

⁹ State of New Jersey Division of Medical Assistance and Health Services: 1115 NJ FamilyCare Demonstration Renewal Request. https://www.state.nj.us/humanservices/dmahs/home/1115_demo.html

¹⁰ Uzazi Village. <http://www.uzazivillage.org/>

¹¹ The Children's Home Society: AMAR Doula Program. <https://www.chsofnj.org/amar-doula/>

¹² State of New Jersey Division of Medical Assistance and Health Services: Doula Care. <https://www.state.nj.us/humanservices/dmahs/info/doula.html>

¹³ National Association of County and City Health Officials: The Continuity of Care in Breastfeeding Support Blueprint. <https://www.breastfeedingcontinuityofcare.org/blueprint>

¹⁴ National Association of County and City Health Officials: The Continuity of Care in Breastfeeding Support Blueprint. <https://www.breastfeedingcontinuityofcare.org/blueprint>

¹⁵ Burke Foundation/New Jersey Health Care Quality Institute: Delivering Better Care: Midwifery Practice in New Jersey report. https://www.njhqcqi.org/wp-content/uploads/2022/06/Delivering-Better-Care-Midwifery-Practice-in-New-Jersey-Report_2022.pdf?utm_source=Newsletter&utm_medium=MailChimp&utm_campaign=Midwifery+Report+6.2022

¹⁶ American College of Nurse-Midwives (2015). "State Fact Sheets," ACNM Department of Advocacy and Government Affairs Grassroots Advocacy Resources, <http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005600/ACNMStateFactSheets8-21-15.pdf>

¹⁷ At the time of public release of the report, the Governor's proposed FY23 budget included \$1 million to support midwifery training and education.

¹⁸ United Health Foundation: America's Health Rankings. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/overall_hwc_a/state/NJ

¹⁹ Maternal Mortality in New Jersey. https://nj.gov/health/fhs/maternalchild/documents/NJ%20Maternal%20Mortality_2014-2016_12.14.21_Final.pdf#:~:text=During%202014-2016%2C%20the%20pregnancy-associated%20mortality%20ratio%20for%20New,pregnancy-associated%2C%20but%20not%20related%20deaths%20was%20higher%20than

FOOTNOTES (cont'd)

²⁰ The data sources that could be better aligned and leverage include:

- NJ Department of Treasury, Division of Pensions and Benefits, which pays for almost 10 % of births has its claims data with cost and quality data.
- NJ FamilyCare, including the MCOs, which pays for over 40 % of births has cost and quality data on providers. It also has quality performance data on the MCOs (Healthcare Effectiveness Data and Information Set (HEDIS), which is one of health care's most widely used measure sets. All MCOs are required to report data to the state for each of the identified HEDIS measures collected, including maternity-linked measures.)
- NJDOH collects maternal mortality and morbidity data, Pregnancy Risk Assessment Monitoring System (PRAMS) survey data, breast-feeding data, Maternal Hospital Report Card data, birth and death certificates, Fetal Death Certificates, and State Health Assessment Data (SHAD) on births and maternal health.
- The Department of Children and Families has non-integrated county-based data from its programs, including family success centers (FSC) and Connecting NJ (formerly Central Intake) as well as the Child Welfare Data Hub, and the three regional maternal consortia they administer.

²¹ Maternal Child Health Services Title V Block Grant FY2022 Application and FY2020 Annual Report. [https://www.nj.gov/health/fhs/maternalchild/documents/MCH%20block%20grant/njMCHBG072921%20\(2\).pdf](https://www.nj.gov/health/fhs/maternalchild/documents/MCH%20block%20grant/njMCHBG072921%20(2).pdf)

²² Several commenters endorsed the Irth App which is a “yelp-like” review sharing platform for people of color to review prenatal, pregnancy, and pediatrics care. <https://irthapp.com/>

²³ 2021 Leapfrog Group Hospital Survey: Maternity Measures at pp. 124-132. https://www.leapfroggroup.org/sites/default/files/Files/2021HospitalSurvey_20210913_v8.2%20%28version%203%29.pdf

²⁴ Main, E., Markow, C., and Gould, J. (2018). Addressing maternal mortality and morbidity in California through public-private partnerships. HealthAffairs. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0463>

²⁵ Alliance for Innovation on Mental Health. <https://safehealthcareforeverywoman.org/aim/resources/>

²⁶ NAACP Maternal Experience Survey. <https://www.acnj.gov/News/View/34/naacp-maternal-experience-survey>

²⁷ Patient-Centered Outcomes Research Institute: Research we support. <https://www.pcori.org/research/about-our-research/research-we-support>

²⁸ State of New Jersey Division of Medical Assistance and Health Services: Perinatal Episode of Care Pilot. <https://www.nj.gov/humanservices/dmahs/info/perinatalepisode.html>

²⁹ Southern New Jersey Perinatal Collaborative: Universal Prenatal Screening. <https://www.snjpc.org/what-we-do-for-providers/screening.html>

³⁰ NJFamilyCare Announcement. https://www.state.nj.us/humanservices/dmahs/home/NJFC_maternity_reimbursement.pdf

³¹ Griffen, A. et al. (2021). Perinatal mental health care in the United States: An overview of policies and programs. HealthAffairs. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.00796>

³² US Preventative Services Task Force: A and B Recommendations. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>

³³ NJ FamilyCare Newsletter. <https://www.njmmis.com/>

³⁴ Guyer, B., Barth, M., Bishai, D., Caughy, M., Clark, B., Burkom, D., Genevro, J., Grason, H., Hou, W., Keng-Yen, H., Hughart, N., Snow Jones, A., McLearn, K.T., Miller, T., Minkovitz, C., Scharfstein, D., Stacy, H., Strobino, D., Szanton, E., & Tang, C. (2003). Healthy Steps: The first three years: The Healthy Steps for Young Children Program National Evaluation. https://ztt-healthysteps.s3.amazonaws.com/documents/139/attachments/2003_HS_National_Evaluation_Report.pdf?1539967.

³⁵ Johnston, B.D., Huebner, C.E., Anderson, M.L., Tyll, L.T., & Thompson, R.S. (2006). Healthy Steps in an integrated delivery system: Child and parent outcomes at 30 months. Archives of Pediatrics & Adolescent Medicine, 160(8), 793–800.

³⁶ Buchholz, M., & Talmi, A. (2012). What we talked about at the pediatrician's office: Exploring differences between Healthy Steps and traditional pediatric primary care visits. Infant Mental Health Journal, 33(4), 430–436.

FOOTNOTES (cont'd)

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- ³⁸ Briggs, R. D., Silver, E.J., Krug, L.M., Mason, Z.S., Schrag, R.D.A., Chinitz, S., & Racine, A.D. (2014). Healthy Steps as a moderator: The impact of maternal trauma on child social-emotional development. *Clinical Practice in Pediatric Psychology*, 2(2), 166–175.
- ³⁹ Hughes, S., Herrera-Mata, L., & Dunn, J. (2014). Impact of Healthy Steps on developmental referral rates. *Family Medicine*, 46(10), 788–791.
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- ⁴¹ Preliminary data from the HealthySteps Outcome Pilot Study.
- ⁴² The HealthySteps National Office. (2020). Embracing Growth: 2019 Annual Report. https://ztt-healthysteps.s3.amazonaws.com/documents/309/attachments/Embracing_Growth_2019_Annual_Report.pdf?1596829170.
- ⁴³ Davis, A., Vivrette, R., Carter, T., Eberhardt, C., Edwards, S., Connors, K., & Reavis, K. (in press). Impact of an approach to integrated care for young children in low-income urban settings: Lessons from the Perspectives of Primary Care Clinicians. *Journal of Clinical Practice in Pediatric Psychology*.
- ⁴⁴ Leifheit, Kathryn M et al. Severe Housing Insecurity during Pregnancy: Association with Adverse Birth and Infant Outcomes. *International journal of environmental research and public health* vol. 17,22 8659. 21 Nov. 2020, doi:10.3390/ijerph17228659
- ⁴⁵ The Center for Great Expectations: Adult Residential Mommy and Me Program. <https://www.cge-nj.org/programs/adult-program/>
- ⁴⁶ State of New Jersey Department of Community Affairs State Rental Assistance Program. <https://www.nj.gov/dca/divisions/dhcr/offices/srap.html>
- ⁴⁷ State of New Jersey Division of Medical Assistance and Health Services: 1115 NJ FamilyCare Demonstration Renewal Request. https://www.state.nj.us/humanservices/dmahs/home/1115_demo.html
- ⁴⁸ At the time of report release, a package of childcare-related bills had been introduced in the NJ State Senate and were pending legislative review.
- ⁴⁹ Advocates for Children of New Jersey: FY23 Budget Testimony. <https://acnj.org/acnj-fy2023-budget-testimony-on-child-care-by-cynthia-rice/>
- ⁵⁰ At the time of report release, a package of childcare-related bills had been introduced in the NJ State Senate and were pending legislative review.
- ⁵¹ US Department of Health and Human Services: Title V Block Grant. <https://www.hhs.gov/guidance/document/title-v-maternal-and-child-health-services-block-grant-states-program-guidance-and-forms-2#:~:text=As%20one%20of%20the%20largest,special%20needs%2C%20and%20their%20families.>
- ⁵² Maternal Child Health Services Title V Block Grant FY2022 Application and FY2020 Annual Report. [https://www.nj.gov/health/fhs/maternalchild/documents/MCH%20block%20grant/njMCHBG072921%20\(2\).pdf](https://www.nj.gov/health/fhs/maternalchild/documents/MCH%20block%20grant/njMCHBG072921%20(2).pdf)
- ⁵³ A new campaign has been launched in June 2022 to raise more awareness and allow for families to self-refer for services.
- ⁵⁴ State of New Jersey Department of Children and Families: Home Visitation Programs. <https://www.nj.gov/dcf/families/early/visitation/>
- ⁵⁵ State of New Jersey Department of Children and Families: Home Visitation Programs FAQs. https://www.nj.gov/dcf/families/early/visitation/hv_faqs.html#5