Nurture NJ Evaluation

Following the Science: New Jersey's Policy Approaches to Improving Maternal and Infant Health

Rutgers School of Public Health

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Table of Contents

Executive Summary

Between the inception of Nurture NJ in 2019 and January 1, 2025, Governor Murphy has signed 71 pieces of maternal and infant health legislation into law. As a component of evaluating Nurture NJ, the Rutgers School of Public Health conducted a review of the 71 enacted policies and two assembly resolutions, categorizing them into six key focus areas, and then reviewing the scientific literature associated with each policy. These focus areas are listed in the table below, along with the number of policies enacted within each area. A complete list of the legislation by focus area is included as an appendix.

Focus Area	Number of Legislative Actions
1. Maternal and Child Health Care Delivery and Access	**20**
2. Parental and Child Supports	**18**
3. Family Planning and Fertility Services	**11**
4. Education, Programs, and Resources	**10**
5. Legal Agreements and Safeguards	**7**
6. Data, Surveillance, and Quality Improvement	**7**
Total	**73**

Rutgers' review of the research literature underlying the 73 policy approaches revealed that the majority of the policies were supported by strong or emerging scientific evidence. Evaluating the intermediate and long-term outcomes of the policies implemented as part of Nurture NJ has the potential to provide additional insights into which policies are most effective in improving maternal and infant health and well-being.

Nurture NJ policies with the strongest evidence base focused on reducing early elective deliveries, creating universal newborn home visiting programs, and increasing access to family planning services. Policies grounded in more emerging evidence reflected innovative, newer, or less extensively studied approaches. Examples of these include the perinatal episode of care pilot program and the maternity care shared decision-making tool.

Policies that would not be expected to have a scientific basis were excluded from our analysis. These included policies that simply recognize important annual events (e.g., P.L. 2019, JR-23, which designates October of each year as "Pregnancy and Infant Loss Remembrance Month" in New Jersey) or require websites or other information to be made available.

However, these policies are still included in the overall legislative count and are categorized within the six focus areas.

Legislative focus areas with examples:

1. **Maternal and child health care delivery and access** policies target the provision of clinical practice, including enhanced availability of perinatal health care services, maternal and infant screenings, provider training, and nursing and doula care availability.

   For example, to address the need for more perinatal health care professionals in the state, New Jersey enacted several policies. These included **P.L. 2019, c. 18**, which established reciprocity for out-of-state certified nurse aides, and **P.L. 2023, c. 244**, which provides loan redemption for nurses who commit to teaching at in-state nursing schools for five years.

   In addition, to expand access to doula care, New Jersey implemented **P.L. 2019, c. 85**, which provides Medicaid coverage for doula services, and **P.L. 2020, c. 32**, which requires hospitals to allow a support person to accompany a woman during childbirth.

2. **Parental and child support** policies aim to create a supportive ecosystem for parents and families during the perinatal period and beyond. These encompass areas such as paid family leave, medical and temporary disability leave, universal newborn home visitation, childcare, and increasing the Earned Income Tax Credit (EITC) and minimum wage.

   For example, New Jersey enacted **P.L. 2019, c. 37**, which expands the law concerning family leave, temporary disability and family temporary disability leave, and domestic or sexual violence safety leave, and **P.L. 2018, c. 45**, which increases the New Jersey EITC and provides credit for child and dependent care expenses.

   New Jersey also passed **P.L. 2021, c. 187**, which establishes a statewide universal newborn home visitation program in the New Jersey Department of Children and Families, advancing New Jersey as a national model for maternal and infant care, and **P.L. 2019, c. 343**, which requires health benefits and Medicaid coverage for breastfeeding support.

3. **Fertility and family planning services** policies aim to improve insurance coverage for fertility care, increase contraception availability in Medicaid and private insurance plans, and dedicate more funding for family planning services.

   For example, New Jersey also enacted **P.L. 2018, c. 1**, which provides Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the Federal Poverty Level, and **P.L. 2019, c. 376**, which expands contraception coverage required under private insurance and Medicaid from a 6- to a 12-month supply.

   The state also enacted **P.L. 2019, c. 306**, which mandates health benefits coverage for fertility preservation services, and **P.L. 2021, c. 375**, which codified the constitutional right to freedom of reproductive choice in New Jersey.

4. **Education, programs, and resources** policies aim to improve maternal nutrition and expand state benefits for menstrual hygiene, diapers, and reproductive life planning.

   For example, New Jersey enacted **P.L. 2019, c. 91**, which directs the Department of Agriculture to establish a food desert produce pilot program, and **P.L. 2023, c. 267**, which directs the Department of Health (DOH) to permit the online purchase of eligible foods, including infant formula, using federal Women, Infants and Children (WIC) funds.

   New Jersey also passed **P.L. 2019, c. 236**, which established the “My Life, My Plan” program, an initiative that supports reproductive life planning for all women of childbearing age and their families.

Legislative focus areas with examples (continued):

5. **Legal agreements and safeguard protection measures**, such as those relating to age for marriage or civil union, adoption policies, and the New Jersey Safe Haven Infant Protection Act, are based on laws that support human rights in New Jersey.

   These laws codify a number of important legal processes and protections. They include gestational carrier agreements, adoption protocols, and support for vulnerable populations such as new parents surrendering infants, survivors of sexual assault, and reproductive health care recipients.

6. **Data, surveillance, and quality improvement activities** aim to strengthen data systems and advance research on racial and ethnic health disparities to inform practices, shape quality improvement initiatives, and promote improved maternal and child health.

   For example, New Jersey passed **Assembly Resolution (AR) 226** in 2019, which urged the U.S. Centers for Disease Control and Prevention (CDC) to adopt a uniform data system for collecting information on maternal mortality. At the time, only 25 states had maternal mortality review boards; today, 49 states do.

   New Jersey also passed **P.L. 2019, c. 497**, which directs the Office of Minority and Multicultural Health (OMMH) to study the effects of racial and ethnic disparities on the sexual and reproductive health of Black women in the state. Monitoring statewide health outcomes and associated racial and ethnic disparities is crucial for identifying strategies to eliminate these disparities.

Nurture NJ policies exemplify a commitment to leveraging science and evidence to improve maternal and child health. These policies aim to drive improvements in pregnancy-related experiences and outcomes. Monitoring and evaluating the outcomes of these policies, as well as understanding implementation barriers and facilitators, can guide future investments and policymaking in New Jersey and throughout the United States.

Scientific Underpinnings for Policies

Methodology

The Rutgers School of Public Health Nurture NJ Evaluation team reviewed a comprehensive list of maternal and child health policies enacted by the New Jersey State Legislature since 2018. To complete this review, the team reviewed policies provided by the First Lady's Office, searched the website of the New Jersey State Legislature, and reviewed the Maternity Action Plan from the New Jersey Health Care Quality Institute (New Jersey Health Care Quality Institute, 2022).

The Rutgers team identified 71 policies and 2 assembly resolutions and categorized them into six focus areas:

Legislative Focus Area 1: Maternal and Child Health Care Delivery and Access (20 policies)

Legislative Focus Area 2: Parental and Child Supports (18 policies);

Legislative Focus Area 3: Family Planning and Fertility Services (11 policies);

Legislative Focus Area 4: Education, Programs, and Resources (10 policies);

Legislative Focus Area 5: Legal Agreements and Safeguards (7 policies); and

Legislative Focus Area 6: Data, Surveillance, and Quality Improvement (7 policies).

Evaluation team members with expertise relevant to each piece of legislation reviewed and synthesized the scientific literature and supporting evidence undergirding the specific policies. This analysis excluded policies based on legal rights, which would not be expected to have scientific underpinnings. Following the review of the literature and a summary of the available evidence, at least one additional team member reviewed the summary for accuracy and clarity.

Legislative Focus Area 1: Maternal and Child Health Care Delivery and Access

Legislation in this section seeks to improve the provision of clinical practice through initiatives to increase screening, improve patient engagement, enhance availability of health care services, and ensure provider training. The policies categorized in this section focus on (1) nonmedically indicated early elective deliveries, (2) perinatal screening, (3) a maternity care shared decision-making tool, (4) perinatal episode of care, (5) group prenatal care, (6) doula care, (7) nursing, (8) explicit and implicit bias training, (9) screening for perinatal mood and anxiety disorders, (10) personalized postpartum care, and (11) standards for respectful care.

Nonmedically Indicated Early Elective Deliveries (P.L. 2019, c. 87)

Research shows that early elective birth is a risk factor for numerous maternal and neonatal morbidities. It is also a modifiable risk as these types of births can be limited through adjusting professional recommendations, payer policies, and legislative actions such as those taken in New Jersey.

To reduce nonmedically indicated early elective deliveries, New Jersey enacted P.L. 2019, c. 87. This law prohibits health benefits coverage for certain nonmedically indicated early elective deliveries under Medicaid, the State Health Benefits Program (SHBP), and the School Employees' Health Benefits Program (SEHBP). The legislation states, "No provider shall be approved for reimbursement by the Division of Medical Assistance and Health Services in the Department of Human Services under Medicaid for a non-medically indicated early elective delivery performed at a hospital earlier than the 39th week of gestation."

Due to strong evidence of risks associated with elective early deliveries, professional organizations—including the American College of Obstetricians and Gynecologists, the Society for Maternal and Fetal Medicine, and the Association of Women's Health, Obstetric and Neonatal Nurses—support avoiding nonmedically indicated elective birth until after 39 weeks' gestation (American College of Obstetrics and Gynecology, 2019; Association of Women's Health, 2019).

Scientific evidence shows that early elective induction of labor is associated with complications for women and birthing people, including an increased rate of Cesarean birth, which may then result in repeat Cesarean births in future pregnancies. Cesarean birth is associated with increased risks of bleeding and infection compared to vaginal delivery (Clark et al., 2009; Maslow, 2000). Moreover, infants born prior to 39 weeks are at increased risk for numerous neonatal morbidities and mortality, compared to those born at or after 39 weeks.

These preterm infants have an increased risk of short-term respiratory conditions, including pneumonia, respiratory distress syndrome, transient tachypnea of the newborn, respiratory failure, and ventilator use (Hibbard & Wilkins, 2010). They also have an increased overall risk of both respiratory and nonrespiratory morbidity compared to infants born after 39 weeks (Tita et al., 2009). Infants born before 39 weeks of gestation also face increased rates of poor longer-term outcomes, including delayed neurologic development (Petrini et al., 2009; Pitcher et al., 2012) and poor academic performance (Woythaler et al., 2015).

In addition to New Jersey, states including Oregon, South Carolina, and Ohio, have developed and implemented state Medicaid or public health initiatives to eliminate early elective deliveries (American College of Obstetrics and Gynecology, 2019). Currently, 20 states have enacted policies that reduce payments or do not cover procedures that are not medically indicated, such as early elective deliveries, elective inductions, and Cesarean sections (Mathematica, 2020).

State policies that prohibit hospitals from planning nonmedically indicated deliveries before 39 weeks' gestation have significantly reduced the rate of early elective deliveries (American College of Obstetrics and Gynecology, 2019). For example, there have been significant reductions in both nonmedically indicated inductions of labor and Cesarean births in South Carolina (National Institute for Health Care Management, n.d.) and Oregon (Snowden et al., 2016). Notably, these reductions in elective early deliveries have had no negative neonatal consequences; for example, stillbirth rates have not increased as a result of these initiatives (MacDorman et al., 2015; Tita, 2016).

Perinatal Screening (P.L. 2019, c. 88, c. 498, c. 296, c. 390, P.L. 2021, c. 413)

New Jersey has enacted legislation to implement screenings at key points during pregnancy and the postpartum period. These screenings aim to identify risk factors and facilitate referrals to appropriate resources. Standardized screening tools, such as the Perinatal Risk Assessment (PRA), provide a standardized method for assessing pregnant individuals' risk factors.

These risk factors include social and structural determinants of health (Tully et al., 2022), environmental hazards, substance use disorders (Committee on Obstetric Practice American Society of Addiction Medicine, 2017), intimate partner violence (Committee on Healthcare for Underserved Women, 2012), and chronic conditions such as hypertension (Daubert et al., 2024; Leonard et al., 2024). Without screening, these conditions may not be addressed, potentially impacting the health of both the individual and the fetus.

For instance, P.L. 2019, c. 88 codifies current practices regarding the completion of the PRA by Medicaid providers. Risk assessment for pregnant and postpartum individuals and their neonates is a cost-effective and expedient way to prevent or treat conditions associated with poor outcomes and link individuals to services and resources (National Academies of Sciences et al., 2020).

As many as 5 percent of postpartum individuals visit the emergency room within six weeks of giving birth (Reische et al., 2024). To address this, P.L. 2019, c. 498 requires hospital emergency departments to screen individuals of childbearing age about recent pregnancy history. This screening helps identify individuals in the postpartum period and reduces the risk of misdiagnosis or dismissal of symptoms associated with serious postpartum conditions, such as vaginal bleeding, fever, hypertension, and psychiatric emergencies. These symptoms can be incorrectly assessed if a clinician is unaware of a recent pregnancy (Reische et al., 2024).

Newborn screening is a cost-effective strategy for identifying conditions that can impact the long-term health of infants and children (McCandless & Wright, 2020). Early diagnosis and prompt intervention can minimize the risk of preventable and possibly irreversible poor neonatal outcomes (McCandless & Wright, 2020). Accordingly, P.L. 2019, c. 296 established a Newborn Screening Advisory Review Committee and mandated screening for various disorders in infants (New Jersey Department of Health, 2024).

New Jersey also enacted P.L. 2019, c. 390, which mandates screening newborns for spinal muscular atrophy (SMA), a genetic disorder that can be fatal without prompt diagnosis, monitoring, and treatment (Health Resources and Services Administration, 2018). SMA was added to the federally recommended list of routine screenings in 2018, and all states implemented this screening by 2024 (F. K. Lee et al., 2024).

Other key related legislation includes P.L. 2021, c. 413, which mandates screening newborns for congenital cytomegalovirus (CMV) and establishes a related public awareness campaign. While pregnant women infected with CMV often exhibit minimal or no symptoms, they can transmit the virus to their fetus, potentially causing severe symptoms or late-onset hearing loss and developmental delays.

Maternity Care Shared Decision-Making Tool (P.L. 2019, c. 133)

Shared decision-making enhances patient understanding and engagement in health care decisions, improving safety, quality, and satisfaction with care (Goldberg, 2009; E. O. Lee & Emanuel, 2013; Lippke et al., 2019; Say et al., 2011; Stacey et al., 2017). This process encourages patients to actively participate in creating their health care plans (American College of Obstetrics and Gynecology, 2021). By emphasizing informed consent, the dialogue between patients and providers explores the benefits and risks of options, considering the patient's values and priorities (American College of Obstetrics and Gynecology, 2021).

New Jersey enacted P.L. 2019, c. 133 to promote shared decision-making in maternal health care. This law establishes a maternal health care pilot program tasked with developing, implementing, and evaluating a shared decision-making tool. This tool, created in consultation with the New Jersey Health Care Quality Institute, is intended for use by at least one hospital or birth center offering maternity services in each of the state's regions.

To translate the evidence on shared decision-making into practice, Ariadne Labs created TeamBirth in 2018. This initiative aims to systematically implement shared decision-making in hospitals to improve outcomes for pregnant and birthing people ("TEAMBIRTH," n.d.). Research assessing the feasibility and acceptance of TeamBirth in U.S. hospitals shows that the model is a useful strategy for promoting patient-centered care, including shared decision-making (Spigel et al., 2022).

Another example of a shared-decision model is the SHARE Approach developed by the Agency for Healthcare Research and Quality (AHRQ). This five-step model for health care providers includes a tool kit to facilitate this evidence-based approach to patient care (The SHARE Approach, n.d.).

Perinatal Episode of Care (P.L. 2019, c. 86)

Medicaid covers nearly half of all pregnancy and birth-related care in the U.S. To reduce costs, Medicaid has adopted "episode-based payments", which bundle all costs associated with specific health conditions into a single payment. Under this model, provider reimbursements vary based on the cost and quality of care, measured by specific services and metrics.

To improve the quality and equity of perinatal care while also lowering costs, New Jersey passed P.L. 2019, c. 86. This legislation established a three-year perinatal episode of care (EOC) pilot program within the state's Medicaid program, NJ FamilyCare. Provider participation in the program is voluntary, and financial incentives or penalties are applied based on their level of participation and performance outcomes (New Jersey Department of Human Services, 2024a).

Around ten states have implemented EOC models within their Medicaid programs (R. Johnson et al., 2023). Among the earliest adopters, Arkansas and Tennessee established their EOC programs in 2012 and 2014, respectively (Medicaid and CHIP Payment and Access Commission, 2021). An analysis of these states' outcomes after EOC implementation revealed that both initiatives increased rates of some, but not all, recommended testing and screenings.

For example, following EOC implementation, Tennessee saw increased rates of testing for HIV and group B strep, and Arkansas experienced a rise in screening rates for chlamydia. Additionally, Arkansas reported a reduction in emergency room visits by pregnant individuals (Toth et al., 2020). Notably, both states' EOC programs resulted in overall cost savings (Mathematica, 2020).

Despite these benefits, overall evidence of the efficacy of EOCs in improving intended quality metrics remains inconclusive. Nevertheless, a reported positive outcome is that participating providers have increased investment in quality improvement efforts, driven by the EOCs' mandatory reporting protocols (Medicaid and CHIP Payment and Access Commission, 2021).

Group Prenatal Care (P.L. 2019, c. 237)

Innovative, evidence-based interventions like group prenatal care can improve health outcomes and the overall care experience, particularly for birthing people of color. One such model, CenteringPregnancy, brings together people at similar stages of pregnancy. This program offers prenatal care in a group setting, providing educational and support sessions on relevant topics to groups of about 8-12 pregnant people with similar gestational ages. Participants attend ten prenatal visits, each lasting 90 to 120 minutes.

CenteringPregnancy encourages active engagement in care. Participants take part in group education sessions, track their weight and blood pressure, and record their health data. They also have individual time with their provider. Peer social support, a built-in aspect of the program that often extends beyond the group sessions, is another key factor in CenteringPregnancy's documented positive outcomes.

In 2019, New Jersey enacted legislation (P.L. 2019, c. 237) requiring Medicaid coverage for group prenatal care services under certain circumstances. This legislation expanded Medicaid to include coverage of group prenatal care services such as CenteringPregnancy.

Research on the CenteringPregnancy model suggests that birthing people who complete at least five sessions experience several benefits. These include reduced rates of postpartum depression symptoms at six months postpartum (Liu et al., 2021), a lower likelihood of having another pregnancy within a year (Keller et al., 2023), and higher rates of well-child visits in the first 15 months (Heberlein et al., 2023).

Doula Care (P.L. 2019, c. 85, P.L. 2019, JR-3, P.L. 2020, c. 32, P.L. 2023, c. 286)

Doulas are nonclinical health care professionals who provide continuous physical, emotional, and informational support to their clients throughout pregnancy, labor, and the postpartum period.

Benefits of doula care include increased rates of vaginal birth and breastfeeding initiation and decreased rates of preterm birth, use of pain medication, and Cesarean birth (Bohren et al., 2017; Kozhimannil, Jou, et al., 2016; Thurston et al., 2019). Doulas also facilitate more patient-centered care, resulting in more positive birth experiences and lower rates of postpartum anxiety and depression (Falconi et al., 2022).

Community doulas share the lived experiences of their clients, possessing an intimate understanding of their language, culture, and customs. Going beyond typical doula care, they accompany patients to appointments, offer emotional support, and connect clients with community resources. This helps to mitigate the impact of social determinants of health (Hans et al., 2018; Kozhimannil, Vogelsang, et al., 2016; Wint et al., 2019).

Historically, access to doula care has been limited by a lack of awareness of its benefits. To facilitate greater access, New Jersey passed legislation (P.L. 2019, c. 85) in 2019 that expanded Medicaid/NJ FamilyCare coverage to include community doula care. Given that Medicaid is the largest payer of health care coverage for pregnant people in the U.S., this significantly broadened access to doula care and its associated benefits, especially for individuals facing health disparities (Bakst et al., 2020; Falconi et al., 2022; Kozhimannil, Vogelsang, et al., 2016; Wint et al., 2019).

Building on this progress, NJ FamilyCare increased reimbursement rates for community doula care in March 2023, raising the rate from $900 to $1,165 for eight prenatal visits and labor support, retroactive to July 1, 2022 (The Official Site of the State of New Jersey, 2023). To further raise public awareness of doula services, New Jersey passed P.L. 2019, JR-3, which designated March 22nd to 28th of each year as "Doula Appreciation Week."

In addition to these policies, P.L. 2020, c. 32 requires hospitals to allow an individual to accompany a woman during childbirth, and P.L. 2023, c. 286 requires that hospitals allow patients to have doula support before, during, and after giving birth and designate a staff member as a doula-hospital liaison.

Early research in Minnesota and Oregon, the first two states to cover doula care under Medicaid, predicted overall cost savings (Kozhimannil, Hardeman, et al., 2016; Tillman, 2012). These states passed Medicaid legislation for doula care in 2014 and 2017, respectively, followed by New Jersey and Rhode Island in 2021 (Chen, 2022). Since then, more states have made doula care a Medicaid benefit (Hasan, 2024). Most states that cover doula care through Medicaid, including New Jersey, fund both the birth and doula accompaniment to prenatal and postpartum visits, a practice shown to further improve perinatal outcomes (Hasan, 2024; Ogunwole et al., 2020; Wint et al., 2019).

Nursing (P.L. 2019, c. 18, P.L. 2023, c. 244)

Nurses play a critical role in perinatal health care, caring for birthing people throughout preconception, pregnancy, birth, and the postpartum period, as well as for newborns. However, workforce shortages present a major barrier to care. The U.S. Health Resources and Services Administration (HRSA) projects a national shortage of nearly 80,000 registered nurses by 2025, with New Jersey anticipated to have one of the largest shortages by 2035 (HRSA, 2022).

The National Academy of Medicine's report, The Future of Nursing 2020–2030, recommends a substantial increase in the number and types of nurses, along with economic support to diversify the nursing workforce (National Academies of Sciences, Engineering, and Medicine; National Academy of Medicine; Committee on the Future of Nursing 2020–2030, 2021).

To address nursing shortages, New Jersey enacted two pieces of legislation. P.L. 2019, c. 18 established reciprocity for out-of-state certified nurse aides, while P.L. 2023, c. 244 offers loan redemption for nursing school faculty who commit to five years of employment in the state. States with multistate licenses experience greater job mobility and flexibility for nurses (Bauer et al., 2023), while loan forgiveness programs increase nursing faculty applications and hires (Young & Adams, 2024) and influence where individuals practice (Fritsma et al., 2023).

Explicit and Implicit Bias Training (P.L. 2021, c. 79)

Explicit biases in health care can impact providers' perceptions of patients (Dehon et al., 2017; Maina et al., 2018) and are associated with differences in treatment recommendations, lower-quality clinical decision-making, and lower empathy (Dehon et al., 2017; FitzGerald & Hurst, 2017; Maina et al., 2018). Implicit biases are associated with poorer patient experiences and differences in care delivery (Chapman et al., 2013; Cooper et al., 2022; Dehon et al., 2017; Maina et al., 2018), and perpetuate health disparities in marginalized communities (Chapman et al., 2013; Dehon et al., 2017).

To reduce racial and ethnic disparities in maternal and infant health outcomes, the New Jersey State Legislature passed P.L. 2021, c. 79. This law requires all health care professionals providing prenatal and perinatal care to undergo implicit and explicit bias training. The State Attorney General and the New Jersey Department of Consumer Affairs subsequently mandated that state licensing boards require this training for license maintenance (WC, 2024).

The New Jersey Hospital Association, in collaboration with the New Jersey Department of Health (DOH) offers implicit bias training to healthcare providers. This training defines conscious and unconscious bias, examines the historical context of oppression in minority communities, identifies barriers to communication and inclusion, and provides strategies for implementing reproductive justice (New Jersey Hospital Association, n.d.).

Research on implicit bias training for health care providers shows limited evidence of effectiveness in improving patient outcomes or reducing health disparities (Hagiwara et al., 2024). Systematic reviews have found mixed results in reducing implicit biases, raising concerns about effectiveness (Hagiwara et al., 2024). Furthermore, some studies suggest potential negative impacts, such as increased stereotyping (Cooper et al., 2022), possibly due to the incompatibility of training programs with existing discriminatory practices in clinical settings (Vela et al., 2022).

However, mandating bias training for health care providers is a step towards increasing providers' awareness of their implicit biases. Evidence suggests that effective implicit bias training should include clinical setting-specific scenarios (Kruse et al., 2022), emphasize partnership building, incorporate emotional regulation strategies (Cooper et al., 2022), and be repeated over time (Cooper et al., 2022; Gill et al., 2022). Institutional leaders must also support these trainings and shift norms to facilitate implementation (Garrett et al., 2023). Finally, efficacy should be measured by specific outcomes, including changes in clinician behavior, patient perceptions of care quality, and health outcomes in marginalized populations (Cooper et al., 2022).

Screening for Perinatal Mood and Anxiety Disorders (P.L. 2021, c. 120 and c. 380)

Poor prenatal mental health, encompassing conditions like prenatal depression and anxiety, is associated with an increased risk of pregnancy complications, including hypertensive disorders and increased rates of Caesarean delivery (Runkle et al., 2023). It can also contribute to postpartum depression (Ghaedrahmati et al., 2018), lower rates of breastfeeding initiation, and shortened duration of breastfeeding (Ahlqvist-Björkroth et al., 2016; Pippins et al., 2006; Rahman et al., 2015).

Poor maternal perinatal health can also negatively impact infant health, manifesting in preterm birth, low birth weight, high infant emotional reactivity (Spry et al., 2020; Voit et al., 2022), and other serious neuropsychiatric conditions later in life (Pezley et al., 2022). These impacts are often compounded for women with lower incomes and those from racial and ethnic minorities who report higher rates of perinatal mood disorders but lack access to care, treatment, financial resources, and paid leave (Shuffrey et al., 2022).

Support for perinatal mental health is associated with improved outcomes for both parent and child. These benefits include higher rates of breastfeeding initiation and duration (Pezley et al., 2022), higher infant birth weights, and lower incidences of perinatal conditions such as hypertension (Abera et al., 2024). Perinatal mental health support is also linked to a decreased incidence of instrument-assisted or Cesarean deliveries (Abera et al., 2024).

Expanding access to mental health care through population-based initiatives can further promote positive changes in maternal and infant health. However, these efforts must address structural inequities and barriers to care (Shuffrey et al., 2022). The U.S. Preventive Services Task Force recommends mental health screening for all pregnant women through at least one year postpartum (Shuffrey et al., 2022).

New Jersey is taking action to promote perinatal mental health. Legislation passed in 2021 (P.L. 2021, c. 120 and c. 380) requires the state's DOH and Department of Human Services to secure federal funding for maternal mental health initiatives and develop plans to improve perinatal mood and anxiety disorder screenings.

These plans must (1) provide strategies that increase awareness among behavioral health providers in the state about the effects of perinatal mood and anxiety disorders on maternal and infant health outcomes, (2) establish a referral network for women in need of treatment, (3) increase access to formal and informal peer support services, (4) reduce stigma related to perinatal mood and anxiety disorders, and (5) provide funding for screening, referral treatment, and support services.

Personalized Postpartum Care (P.L. 2024, c. 89)

Postpartum health care is crucial for everyone, regardless of pregnancy outcome, including live birth, pregnancy loss, or stillbirth. Most preventable pregnancy-related deaths in the U.S. occur postpartum, highlighting the need for clear guidance on warning signs and access to comprehensive care.

To address this, New Jersey enacted P.L. 2024, c. 89, which establishes requirements for patient care plans after any pregnancy outcome. These plans aim to personalize treatment and improve patient education on postpartum symptoms, ultimately improving outcomes through comprehensive care and education.

Standards for Respectful Care (AR219)

Respectful maternity care is a fundamental human right and a key strategy for ensuring positive childbirth experiences (World Health Organization, 2014, 2018, 2023). However, persistent disparities in maternal mortality and morbidity in the U.S., particularly among people of color, highlight the need for improvements in respectful maternity care during pregnancy and childbirth (Mohamoud et al., 2023; S. J. Patel et al., 2024).

To address this, New Jersey adopted Assembly Resolution (AR) 219, encouraging the state DOH to develop and promote standards for respectful care during childbirth. The U.S. Department of Health and Human Services and the Alliance for Innovation on Maternal Health also recognize such standards as critical for improving maternal health outcomes (Health Resources and Services Administration & American College of Obstetrics and Gynecology, 2021; U.S. Department of Health and Human Services, 2020).

Legislative Focus Area 2: Parental and Child Supports

Legislation in this section provides critical support to new parents and children. The policies categorized in this section focus on (1) paid family, medical, and temporary disability leave, (2) lactation support, (3) human breast milk and breastfeeding support, (4) economic interventions, (5) childcare, and (6) universal newborn home visitation.

Paid Family, Medical, and Temporary Disability Leave (P.L. 2018, c. 10 and c. 122, P.L. 2019, c. 37)

The U.S. is the only high-income country without a national paid leave program. Paid family, medical, and temporary disability leave allows workers to care for themselves and their families during periods when they are unable to work or when working would interfere with their ability to care for family members, including newborns. Businesses benefit from paid leave policies through improved retention and productivity (Romig & Bryant, 2021).

Access to paid leave benefits in the postpartum period is associated with increased breastfeeding initiation and duration, increased attendance at postpartum health care visits, and lower risk of postpartum depression (Cooper et al., 2022; Pac et al., 2019; Perry et al., 2024). Similarly, access to paid temporary disability leave during the prenatal period is associated with lower incidence of low birth weight and lower odds of maternal and infant hospital admissions (Jou et al., 2018; Stearns, 2015). These associations are particularly pronounced in people covered by Medicaid (Perry et al., 2024).

Increasing access to paid family and sick leave is also critical for promoting racial equity. Compared to white workers, Black workers are more likely to be employed in low-wage jobs, which are less likely to offer employer-based paid leave policies. In addition, unpaid leave is unaffordable for many workers overall and particularly for people in low-wage jobs (Romig & Bryant, 2021).

To facilitate greater access to paid leave, New Jersey has enacted several pieces of legislation. These policies include P.L. 2018, c. 10, which allows employees to earn paid sick leave, P.L. 2018, c. 122, which revises the law concerning temporary disability leave, and P.L. 2019, c. 37, which expands the law concerning family leave, temporary disability and family temporary disability leave, and domestic or sexual violence safety leave.

Lactation Support (P.L. 2019, c. 242)

Exclusive breastfeeding for the first six months of life is recommended by the American Academy of Pediatrics (AAP) (Meek et al., 2022), the World Health Organization (WHO) (World Health Organization, n.d.-a), and UNICEF (UNICEF, 2018). Continuing breastfeeding for up to two years is recommended by the U.S. Dietary Guidelines for Americans 2020–2025, the AAP, and the WHO (CDC, 2024).

Scientific evidence shows that breastfeeding provides numerous health benefits for both mothers and infants, including protection against certain diseases, essential nutrients for infants, and improved mental health for the mother (Meek et al., 2022; Pezley et al., 2022). Efforts to support breastfeeding in different environments, such as work and school, can positively impact breastfeeding initiation and duration.

To facilitate breastfeeding and help overcome barriers to initiation and continuation, New Jersey enacted P.L. 2019, c. 242. This law requires certain public facilities and offices to provide on-site lactation rooms. It also requires the DOH to provide information about lactation room availability and the Department of Education to provide information on lactation policies in schools.

Workplace interventions, such as having lactation spaces and organizational policies supporting breastfeeding, are key to promoting breastfeeding among working mothers (Vilar-Compte et al., 2021). Women with access to private space and adequate break times are twice as likely to be exclusively breastfeeding at six months than women who do not have access to such support (Kozhimannil, Jou, et al., 2016). Furthermore, research indicates that women want breastfeeding legislation to protect and support their right to lactation (Chang et al., 2021).

Human Breast Milk and Breastfeeding Support (P.L. 2019, c. 317 and c. 343)

Exclusive breastfeeding for the first six months of life is recommended by major health organizations, including the American Academy of Pediatrics (Meek et al., 2022), the WHO (World Health Organization, n.d.-a), and UNICEF (UNICEF, 2018). However, disparities in breastfeeding rates exist by race, ethnicity (Marks et al., 2023), and income (Carpay et al., 2021).

To address this, New Jersey passed legislation (P.L. 2019, c. 317 and c. 343) requiring Medicaid coverage for pasteurized donated human breast milk under certain circumstances, and breastfeeding support services (Carpay et al., 2021). Policy changes to the Affordable Care Act mandating lactation support services have also been shown to increase breastfeeding duration and exclusivity among eligible populations (Gurley-Calvez et al., 2018).

Multilevel interventions, such as initiating breastfeeding within one hour of birth, giving only breast milk, rooming-in policies, and having a breastfeeding-friendly hospital designation, have also been shown to increase breastfeeding outcomes for low-income women (Beauregard et al., 2022; French et al., 2023). As Medicaid disproportionately covers mothers of color (Pillai et al., 2024), ensuring Medicaid coverage for human milk and breastfeeding support has the potential to increase equity in breastfeeding among vulnerable populations.

Economic Interventions (P.L. 2018, c. 9 and c. 45, P.L. 2021, c. 130, P.L. 2022, c. 24, P.L. 2023, c. 72, P.L. 2019, c. 32)

Economic interventions, such as the Earned Income Tax Credit (EITC), child tax credits, and minimum wages, can reduce poverty and material hardship. This, in turn, increases opportunities for individuals and families to thrive. Poverty rates among Black and Hispanic families are higher than among white families, and economic interventions have been found to reduce racial inequities (Hoynes, 2019).

The EITC and child tax credits are associated with a number of benefits for maternal and child health. In the short term, more generous programs lead to improvements in birth weight, parental mental health, maternal smoking, and home environment (Aizer et al., 2023; Averett & Wang, 2018; Evans & Garthwaite, 2014; Komro et al., 2019). For example, one study found that higher EITC payments during pregnancy improved biological markers of maternal health, including measures of inflammation and high blood pressure (Evans & Garthwaite, 2014).

Studies have also shown that raising the minimum wage is associated with a decrease in maternal stress (Rokicki et al., 2023) and improved birthweights and child health (Wehby et al., 2020, 2022). Moreover, as part of the Equal Pay Act, companies contracting with the state must disclose wage and demographic data for all employees who are involved. Transparency in wage compensation can reduce the gender wage gap for women (Bennedsen et al., 2023).

Since 2018, New Jersey has passed key legislation leveraging economic interventions to improve the lives of its residents. P.L. 2018, c. 9 addresses equal pay and employment discrimination, and P.L. 2018, c. 45 increases the New Jersey EITC and provides tax credits for child and dependent care expenses.

New Jersey subsequently expanded upon these policies. P.L. 2021, c. 130 expanded eligibility under the New Jersey EITC program to allow taxpayers who are at least 18 years of age or older to qualify for a modified benefit, P.L. 2022, c. 24, established a child tax credit under the gross income tax, and P.L. 2023, c. 72 increased this child tax credit. Finally, New Jersey passed P.L. 2019, c. 32, which raised the overtime hourly minimum wage to $15.00.

Childcare (P.L. 2021, c. 47, c. 324, c. 144, P.L. 2022, c. 25, P.L. 2019, c. 426)

Access to quality childcare supports economic stability by allowing parents to return to the workplace and improves maternal health outcomes (Holicky et al., 2024). Lack of access to quality childcare can hinder perinatal health care (Holicky et al., 2024) by preventing mothers from initiating prenatal care (Fryer et al., 2019) and attending postpartum health care visits, including referrals for postpartum mental health care (Boyd et al., 2011). These factors contribute to poor maternal mental health and negative perinatal outcomes (A. D. Johnson & Padilla, 2019). Conversely, feeling confident in childcare options is linked to a lower likelihood of depression in mothers (A. D. Johnson & Padilla, 2019).

The New Jersey State Legislature has worked to increase New Jersey families' access to quality childcare options. These efforts include policies providing financial support for childcare workforce development, facility improvements, and increasing the availability of childcare slots for infants and toddlers.

For example, New Jersey enacted legislation (P.L. 2021, c. 47, and P.L. 2022, c. 25) which provided $38 million in state and federal funds to increase access to childcare. Of this funding, $28 million was dedicated to expanding infant and toddler care through the state's "Thriving by Three" grant program (New Jersey Department of Human Services, 2024). To ensure quality, participating centers must meet state and federal standards and participate in Grow NJ Kids, the state's quality rating and improvement system. The remaining $10 million provides direct financial assistance to childcare providers statewide.

Further supporting childcare access, New Jersey passed P.L. 2021, c. 324, which provides subsidy payments to centers based on enrollment, and P.L. 2021, c. 144, which allocates $100 million to the Department of Consumer Affairs for grants and technical assistance to licensed providers. This funding supports workforce development and other improvements. Finally, New Jersey passed P.L. 2019, c. 426, which established a pilot program for childcare services in public schools for preschool-aged children. This multifaceted approach demonstrates New Jersey's commitment to accessible and affordable childcare.

Universal Newborn Home Visitation (P.L. 2021, c. 187)

Research demonstrates that home visiting programs offer numerous benefits for both infants and mothers. These programs increase medical care utilization and immunizations for infants (McKelvey et al., 2021, 2024), reduce rates of child maltreatment (Goodman et al., 2021), and increase exclusive breastfeeding at six months (Brodribb et al., 2020). Home visiting programs also improve maternal mental health (Dodge et al., 2019; Goldfeld et al., 2021) and decrease parenting stress at three months postpartum (Roberti et al., 2022).

Recognizing these benefits, the New Jersey State Legislature passed P.L. 2021, c. 187, establishing a statewide universal newborn home visitation program within the New Jersey Department of Children and Families (DCF). This initiative positions New Jersey as a national model for maternal and infant care.

Legislative Focus Area 3: Family Planning and Fertility Services

Legislative policies in this section seek to improve coverage and care for individuals seeking to have a child or not have a child, which are critical components of reproductive justice. The policies categorized in this section focus on (1) family planning and (2) fertility services.

Family Planning (P.L. 2018, c. 1 and 2, P.L. 2019, c. 151, c. 277 and c. 361, P.L. 2021, c. 375 and c. 376, P.L. 2023, c. 2)

Access to high-quality, comprehensive, and affordable family planning services is critical for advancing reproductive justice. Family planning empowers individuals to make informed decisions about their reproductive health, benefiting both the individual and society. Contraception, along with evidence-based, noncoercive contraceptive care, is part of routine health care and should be accessible to all.

Public funding of family planning services is crucial to increasing accessibility, as cost remains a primary barrier to accessing contraceptive care (Fuentes et al., 2023). According to the Guttmacher Institute, publicly funded family planning services in the U.S. prevented nearly two million unintended pregnancies in 2016 (Frost et al., 2019).

New Jersey has enacted several policies aimed at improving access to family planning services. The state passed P.L. 2018, c. 1, which provides Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the Federal Poverty Level, and P.L. 2018, c. 2, which made a FY2018 supplemental appropriation of $7,453,000 to the DOH for family planning services. Finally, New Jersey enacted P.L. 2019, c. 151, which appropriated $10,453,000 in Grants-in-Aid state funds for family planning services.

In addition to these measures, New Jersey enacted P.L. 2019, c. 277, which provided a FY2020 supplemental appropriation of $9.5 million to the DOH for family planning services, and P.L. 2019, c. 361, which updated health benefits coverage requirements for certain contraceptives. New Jersey also passed P.L. 2021, c. 375, which codified the constitutional right to freedom of reproductive choice, and P.L. 2021 c. 376, which expanded contraception coverage required under private insurance and Medicaid from a 6- to a 12-month supply.

New Jersey provides many critical health care services within the context of family planning. These include contraceptive services, pregnancy testing and counseling, fertility services, sexually transmitted infection (STI) services (including HIV/AIDS), other preconception health services (e.g., screening for obesity, smoking, and mental health), and cancer screenings.

These services enhance public health outcomes. They help people control the timing of their pregnancies by allowing them to time, space, prevent, or delay pregnancy. In New Jersey, fewer than half of all pregnancies are intended, with New Jersey being one of three states with the highest share of pregnancies reported as “wanted later” or “not wanted” (Kost et al., 2021). Unintended pregnancies are associated with a range of poorer maternal and infant health outcomes (Nelson et al., 2022). Studies show that access to contraception significantly reduces unintended pregnancies (Aztlan-James et al., 2017).

Contraceptive access is associated with better maternal and infant health outcomes. For example, planned pregnancies are linked to reduced rates of maternal depression and maternal experiences of interpersonal violence as well as lower rates of preterm birth and low birth weight (Nelson et al., 2022). Similarly, birth spacing of at least 18 months reduces the risk of low birth weight and preterm birth (Ahrens et al., 2019).

Contraception also reduces pregnancy-related morbidity and mortality and the risk of developing certain reproductive cancers, and can be used to treat many menstrual-related symptoms and disorders (Frost et al., 2019; Kavanaugh & Anderson, 2013).

Critically, family planning providers are often the only and preferred source of health care for many individuals. Among women who utilize clinics for sexual and reproductive health care, two-thirds report that the clinic is their usual source of health care (Frost et al., 2019). Men also receive family planning services, either independently or as partners of clients (Shand & Marcell, 2021).

Family planning services encompass a range of critical health needs that benefit both men and women. These include services that prevent, screen for, and treat sexually transmitted infections (STIs) such as chlamydia, gonorrhea, HIV, human papillomavirus (HPV), as well as services that address cervical cancer and addressing intimate partner violence (Kavanaugh & Anderson, 2013). Thus, increased funding for clinical services that prevent and treat STIs is needed, especially as New Jersey continues to see significant increases in syphilis, which rose 72 percent between 2019 and 2022 (New Jersey Department of Health, 2023).

Access to contraception is also associated with broader social and economic impacts. The ability to plan, space, and prevent pregnancies is linked to improved educational attainment, financial stability, and better overall life outcomes for women and families (Bernstein et al., 2019; Sonfield et al., 2013). By enabling women to delay childbearing, contraception allows them to complete their education, advance in their careers, and achieve greater lifetime earnings, ultimately reducing reliance on public assistance programs (Bailey, 2013).

In addition to these benefits of publicly supported contraceptive services, public cost savings result from helping people achieve their reproductive goals and avoid adverse sexual and reproductive health outcomes (Bernstein et al., 2021). Indeed, publicly funded family planning saves state and federal governments billions in health care costs. Medicaid, for example, saves an estimated $4.83 for every dollar invested in contraceptive services through publicly funded programs (Frost et al., 2019).

Medicaid coverage for family planning services has significant, positive impacts on public health, cost-effectiveness, and health equity, as demonstrated by considerable scientific evidence. It addresses significant health disparities, particularly among women with lower incomes, women of color, and young women who often face barriers to accessing reproductive health services (Ranji et al., 2019).

Recent studies have identified positive effects of Medicaid expansion on a range of factors, including coverage during and after pregnancy, better access to prenatal and postpartum care, improved birth and postpartum outcomes, increased use of the most effective contraceptive methods, and better HIV screening rates and outcomes (Darney et al., 2020; Guth & Published, 2023).

Increasing access to family planning services can be achieved by authorizing pharmacists to dispense certain types of contraception without a prescription. Accordingly, New Jersey's P.L. 2023, c. 2 permits pharmacists to dispense self-administered hormonal contraceptives under a standing order, following protocols established by the Board of Pharmacy and the Board of Medical Examiners.

This approach is supported by a recent systematic review, which found that at least half of pharmacists felt comfortable prescribing contraception. Both pharmacists and patients identified several benefits of pharmacist-prescribed contraception, including increased access to contraceptive options, a reduced rate of unintended pregnancy, and enhanced professional development for pharmacists (Eckhaus et al., 2021).

Finally, research demonstrates the safety of pharmacist-prescribed contraception. For example, a study of the Oregon Medicaid population found that pharmacists adhered to prescribing protocols and accurately identified contraindications (L. Anderson et al., 2019). By providing these services, pharmacies can play a role in improving health equity (Cameron et al., 2022) by making contraception more accessible.

In short, public funding of family planning services is both scientifically sound policy and a critical step toward reproductive justice. It improves public health, reduces health care costs, and ensures that all people—regardless of race, income, or geography—can exercise their reproductive rights.

Fertility Services (P.L. 2023, c. 258, P.L. 2019, c. 306 and c. 268)

The ability to choose whether to have a child and receive the support needed to make that decision is a human right. (World Health Organization, 2022). However, barriers to accessing infertility treatments create disparities in care and outcomes (ASRM Ethics Committee, 2021).

To address this issue, New Jersey enacted several laws designed to expand access to and regulate infertility treatments. Most significantly, P.L. 2023, c. 258, which expands health insurance coverage for infertility treatments. More specifically, the law requires insurance plans for groups of over 50 people to provide comprehensive coverage for medically necessary infertility treatments, including in vitro fertilization (IVF), genetic testing, artificial insemination, and the use of donor gametes or embryos. Coverage is determined by physician recommendation and aligns with American Society for Reproductive Medicine (ASRM) guidelines (ASRM Practice Committee Documents, n.d.).

This law also mandates infertility coverage regardless of age, sexual orientation, or marital status, promoting equitable access to medical care (Insogna & Ginsburg, 2018). Currently, 22 states have passed legislation requiring insurers to cover the diagnosis and treatment of some types of infertility (The National Infertility Association, 2024). New Jersey's insurance mandate is thus a crucial step in expanding access to fertility care, especially considering that fewer than 25 percent of infertile couples have sufficient access due to the high cost of treatment (ASRM Ethics Committee, 2021; Peipert et al., 2022).

New Jersey also enacted **P.L. 2019, c. 306**, which mandates health benefits coverage for fertility preservation services. This legislation helps ensure that individuals undergoing treatments that threaten their fertility can preserve their reproductive options. By doing so, the law helps protect the reproductive rights and health of its residents, reduces health disparities, and promotes the well-being of individuals facing life-altering medical treatments (Sauerbrun-Cutler et al., 2024).

For instance, cancer therapies, such as chemotherapy agents like cyclophosphamide and radiation therapy targeting pelvic organs, can harm reproductive function. Given the reproductive risks of these therapies and improved long-term survival rates, there is growing interest in expanding reproductive options for cancer patients (R. A. Anderson & Wallace, 2018). However, the expense of fertility preservation services can be a barrier to care (Dorfman et al., 2024; Jackson Levin et al., 2023). New Jersey is one of 11 states that passed fertility prevention mandates between June 2017 and March 2021, highlighting a growing understanding of the need to address this issue.

By ensuring coverage for fertility preservation, New Jersey addresses systemic barriers that disproportionately affect marginalized communities, such as women of color, LGBTQ+ individuals, and people with disabilities. These groups often face significant challenges accessing reproductive health care, including fertility preservation services. Indeed, research indicates that cancer patients from racial/ethnic minorities face greater barriers to receiving care (National Cancer Institute, 2020) and that uninsured individuals are less likely to receive counseling about fertility preservation from their providers (Chin et al., 2016; Flink et al., 2017).

However, emerging research finds that states with mandated insurance coverage for fertility preservation have significantly higher rates of patient-provider discussions about fertility risk compared to states without such legislation (P. Patel et al., 2020). Aligning with the principle of nondiscrimination in health care, New Jersey's legislation helps ensure that all patients, regardless of background or life circumstances, receive equitable access to services that protect their future reproductive options.

Covering fertility preservation services is a cost-effective intervention that can reduce long-term financial and emotional burdens. Potential loss of fertility can negatively impact the well-being of women with gynecologic cancer, and is associated with emotional distress, fear, anxiety, and moderate or severe depression. Studies show that patients who preserve their fertility are more likely to experience improved quality of life and mental health. This is true for cancer survivors in their reproductive years (Letourneau et al., 2012).

Finally, New Jersey supports another aspect of fertility preservation through P.L. 2019, c. 268, which requires the Department of Health (DOH) to regulate and license embryo storage facilities. While technological advances and success rates in IVF have increased since its inception 40 years ago, there is little state or federal regulation of embryo storage. Failures in storage in other states have affected hundreds of patients. New Jersey's legislation is designed to guard against catastrophic storage system failures that may impede fertility treatments.

Legislative Focus Area 4: Education, Programs, and Resources

Legislative policies in this section promote health education, increase public awareness, and improve access to information about health-related services for reproductive-aged people and families. These policies support initiatives that enhance awareness of rights and services and educate the public about programs such as the New Jersey Safe Haven Infant Protection Act. Ultimately, these policies are designed to improve access to reliable information, support informed decision-making, and increase equity. The policies categorized in this section focus on (1) reproductive life planning, (2) public education, (3) maternal nutrition, and (4) menstrual health.

Reproductive Life Planning (P.L. 2019, c. 236)

Reproductive life planning is a critical component of sexual, reproductive, and perinatal health care. It provides individuals with the tools and resources to carefully consider their desires, goals, and values within a longer context (Dehlendorf et al., 2021). This includes understanding the factors that can affect fertility and the course of pregnancy for those who wish to conceive.

To promote greater access to reproductive health care and life planning, New Jersey enacted P.L. 2019, c. 236. This law requires the DOH to establish the "My Life, My Plan" program, which promotes reproductive life planning for individuals of childbearing age and their families. The program offers educational materials and tools to help people consider their goals for family-building within the broader context of career goals, finances, and personal values (Dehlendorf et al., 2021).

Reproductive life planning can directly impact specific health outcomes. For example, it can increase the use of folic acid supplements both before and during early pregnancy, which helps prevent neural tube defects (Viswanathan et al., 2023). Since most people in the U.S. do not consume the recommended amount of folate through diet alone, all professional organizations recommend that anyone planning a pregnancy take a daily supplement containing 400 to 1000 micrograms of folic acid (Chitayat et al., 2016).

Healthy individuals are more likely to have healthy pregnancies and give birth to healthy babies (Stanhope & Kramer, 2021). Therefore, access to preventative prenatal care is crucial for improving long-term outcomes. New Jersey's "My Life, My Plan" program includes information on preventative services, including eligibility for and enrollment in NJ FamilyCare, the state's publicly funded health insurance program.

Public Education (P.L. 2019 c. 250, P.L. 2019, JR-23, P.L. 2023, c.170)

Legislative actions related to public education ensure that people are informed about key policies related to reproductive health, including pregnancy and infant loss. These actions also ensure that accurate information on comprehensive reproductive health and rights is available in multiple languages.

For example, P.L. 2019, c. 250 requires public schools to teach about the New Jersey Safe Haven Infant Protection Act, and P.L. 2019, JR-23 designates October as "Pregnancy and Infant Loss Remembrance Month."

Additionally, P.L. 2023, c. 170 mandates the development of a state website with information on reproductive rights and services, including contraception and abortion, available in multiple languages (https://www.nj.gov/health/reproductivehealth/). Given the current climate where these rights and services are restricted in many states, New Jersey's commitment to providing this information is especially important.

Maternal Nutrition (P.L. 2019, c. 015 and c. 91, P.L. 2023, c. 267)

Many developmental and health-related conditions can be attributed to inadequate diets (Shanahan et al., 2022). Food insecurity, defined as insufficient access to healthy, fresh food, is common in low-income communities and puts pregnant people and children at risk for negative health and behavioral outcomes associated with poor diets (Popkin et al., 2020).

Both undernutrition and overnutrition can contribute to adverse health issues during pregnancy and childhood. Consuming excess calories, often from ultra-processed foods, can contribute to obesity-related diseases such as hypertension and type 2 diabetes. Conversely, inadequate access to micronutrients, often coupled with overnutrition, can lead to cognitive and behavioral health issues (Popkin et al., 2020).

To address food insecurity and increase access to nutritious foods, New Jersey enacted P.L. 2019, c. 015, also known as the "Healthy Small Food Retailer Act." The law directs the DOH to help small food retailers increase the availability of affordable fresh fruits, vegetables, and other healthy foods in both rural and urban neighborhoods.

The state legislature also passed P.L. 2019, c. 91, which directs the Department of Agriculture to establish a food desert produce pilot program, and P.L. 2023, c. 267, which directs the DOH to permit the online purchase of eligible foods, including infant formula, using Women, Infants, and Children (WIC) funds. These funds can also be used for grocery delivery charges from authorized WIC vendors.

Household food insecurity can also influence maternal depression, which can directly affect parental capacity for care, developmental stimulation, and child-parent interactions (Cook & Frank, 2008; Popkin et al., 2020). Access to affordable fresh fruits, vegetables, and other healthy foods can improve maternal health and child well-being. Unfortunately, low-income communities often lack grocery stores that sell fresh, healthy foods at affordable prices (Ghosh-Dastidar et al., 2014).

In the U.S., evidence of the influence of improved food security and healthy eating on child development and maternal wellbeing remains mostly indirect, often relying on the crucial role of nutrition and culinary education for positive outcomes for birthing persons and young children (Eicher-Miller et al., 2009). Studies highlight barriers that may hinder optimal health outcomes associated with healthy diets (e.g., lack of knowledge of food preparation or insufficient time to cook). However, policies can establish the foundation for a healthier food environment, enabling healthy eating patterns for birthing persons and young children and promoting positive health outcomes.

Menstrual Health (P.L. 2023, c. 240 and c. 303, P.L. 2024, c. 27)

Period poverty and menstrual equity refer to the challenges faced by individuals who cannot afford or lack access to adequate menstrual hygiene products (DeMaria et al., 2024; Rome & Tyson, 2024).

Period poverty disproportionately affects marginalized groups such as unhoused people, students, and low-income individuals. For example, a national survey of teens found that one in five struggled to afford period products, and 80 percent either missed or knew someone who skipped school due to lack of access to these products (Rome & Tyson, 2024). Additionally, period poverty has been shown to negatively impact mental well-being (Cardoso et al., 2021).

New Jersey has taken significant steps to address period poverty and improve access to menstrual products. Recent legislation includes **P.L. 2023, c. 240**, which established a menstrual health public awareness campaign; **P.L. 2023, c. 303**, which established the New Jersey Feminine Hygiene Products for the Homeless Act; and **P.L. 2024, c. 27**, which established the State Work First New Jersey Menstrual Hygiene Benefit Program and the State Work First New Jersey Diaper Benefit Program.

These programs provide cash assistance for menstrual products and diapers to reduce hardship caused by lack of access to these essential items and address income-related inequities. These initiatives reflect New Jersey's commitment to promoting reproductive equity and ensuring that menstruation is not a barrier to education or well-being.

Legislative Focus Area 5: Legal Agreements and Safeguards

These measures establish legal processes and protections, such as gestational carrier agreements, adoption protocols, and support for priority populations, including parents surrendering infants, survivors of sexual assault, and reproductive health care recipients.

These laws and protections aim to address systemic vulnerabilities and foster a more equitable environment for all parents and children, including those involved in surrogacy or adoption, while safeguarding those most at risk. Though not directly tied to scientific evidence, these legal measures promote fundamental societal protections and human rights.

The policies categorized in this section focus on (1) reproductive health care protections (**P.L. 2022, c. 50 and c. 51**), (2) gestational carriers (**P.L. 2018, c. 18**), (3) age for marriage or civil union (**P.L. 2018, c.42**), (4) confidentiality (**P.L. 2019, c.175**), (5) adoption (**P.L. 2019, c. 323**), and (6) safe haven (**P.L. 2023, c. 153**). However, since the justification for the policies in this focus area is legal rather than scientific, summaries of the literature have not been provided for this set of policies.

Legislative Focus Area 6: Data, Surveillance, and Quality Improvement

Strengthening data systems and advancing research on racial and ethnic health disparities are essential steps for informing practices, shaping quality improvement initiatives, and promoting maternal and child health. The policies categorized in this section focus on (1) public health surveillance and data on maternal and infant health disparities, (2) data, and (3) the Regional Health Hub Program.

Public Health Surveillance and Data on Maternal and Infant Health Disparities (AR226, P.L. 2019, c. 75, P.L. 2018, c. 22, P.L. 2019, c. 497, P.L. 2023, c. 109, P.L. 2018, c. 82)

Public health surveillance is the "continuous, systematic collection, analysis, and interpretation of health-related data" (World Health Organization, n.d.). It facilitates the assessment of needs for interventions and measures their impact on the population (Nsubuga et al., 2006). Public health surveillance is also critical in identifying and analyzing health disparities.

Developing surveillance systems and analyzing public health data are essential to improving health. Nurture NJ itself was catalyzed by data on the state's maternal health ranking compared to other states, as well as maternal health data showing significant disparities in outcomes between Black and white women.

To facilitate the effective use of surveillance systems as a tool for promoting maternal health, New Jersey passed **Assembly Resolution (AR) 226**, which urged the Centers for Disease Control and Prevention (CDC) to adopt a uniform data system for collecting information on maternal mortality, and **P.L. 2019, c. 75**, which established the New Jersey Maternal Care Quality Collaborative, the New Jersey Maternal Mortality Review Committee (MMRC), and the New Jersey Maternal Data Center.

New Jersey established the MMRC when only 25 states in the U.S. had maternal mortality review boards and urged the establishment of such boards in all 50 states. Since then, additional states have established maternal mortality review boards and, today, 49 states, the District of Columbia, New York City, Philadelphia, and Puerto Rico have such structures (Guttmacher Institute et al., 2019).

In New Jersey, legislative actions related to surveillance of disparities include requiring the Child Fatality and Near Fatality Review Board (CFNFRB) and the Office of Minority and Multicultural Health (OMMH) to study racial and ethnic disparities in infant mortality and sexual and reproductive health. In 2018, the New Jersey State Legislature enacted **P.L. 2018, c. 22**, directing the CFNFRB to study the effects of racial and ethnic disparities on infant mortality.

Established with the passage of the New Jersey Comprehensive Child Abuse Prevention and Treatment Act, the CFNFRB resides within the New Jersey Department of Children and Families (DCF) but operates independently of the department (New Jersey Department of Human Services, n.d.). Appointed by the Governor, this multidisciplinary board consists of officials and public individuals with expertise or experience in child abuse. The act requires the board to share its findings and recommendations for legislative and other actions to reduce infant mortality statewide, increase health care access and breastfeeding support for underserved racial and ethnic populations, and reduce or eliminate racial and ethnic disparities.

In addition to the legislation above, **P.L. 2019, c. 497** directs New Jersey's OMMH to study the effects of racial and ethnic disparities on the sexual and reproductive health of Black women in the state. Monitoring statewide health outcomes and associated racial and ethnic disparities is a critical step in identifying strategies to eliminate these disparities. The act also mandates that the OMMH publish the study results and issue legislative recommendations to address racial and ethnic health disparities affecting the reproductive health of Black women in New Jersey.

Research shows that access to health care, social determinants of health, and systemic factors all contribute to infant mortality rate disparities. Systemic factors, such as the experience of racial discrimination, lower income, and poor residential environments, have been linked to higher infant mortality rates in Black populations (Crear-Perry et al., 2021; David & Collins, 2011; Jang & Lee, 2022). These effects are compounded by additional factors, including lower quality of care and lack of medical insurance (Crear-Perry et al., 2021; Jang & Lee, 2022).

Disparities also persist in breastfeeding initiation and duration, which this legislation also seeks to address. In 2019, 70.9 percent of Black mothers in the U.S. initiated breastfeeding, compared to 81 percent of white mothers, 80.9 percent of Hispanic mothers, and 83.2 percent of Asian mothers (Chiang, 2021). Breastfeeding has been linked to a lower risk of infant mortality, including Sudden Infant Death Syndrome (Dieterich et al., 2013).

Other factors contributing to higher infant mortality rates among Black women include higher incidences of in-hospital formula feeding in hospitals serving predominantly Black communities, lack of community and social supports (Jiang et al., 2024; Jones et al., 2015), higher rates of poverty, and lack of access to paid leave (Centers for Disease Control and Prevention, 2022).

All of these factors impede the initiation and/or duration of breastfeeding in Black mothers, compared to their white, Hispanic, and Asian counterparts (McKinney et al., 2016). Therefore, increasing marginalized communities' access to baby/breastfeeding friendly labor and delivery spaces and paid leave should improve infant health equity.

In response to these circumstances, New Jersey passed **P.L. 2023, c. 109**, which created the New Jersey Maternal and Infant Health Innovation Authority (MIHIA). Governed by a 15- member board and lead by a President and Chief Executive Officer, this Authority is tasked with overseeing the Maternal and Infant Health Innovation Center (MIHIC), and will be the government entity that continues the vital work of Nurture NJ for years to come (Maternal and Infant Health innovation Authority, 2024; New Jersey Economic Development Authority, n.d.).

Located in Trenton, the MIHIC is intended to serve as an anchor for the equitable provision of maternal and infant health care services, social services, and wraparound supports. It will conduct data analysis and first-in-class research on maternal health care and equity in care, while also providing training and education for the perinatal workforce (New Jersey Economic Development Authority, n.d.).

New Jersey also passed **P.L. 2018, c. 82**, which established the New Jersey Report Card of Hospital Maternity Care. In general, these types of report cards provide information to the public and may motivate institutions to work internally to improve their rankings and brand, making them useful tools for spurring improvements in patient care.

The scientific literature on the impact of hospital report cards presents mixed findings. This ambiguity arises from the difficulty of isolating the effects of public reporting from other concurrent quality improvement initiatives. Moreover, institutions demonstrating high initial performance may experience a ceiling effect, limiting their ability to improve their metrics (Jolles & Hoehn-Velasco, 2021).

Regional Health Hub Program (P.L. 2019, c. 517)

In 2011, New Jersey established the Medicaid Accountable Care Organization (ACO) demonstration project to improve health outcomes, quality, and access to care through regional collaboration and shared accountability to reduce costs (New Jersey Department of Human Services, n.d.).

The project aimed to help the New Jersey Medicaid program test whether the ACO could serve as an alternative to managed care, evaluate how care management and care coordination could be delivered to certain patients, expand Medicaid to better integrate social services, and test payment reform models (Trenton Health Team, 2019).

However, the project did not lead to a sustainable care model, and the ACO evolved into community health coalitions focused on coordinating and enhancing care (DeLia & Yedidia, 2020). As a result, **P.L. 2019, c. 517** subsequently established the Regional Health Hub Program as a replacement to the ACO demonstration project and designated existing and similar accountable care organizations as Regional Health Hubs.

This legislation created four regional Health Hubs in the State of New Jersey to work with Medicaid and state agencies to improve health outcomes with a focus on reducing disparities. The legislation specified that each Health Hub:

1. identify existing and emerging threats to health and well-being, as well as problems with the state's regional health care delivery systems, and identify and determine how to implement solutions to these problems;

2. promote and facilitate cooperation, coordination, innovation, and goal setting by and among the relevant stakeholders;

3. evaluate the progress that has been made in achieving identified goals and priorities; and

4. otherwise encourage and enable the overall improvement of the health of New Jersey residents and the delivery of health care throughout the state.

The four Health Hubs established in New Jersey are (1) the Greater Newark Health Care Coalition, (2) the Camden Coalition, (3) the Health Coalition of Passaic County, and (4) the Trenton Health Team.

While the services offered by these hubs vary, all are involved in efforts to improve maternal and child health. Kathleen Noonan, CEO of the Camden Coalition, notes that the hubs operate health information exchanges (HIEs) that collect and analyze health data to identify patterns and unmet needs while also bringing together a wide range of stakeholders like health care providers, nonprofits, social service agencies, and consumers to improve access to and utilization of services (K. Noonan, personal communication, March 6, 2024).

Glossary

Terms and Acronyms	
Accountable Care Organization (ACO)	Groups of doctors, hospitals, and other healthcare providers who come together voluntarily to give coordinated high-quality care to a designated group of patients.
Affordable Care Act	The Affordable Care Act, also known as Obamacare, is a comprehensive health care reform law enacted in 2010.
Agency for Healthcare Research and Quality (AHRQ)	A government agency within the United States' Department of Health and Human Services that supports research to improve the quality, safety, efficiency, and effectiveness of health care for all Americans.
Alliance for Innovation on Maternal Health	A national, cross-sector quality improvement initiative aimed at supporting best practices that make birth safer, improve maternal health outcomes, and save lives.
American Society for Reproductive Medicine (ASRM)	A multidisciplinary organization dedicated to the advancement of science and practice of reproductive medicine.
Artificial insemination	A procedure that involves introducing sperm into the female reproductive tract to achieve pregnancy.
Assembly Resolution (AR[#])	An action of the Legislature that expresses the policies, sentiment, opinions, or direction of one or both Houses.
Board of Medical Examiners	A state board responsible for protecting the public's health and safety by determining the qualifications of applicants for licensure, establishing standards for practice, and disciplining licensees who do not adhere to those requirements.
Board of Pharmacy	A professional licensing board that protects the public by regulating the dispensing of prescription medications.
Centers for Disease Control and Prevention (CDC)	A federal agency that serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of people in the United States.
CenteringPregnancy	Centering Pregnancy is group prenatal care bringing women due at the same time out of exam rooms and into a comfortable group setting.

Glossary (continued)

Terms and Acronyms	
Child Fatality and Near Fatality Review Board (CFNFRB)	Established by the New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA), the Board reviews child fatalities and near fatalities to identify their causes, relationship to governmental support systems, and methods of prevention.
Children's Health Insurance Program (CHIP)	An insurance program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance. CHIP covers pregnant women in some states.
Cytomegalovirus (CMV)	A common virus related to the herpes virus group that infects people of all ages.
Congenital Cytomegalovirus (Congenital CMV)	A viral infection that occurs when a baby is born with cytomegalovirus. It is the most common infectious cause of birth defects in the United States.
Department of Health (DOH)	A state-level department that promotes the health and well-being of individuals and communities throughout New Jersey.
Department of Human Services (DHS)	A state-level agency providing numerous programs and services addressing economic and health challenges. It includes health insurance through New Jersey FamilyCare or Medicaid.
Earned Income Tax Credit (EITC)	A federal tax credit for working people with low and moderate incomes.
Embryo	The early stage in the development of humans and other animals or plants.
Episode of care (EOC)	A set of services provided to treat a clinical condition or procedure.
Equal Pay Act	The Equal Pay Act (EPA) of 1963 is a federal law that protects against sex-based pay discrimination.
Federal Poverty Level	A measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits.

Glossary (continued)

Terms and Acronyms	
Gametes	A reproductive cell of an animal or plant.
Genetic testing	Tests that look for genetic changes in a person's DNA.
Health Information Exchanges (HIEs)	A system that allows health care professionals and patients to appropriately access and securely share a patient's medical information electronically.
Human immunodeficiency virus (HIV)	A virus that attacks the body's immune system.
Human papillomavirus (HPV)	A viral infection that commonly causes skin or mucous membrane growths.
Infant mortality rate	The probability of a child born in a specific year or period dying before reaching the age of one, per 1,000 live births.
Intimate partner violence	Abuse or aggression that occurs in a romantic relationship. Intimate partner refers to both current and former spouses and dating partners.
In vitro fertilization (IVF)	IVF is a medical procedure where an egg is fertilized by sperm in a laboratory, instead of inside a woman's body.
Medicaid	A joint federal and state program that covers medical costs for some people with limited income and resources.
New Jersey Department of Children and Families (NJ DCF)	A state government agency dedicated to serving and supporting at-risk children and families.
NJ FamilyCare	New Jersey's publicly funded health insurance program - includes CHIP, Medicaid, and Medicaid expansion populations.
New Jersey Health Care Quality Institute (NJHCQI)	A nonprofit organization that works to improve the safety, quality, and affordability of health care.

Glossary (continued)

Terms and Acronyms	
New Jersey Maternal and Infant Health Innovation Authority (NJ MIHIA)	The New Jersey Maternal and Infant Health Innovation Authority is tasked with overseeing the New Jersey Maternal and Infant Health Innovation Center and will be the government entity that continues the work of Nurture NJ for years to come.
New Jersey Maternal and Infant Health Innovation Center (NJ MIHIC)	MIHIC is intended to serve as an anchor for the equitable provision of maternal and infant health care services and a hub for innovation in care. It will provide social services and wraparound supports, conduct data analysis and research on maternal health care and equity in care, and provide training for the perinatal workforce.
New Jersey Maternal Data Center	A website that provides data and resources to improve maternal health in New Jersey.
New Jersey Maternal Mortality Review Committee (MMRC)	The Maternal Mortality Review Committee reviews and reports on annual maternal death rates and the causes of maternal death in the state and provides recommendations to improve maternal care and reduce adverse outcomes associated with pregnancy.
New Jersey Safe Haven Infant Protection Act	A law that allows a distressed parent who is unable to care for an infant to give up custody of a baby who is less than 30 days old, safely, legally and anonymously.
Perinatal Risk Assessment (PRA)	A set of forms designed to provide a uniform tool that includes all clinical and psychosocial risk factors that affect pregnant women.
Public Law, Chapter (P.L. [year], c. [#]) **Public Law, Joint Resolution (P.L. [year], JR-[#])**	In New Jersey, Public Law refers to a bill that has been passed by both houses of the Legislature (the Senate and General Assembly) and has been approved by the Governor. Chapter - Each Public Law is assigned a chapter number based on the order in which it was approved by the Governor during a given legislative session. Joint Resolution - This is a formal expression of opinion or intent by both houses of the Legislature and requires approval by the Governor.

Glossary (continued)

Terms and Acronyms	
School Employees' Health Benefits Program (SEHBP)	Established in 2007, it offers medical, dental, and prescription drug coverage to qualified local education public employees, retirees, and eligible dependents.
Sexually Transmitted Infections (STIs)	Infections that are passed from one person to another through sexual contact.
State Health Benefits Program (SHBP)	Established in 1961, it offers medical, dental, and prescription drug coverage to qualified state and local government public employees, retirees, and eligible dependents.
SHARE Approach	A five-step process for shared decision-making that includes exploring and comparing the benefits, harms, and risks of each option through dialogue with the patient.
Spinal Muscular Atrophy (SMA)	A genetic disease affecting the central nervous system, peripheral nervous system, and voluntary muscle movement.
Sudden Infant Death Syndrome	The sudden death of a baby younger than one year of age that does not have a known cause, even after a full investigation.
Syphilis	A preventable and curable bacterial sexually transmitted infection.
TeamBirth	A care process to improve communication, teamwork, and shared decision-making throughout the birthing process.
Women, Infants, and Children (WIC)	WIC, which stands for the Special Supplemental Nutrition Program for Women, Infants, and Children, is a federal assistance program designed to safeguard the health of low-income women, infants, and children up to age five who are at nutritional risk.
World Health Organization (WHO)	A United Nations agency that works to promote health, keep the world safe, and serve the vulnerable.

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Appendix

Legislation	Focus Area
P.L. 2019, c. 87--Prohibits health benefits coverage for certain non-medically indicated early elective deliveries under Medicaid, the State Health Benefits Program, and School Employees Health Benefits Program	MCH Care Delivery and Access
P.L. 2019, c. 88--Codifies current practice re: completion of Perinatal Risk Assessment for Medicaid providers	MCH Care Delivery and Access
P.L. 2019, c. 498 – Requires hospital emergency departments to ask people of childbearing age about recent pregnancy history	MCH Care Delivery and Access
P.L. 2019, c. 296 – Revises Newborn Screening program in the Department of Health	MCH Care Delivery and Access
P.L. 2019, c. 390-Reuires newborn infants be screened for spinal muscular atrophy	MCH Care Delivery and Access
P.L. 2021, c. 413--Establishes requirements to commence screening newborn infants for congential cytomegalovirus infenction; establishes public awareness campaign	MCH Care Delivery and Access
P.L. 2019, c. 133--Establishes maternal health care pilot program to evaluate shared decision-making tool developed by DOH and used by hospitals providing maternity services and by birthing centers	MCH Care Delivery and Access
PP.L. 2019, c. 86 - Establishes perinatal episode of care pilot program in Medicaid	MCH Care Delivery and Access
P.L. 2019, c. 237 - Requires Medicaid coverage for group prenatal care services under certain circumstances	MCH Care Delivery and Access
P.L. 2019, c. 85 - Provides Medicaid coverage for doula care	MCH Care Delivery and Access
AP.L. 2019, JR-3 - Designates March 22 to March 28 of each year as "Doula Appreciation Week"	MCH Care Delivery and Access
P.L. 2020, c. 32 - Requires hospitals to permit individual to accompany woman during childbirth	MCH Care Delivery and Access
P.L. 2023, c. 286 - Requires certain health care facilities to develop certain doula policies and procedures	MCH Care Delivery and Access

Appendix (continued)

Legislation	Focus Area
P.L. 2019, c. 18 - Establishes reciprocity requirements for out-of-State certified nurse aides to practice in NJ	MCH Care Delivery and Access
P.L. 2023, c. 244 - Provides loan redemption in exchange for full-time and part-time faculty employment at school of nursing in the state for a five-year period	MCH Care Delivery and Access
P.L. 2021, c. 79 - Requires certain health care professionals to undergo explicit and implicit bias training	MCH Care Delivery and Access
P.L. 2021, c. 120 - Requires DOH and DHS to identify and take appropriate steps to secure federal sources of funding to support maternal mental health	MCH Care Delivery and Access
P.L. 2021, c. 380 - Requires DOH to develop and implement plan to improve access to perinatal mood and anxiety disorder screening	MCH Care Delivery and Access
P.L. 2024, c. 89 - Establishes requirements concerning the provision of postpartum care, pregnancy loss, and stillbirth information and development of personalized postpartum care plans	MCH Care Delivery and Access
AR219 - Encourages DOH to develop standards for respectful care at birth and to conduct public outreach initiative	MCH Care Delivery and Access
P.L.2018, c.10 - Concerns earned sick leave to employees.	Parental and Child Supports
P.L. 2018, c. 122 - Revises law concerning temporary disability leave	Parental and Child Supports
P.L. 2019, c. 37 - Revises law concerning family leave, temporary disability and family temporary disability leave, and domestic or sexual violence safety leave	Parental and Child Supports
P.L. 2019, c. 242 – Requires certain public facilities and offices to provide on-site lactation room; DOH to provide information about lactation room availability; and DOE to provide information on lactation policies in schools	Parental and Child Supports
P.L. 2019, c. 317 – Requires Medicaid coverage for pasteurized donated human breast milk under certain circumstances	Parental and Child Supports

Appendix (continued)

Legislation	Focus Area
P.L. 2019, c. 343 – Requires health benefits and Medicaid coverage for breastfeeding support	Parental and Child Supports
P.L.2018, c. 9 – Addresses equal pay and employment discrimination	Parental and Child Supports
P.L.2018, c. 45 – Increases New Jersey Earned Income Tax Credit; provides credit for child or dependent care expenses; taxes "investment management services"	Parental and Child Supports
P.L. 2021, c. 130 – Expands eligibility under New Jersey earned income tax credit program to allow taxpayers who are at least 18 years of age or older to qualify for modified benefit	Parental and Child Supports
P.L.2022, c. 24. – Provides child tax credit under gross income tax	Parental and Child Supports
P.L. 2023, c. 72 – Increases child tax credit under gross income tax	Parental and Child Supports
P.L. 2019, c. 32 – Raises, over time, hourly minimum wage to $15.00	Parental and Child Supports
P.L. 2021, c. 47 – Makes $10 million in federal funds available to EDA to support childcare providers in need	Parental and Child Supports
P.L. 2021, c. 324 – Requires that certain provider subsidy payments for childcare services be based on enrollment	Parental and Child Supports
P.L. 2021, c. 144 – Appropriates $100,000,000 to DCA for purpose of studying and providing grants and technical assistance to licensed and registered childcare providers to support workforce development and other improvements	Parental and Child Supports
P.L. 2022, c. 25 – Establishes Thriving By Three competitive grant program for infant and toddler childcare programs; appropriates $28 million	Parental and Child Supports
P.L. 2019, c. 426 – Establishes pilot program in DCF to study impact of childcare services provided by community providers operating in public school facilities; requires community providers to meet certain criteria	Parental and Child Supports

Appendix (continued)

Legislation	Focus Area
P.L. 2021, c. 187 – Establishes a statewide universal newborn home visitation program in the New Jersey Department of Children and Families, advancing New Jersey as a national model for maternal and infant care	Parental and Child Supports
P.L. 2018, c. 1 - Provides Medicaid coverage for family planning services to individuals with incomes up to 200% FPL	Family Planning and Fertility Services
P.L. 2018, c. 2 - Makes FY2018 supplemental appropriation of $7,453,000 to DOH for family planning services	Family Planning and Fertility Services
P.L. 2019, c. 151 – Appropriates $10,453,000 in Grants-in-Aid state funds for family planning services	Family Planning and Fertility Services
P.L. 2019, c. 277 – Makes FY2020 supplemental appropriation of $9.5 million to DOH for family planning services	Family Planning and Fertility Services
P.L. 2019, c. 361 – Revises law requiring health benefits coverage for certain contraceptives	Family Planning and Fertility Services
P.L. 2021, c. 375 – Codifies constitutional right to freedom of reproductive choice	Family Planning and Fertility Services
P.L. 2021, c. 376 - Expands contraception coverage required under private insurance and Medicaid from a 6-month supply to a 12-month supply	Family Planning and Fertility Services
P.L. 2023, c. 2 - Permits pharmacists to furnish self-administered hormonal contraceptives pursuant to a standing order, in accordance with protocols established by Board of Pharmacy and Board of Medical Examiners	Family Planning and Fertility Services
P.L. 2023, c. 258 - Expands health insurance for fertility treatments	Family Planning and Fertility Services
P.L. 2019, c. 306 - Mandates health benefits coverage for fertility preservation services under certain health insurance plans	Family Planning and Fertility Services
P.L. 2019, c. 268 - Requires the DOH to regulate and license embryo storage facilities	Family Planning and Fertility Services

Appendix (continued)

Legislation	Focus Area
P.L. 2019, c. 236 – Requires DOH to establish "My Life, My Plan" program to promote and support reproductive life planning for all women of childbearing age and their families through dissemination of interactive online educational materials that promote physical and mental health and planning tools	Education, Programs and Resources
P.L. 2019, c. 250 – Requires public school districts to provide instruction on "New Jersey Safe Haven Infant Protection Act" as part of the New Jersey Student Learning Standards	Education, Programs and Resources
P.L. 2019, JR-23 – Designates October of each year as "Pregnancy and Infant Loss Remembrance Month" in New Jersey	Education, Programs and Resources
P.L. 2023, c. 170 - Requires establishment of new State website with information on rights related to, and health benefits for, reproductive health care services	Education, Programs and Resources
P.L. 2019, c. 15 – "Healthy Small Food Retailer Act"	Education, Programs and Resources
P.L. 2019, c. 91 – Directs Department of Agriculture to establish food desert produce pilot program	Education, Programs and Resources
P.L. 2023, c. 267 – Permits online purchase of eligible foods using WIC funds and use of WIC funds for grocery delivery charges	Education, Programs and Resources
P.L. 2023, c. 240 – Establishes menstrual health public awareness campaign	Education, Programs and Resources
P.L. 2023, c. 303 – Establishes "New Jersey Feminine Hygiene Products for the Homeless Act"	Education, Programs and Resources
P.L. 2024, c. 27 – Establishes State Work First New Jersey Menstrual Hygiene Benefit Program and State Work First New Jersey Diaper Benefit Program; appropriates $2.5 million to DHS	Education, Programs and Resources
P.L. 2022, c. 50 – Prohibits extradition of individual from another state back to that state for actions related to conduct concerning reproductive health care services lawful in this State	Legal Agreements and Safeguards

Appendix (continued)

Legislation	Focus Area
P.L. 2022, c. 51 – Concerns protections with respect to nondisclosure of certain patient information relating to reproductive healthcare services, and protecting access to services and procedures related to abortion for certain out-of-State persons	Legal Agreements and Safeguards
P.L. 2018, c. 18--Authorizes certain gestational carrier agreements	Legal Agreements and Safeguards
P.L. 2018, c. 42 – Bars persons under age 18 from marrying or entering into a civil union	Legal Agreements and Safeguards
P.L. 2019, c. 175 – Expands the Address Confidentiality Program to include victims of sexual assault and stalking; and reproductive health service patients and providers	Legal Agreements and Safeguards
P.L. 2019, c. 323 – Establishes process to obtain judgement of adoption for civil union partner or spouse of natural or legal parent of child when that person is named as parent on child's birth certificate	Legal Agreements and Safeguards
P.L. 2023, c. 153 - Allows persons who give birth to children in licensed general hospitals to surrender those children under "Safe Haven Infant Protection Act"	Legal Agreements and Safeguards
AR226 – Urges CDC to adopt uniform data system to collect information on maternal mortality	Data, Surveillance, and Quality Improvement
P.L. 2019, c. 75 - Establishes the NJ Maternal Care Quality Collaborative, NJ MMRC, and NJ Maternal Data Center	Data, Surveillance, and Quality Improvement
P.L. 2018, c. 22 – Requires Child Fatality and Near Fatality Review Board to study racial and ethnic disparities that contribute to infant mortality	Data, Surveillance, and Quality Improvement
P.L. 2019, c. 497 - Requires NJ Office on Minority and Multicultural Health to study racial disparities on SRH of African American women	Data, Surveillance, and Quality Improvement
P.L. 2023, c. 109 – Establishes "New Jersey Maternal and Infant Health Innovation Center Act," and appropriates $2,220,000	Data, Surveillance, and Quality Improvement

Appendix (continued)

Legislation	Focus Area
P.L. 2018, c. 82 - Establishes NJ Report Card of Hospital Maternity Care	Data, Surveillance, and Quality Improvement
P.L. 2019, c. 517 – Provides for establishment of Regional Health Hub Program as replacement to Accountable Care Organization Demonstration Project and designates existing accountable care organizations and look-alike organizations as Regional Health Hubs	Data, Surveillance, and Quality Improvement