

**NEW JERSEY**  
**FISCAL YEAR 2009**  
**PREVENTIVE HEALTH AND HEALTH**  
**BLOCK GRANT APPLICATION**

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**Proposed FFY 2009 Budget**

<b>Asthma Awareness and Education Program</b>	<b>\$ 50,000</b>
<b>Chronic Disease Self-Management Program (CDSMP)</b>	<b>\$ 146,252</b>
<b>Immunization/Vaccine Preventable Disease Program</b>	<b>\$ 225,000</b>
<b>Mercer County Traumatic Loss Coalition</b>	<b>\$ 70,000</b>
<b>New Jersey State Cancer Registry</b>	<b>\$ 120,005</b>
<b>New Jersey Diabetes Prevention and Control Program</b>	<b>\$ 358,638</b>
<b>New Jersey Division on Women's (DOW) Rape Care and Prevention Program</b>	<b>\$ 206,051</b>
<b>New Jersey Heart Disease and Stroke Prevention Program</b>	<b>\$ 80,000</b>
<b>New Jersey Nutrition, Physical Activity, and Obesity Prevention Program</b>	<b>\$ 198,353</b>
<b>Public Health Workforce Development</b>	<b>\$ 804,759</b>
<b>Quality Emergency Medical Services Care</b>	<b>\$ 398,682</b>
<b><u>Administrative Costs (&lt; 10% of total grant award)</u></b>	<b><u>\$ 146,059</u></b>
<b>TOTAL</b>	<b><u>\$2,803,799</u></b>

## **Executive Summary**

This is New Jersey's application for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Fiscal Year 2009. The PHHSBG is administered by the United States Department of Health and Human Services through its administrative agency, the Centers for Disease Control and Prevention (CDC). The New Jersey Department of Health and Senior Services (NJDHSS) is designated as the principal state agency for the allocation and administration of the PHHSBG within the State of New Jersey.

### **Funding Assumptions**

Funding for the Preventive Health and Health Services Block Grant (PHHSBG) funding has decreased from \$3,955,431, in FFY 2002, to \$2,803,799 in FFY 2008 for a reduction of \$1,151,632. The FFY 2009 application is based on the assumption that PHHSBG funding will be at least equal to the FFY 2008 grant award. Any changes in funding are consistent with, and in full compliance with applicable state and federal laws. Implementation of New Jersey's FFY 2008 prevention programs that are funded by the PHHSBG will be contingent upon receipt of level funding for FFY 2009. New Jersey's final FFY 2008 PHHSBG award was \$2,803,799.

### **Proposed Funded Programs**

1. Asthma Awareness and Education Program (New) - HO 7-10
2. Chronic Disease Self Management (Revised) - HO 7-12
3. Immunization/Vaccine Preventable Disease Program - HO 14-1
4. Mercer County Traumatic Loss Coalition (Revised) - HO 18-2
5. New Jersey State Cancer Registry - HO 3-1
6. New Jersey Diabetes Prevention and Control Program - HO 5-1/5-13
7. New Jersey Division on Women's Rape Care and Prevention Program - HO 15-35
8. New Jersey Heart Disease and Stroke Prevention Program - HO 12-2/12-8
9. New Jersey Nutrition, Physical Activity and Obesity Prevention Program - HO19-3
10. Public Health Workforce Development - HO-23-8/23-11
11. Quality Emergency Medical Services Care - HO 1-11

New Jersey's PHHSBG funding is also used to leverage other funds for impacting health problems and addressing major public health issues such as heart disease and stroke prevention, sensitive eye exams for persons with diabetes, suicide prevention for African American adolescent males, and risk factors such as physical inactivity and poor nutrition. All PHHSBG funds are being used to achieve the Nation's health objectives, outlined in *Healthy People 2010*, and those specific to New Jersey, as outlined in *Health New Jersey 2010*.

### **Proposed Changes for FFY 2009**

Changes will be made to the proposed FFY 2009 budget will address the annual increases in salary, due to contractual pay scales and related fringe benefit charges for the budgeted positions (15.5 FTEs, down from 16.5 in FFY 2008). Any positions which are vacated due to retirement or job advancement will be frozen until increased PHHSBG funding can be achieved. The Division of Senior Services has proposed redirecting their funding to support Chronic Disease Self Management. Modest funding for the Asthma Education and Awareness has been added to the proposed PHHSBG application.

Additionally, Heather Howard was appointed by Governor Jon S. Corzine as the Commissioner of Health for the State of New Jersey on January 2, 2008, after the retirement of Dr. Fred M. Jacobs, J.D. On June 30, 2008, the Deputy Commissioner of Health, Dr. Eddy Bresnitz, retired. Dr. Susan Walsh was appointed as the Deputy Commissioner on December 5, 2008.

**Program Title:** **Asthma Awareness and Education Program (AAEP)**

**Program Goals:** Reduce the burden of asthma and improve health outcomes for New Jersey residents with asthma through public awareness regarding asthma management, education targeting the underserved, low-income minority and other at-risk population.

**Program Health Priority:** Health Promotion/Education

**Program Primary Strategic Partners:**

**Internal**

DHSS, Special Child, Adult and Early Intervention  
DHSS, Child, and Adolescent Health  
DHSS, Maternal Child, and Community Health  
DHSS, Office of Primary Care  
DHSS, Office of Women's Health  
DHSS, Occupational Health  
DHSS, Consumer and Environmental Health  
DHSS, Public Employees Occupational Safety and Health (PEOSH)  
DHSS, Office of Local Health  
DHSS, Center for Health Statistics  
DHSS, Comprehensive Tobacco Control Program  
DHSS, Div of Aging and Community Services  
DHSS, Office of Public Health Infrastructure  
DHSS, Minority and Multicultural Health

**External**

NJ Dept. of Environmental Protection  
NJ Dept. of Education  
NJ Dept. of Human Services  
Pediatric/Adult Asthma Coalition of NJ  
NJ Primary Care Association  
Community-based service agencies  
Central NJ Maternal Child Consortium

**Role of the Block Grant Funds:** The role of the Block Grant in this program is to provide funds to support the Pediatric/Adult Asthma Coalition of New Jersey (PACNJ). Funds will pay the partial salary for Assistant Program Manager and Administrative Assistant. Funds will also be used to implement an asthma management strategy and to evaluate an existing asthma intervention for FY2009.

**Program Evaluation Methodology:** The grantee submits quarterly program reports and expenditure reports. The Asthma Program Coordinator reviews the program reports and the fiscal unit reviews the expenditure reports. The Asthma Coordinator and Epidemiologist attends meeting of the PACNJ and its Coordinating Committee. In addition the AAEP staff conducts biannual site visits to the grantees place of business.

**Program Setting or Site:**

Schools or school district

Child care centers  
Community- based organizations  
Conferences

**Program FTE Allocation: 0**

**Program National Health Objective(s):**

HO 7-10: Community Health Promotion Programs

**State Health Objective(s):**

1. By 2010, reduce the annual asthma hospital admission rate per 100,000 population to 150 for the total population, to 250 for Black, non-Hispanic residents, and to 150 for Hispanic residents.  
**Baseline:** 163 per 100,000 for the total population (1998), 412 per 100,000 for Black population (1998), 231 per 100,000 for Hispanic population (1998)
2. By 2010, reduce the annual asthma hospital admission rate per 100,000 population to 340 for all children under 5 years of age, to 800 for Black, non-Hispanic children under 5 years of age, and to 340 for Hispanic children under 5 years of age. **Baseline:** 494 per 100,000 for all children under 5 years of age (1998), 1224 per 100,000 for Black children under 5 years of age (1998), and 545 per 100,000 for Hispanic children under 5 years of age. **Data Source:** Healthy New Jersey 2010: Update 2005

**State Health Problem**

**Health Burden:** An astounding number of New Jersey residents are affected by asthma, a chronic respiratory disease characterized by inflammation and episodic narrowing of the airways. Combined New Jersey Behavioral Risk Factor Survey (NJBRFS) data from 2004-2006 indicate that about 516,088 adults (7.9%) currently have asthma. This data also shows that the estimated number of women with asthma (345,877) is more than double the estimated number of men with asthma (170,201) and that prevalence is higher among black, non-Hispanic adults (10.0%) when compared to Asian, non-Hispanic adults (4.5%), white, non-Hispanic adults (8.0%), and Hispanic adults (7.3%). NJBRFS data from 2002-2004 suggest that asthma prevalence is higher among adults with an annual household income of less than \$25,000 as compared to other income levels. Combined NJBRFS results from the 2005-2006 NJBRFS indicate that approximately 313,379 children have a history of asthma (14.8%) and that approximately 218,914 children (10.3%) currently have asthma.

With appropriate management, asthma can be controlled so that people are able to lead active and healthy lives; however, the burden of asthma morbidity remains high in New Jersey. Results from the 2004-2006 NJBRFS demonstrate that among adults with current asthma, about 37% report they were unable to work or carry out usual activities for at least one day in the prior year because of their asthma and about 17% report one or more emergency department (ED)/urgent care visit for asthma in the prior year. Additionally, the following data illustrates disparities, burden, and area of focus:

- In 2006, there were 15,665 asthma hospitalizations among New Jersey residents representing about 1 of every 100 hospitalizations in the State.

- In 2006, black residents were nearly three times more likely to be hospitalized for asthma when compared to white residents and Hispanic residents were almost one and a half times more likely to be hospitalized for asthma when compared to non-Hispanic residents.
- Children less than five years of age are the most likely to be hospitalized for asthma. School age children experience seasonal peaks in asthma hospitalizations during the fall and spring months. Among adults, women are more likely to be hospitalized for asthma and are hospitalized longer for asthma when compared to men.
- Asthma hospitalization rates vary among the 21 counties of New Jersey with average annual rates in 2003-2006 ranging from about 68 asthma discharges per 100,000 residents (Hunterdon County) to about 337 asthma discharges per 100,000 residents (Essex County).
- In 2006, there were 52,628 ED discharges for asthma among New Jersey residents representing about 2 of every 100 ED discharges statewide.
- In 2006, black residents were nearly four times more likely to be discharged from the ED for asthma when compared to white residents and in 2006, Hispanic residents were more than one and a half times more likely to be discharged from the ED for asthma when compared to non-Hispanic residents.
- Children under five years of age are the most likely to be discharged from the ED for asthma when compared to other age groups. Annual asthma ED discharge rates for asthma during 2004-2006 ranged from about 218 per 100,000 residents (Hunterdon County) to about 1,365 per 100,000 residents (Essex County).

While death from asthma is uncommon, 106 deaths with an underlying cause of asthma were reported among New Jersey residents in 2005 and the extent to which asthma played a role in other instances of mortality is unknown. Higher age adjusted death rates are found among black residents and Hispanic residents as compared to white residents and non-Hispanic residents.

The national burden of asthma signifies multiple opportunities for intervention. Health care providers, public health professionals, health insurers, employers, schools, child care centers, caregivers, and patients with asthma must collaborate to reduce barriers and promote asthma control through appropriate medical assessment, patient monitoring, adherence to treatment recommendations, control of environmental factors, management of co-morbid conditions, and improved access to self-management education and resources.

**Target Population:**

Age: 1-3 years up to 65+

Race/Ethnicity: African Americans, Hispanic, White, Asian, American Indian

Gender: Female/Male

Geography: Urban/rural

Location: Statewide

**Target Populations (Systemic)**

State and local health departments

Community-based organizations

Health Care Systems

### **Population with Disparate Need**

Age: under 5 years,  
Race/Ethnicity: African Americans, Hispanic,  
Gender: Female  
Geography: Urban  
Location: Urban

### **Evidence-Based Guidelines**

National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: Healthy New Jersey 2010  
NHLBI Guidelines

### **Role Under the National Health Objective**

Supplementing Funding

### **Block Grant Funds for the National Health Objective**

Annual Base Current Year: \$50,000  
10-49%: Partial Source of Funding  
Other Sources of Funding for Current Year: \$75,000 (CDC Cooperative Agreement “Addressing Asthma from a Public Perspective”)

### **Essential Services:**

### **Inform and Educate**

**Impact Objective:** By August 31 2009, the revised PACNJ asthma education program for school nurses, “**Asthma Management in the School Setting**” will be updated to reflect current National Heart Lung and Blood Institute (NHLBI) guidelines and changes in medication delivery systems resulting from elimination of inhalers containing chlorofluorocarbons. The program will be made available online from the PACNJ website so school nurses can successfully complete the training and take the on-line quiz from home or school.

### **Activities:**

1. By December, 2008 the State School Nurses Association will provide feedback from school nurses on key elements needed in the revised program
2. By February, 2009 the PACNJ School and Environmental Task Forces will approve a script for the training program
3. By April, 2009 a video company will sign a contract to begin production of key elements to be taped and included in the on-line training
4. By June, 2009 the Evaluation Task Force will work with School Task Force to develop an evaluation quiz.

5. By July 2009 the web designer will create the power point design, including the video clips, and construct the technical component of the on-line quiz that will tally the results and automatically send confirmation and a certificate of completion.
6. By August, 2009, the power point program will be posted on the website and notice will be send to school nurses that the new training is available

### **Evaluate Health Programs**

Impact Objective: By August 2009 PACNJ will have completed an evaluation report on the effectiveness of the PACNJ ATP/website in both English and Spanish.

#### Activities:

1. By December 2008, contract with an agency to conduct a patient interview with 10 asthma patients currently using the PACNJ Asthma Treatment Plan.
2. Submit IRB application(s) as appropriate.
3. By February, 2009 the agency moderator will develop the discussion points and interview questions.
4. By March, 2009 PACNJ will develop a list of patients from PACNJ members who can become a pool for recruiting five English speaking and 5 Spanish speaking families.
5. By June, 2009 the agency moderator will conduct the interviews at the facility.
6. By August 2009, the agency moderator will tabulate the results and generate a report.

**Program Title: Chronic Disease Self-Management Program (CDSMP)**

**Program Goals:**

By 2011, NJ will have a sustainable delivery system for CDSMP, providing statewide access to the program, with an emphasis on reaching minorities and those in urban communities. NJ's sustainability is built upon a strong collaboration between the aging services network and public health, as well as strategic alliances with statewide associations and local partners. By 2010, CDSMP workshops will be conducted for a total of 950 older adults including 850 aged 65+, 96 African-Americans, 80 Hispanics and 32 Asians.

**Program Health Priority:**

Health Promotion/Education

**Program Primary Strategic Partners:**

Internal

DHSS, Div of Aging and Community Services  
DHSS, Office of Public Health Infrastructure  
DHSS, Family Health Services  
DHSS, Minority and Multicultural Health

External

NJ Human Resources Development Institute  
NJ Prevention Network  
NJ RSVP Association  
County Area Agencies on Aging on Aging  
Local Health Depts.  
Community-based service agencies  
Minority community service providers  
Hospitals

**Role of the Block Grant Funds:** The role of the block grant funds is to pay the salary of the Program Manager for the Office of Community Education and Wellness. The program manager is the project director for CDSMP.

**Program Evaluation Methodology:**

Reach and outcomes data is collected for CDSMP participants and entered into a central database at DHSS. The data is analyzed by a consultant evaluator. In addition, core reach data is forwarded to a national database administered by the U.S. Administration on Aging and National Council on Aging. Operational data (workshop delivery site, peer leader information, etc) is also collected and maintained by DHSS in a central database. Program monitoring is conducted via site visits, conference calls, data analysis and ongoing in-service training.

**Program Setting or Site:**

Community-based organizations  
Local health departments  
Senior residences or centers

**Program FTE Allocation: 1 FTE**

**Program National Health Objective(s):**

**Goal 1:** Increase quality and years of healthy life (a combined measure that assesses the difference between life expectancy and years of healthy life that reflects the average amount of time spent in less than optimal health because of chronic or acute conditions. Three difference measures of healthy life expectancy are used: expected years in good or better health, expected years free of activity limitations, and expected years free of selected chronic diseases).

**State Health Objective(s):** By 2010, increase days able to do usual activities, due to good physical or mental health, among persons 65+ to 28.7%.

**Baseline:** 27.2%

**Data Source:** New Jersey Department of Health and Senior Services, Center for Health Statistics, Behavioral Risk Factor Surveillance System, 1999.

### **State Health Problem:**

**Health Burden:** The state's rapidly growing older adult population, projections of continued increases in life expectancy and the escalating cost of care underscores the critical need to assist older adults to maintain good health as late into life as possible. NJ's current population of 1,495,460 adults 60+ is projected to reach 2,518,734 by 2030, when this cohort will represent 25.7% of the state's population, with the largest growth within the 85+ cohort.<sup>1</sup> As the state's population ages, the projected cost of health care also increases. Nationally, health care expenditures are anticipated to increase 25% due to the aging population. Chronic conditions can significantly impact quality of life, causing individuals to suffer pain, loss of function and reduced independence. The risk and burden of chronic diseases in NJ is directly linked to poor lifestyle choices, including a lack of physical activity, poor nutrition and the failure to have recommended screenings/immunizations. *The State of Aging and Health in America* (CDC and Merck Institute of Aging and Health, 2007) reports that older New Jerseyans have an average of 5.4 physically unhealthy days per month. Nearly 1/3 participate in no leisure-time physical activity, only 64.3% receive an annual flu shot, and 29.6 report a disability. Eighty percent of older adults have at least one chronic condition and 50% have at least two. Disparity in health status is evidenced by the 16-year difference in healthy life expectancy at birth between white females (69.6 years) and African American males (53.9 years).<sup>2</sup> In addition, there are significant racial and ethnic differences in rates of preventable hospitalizations among older adults. For example, rates for Latinos with hospitalizations for diabetes are five times higher than for whites, and both African-Americans and Latinos are three times more likely than white adults to be admitted for hypertension.<sup>3</sup>

The challenge to NJ's aging and public health networks is to foster collaboration between the public and private sectors at all levels (state, county and local) to support older adults in practicing healthy behaviors. CDSMP is critical in providing services for two populations: 1) those individuals who are unaware of the changes they can make to improve their health and quality of life, and 2) those individuals who are aware of healthy behaviors, but need assistance in identifying and adopting individual changes.

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<sup>1</sup> A Profile of New Jersey Older Adults Aged 60+ Years. Center for Health Statistics, New Jersey Department of Health and Senior Services, 2005.

<sup>2</sup> *Healthy Life Expectancy at Birth in Years, New Jersey, 1996-1998*. Center for Health Statistics, <http://nj.gov/health/chs/stats>.

<sup>3</sup> *Preventable Hospitalizations Among Seniors in New Jersey, 2002*, Yunqing Li and Katherine Hempstead, Center for Health Statistics: <http://nj.gov/health/chs/stats>.

To date, 89% of participants in NJ's CDSMP workshops reported having one or more chronic conditions (62% had 1-2 conditions, 21% had 3-4, and 6% had 5 or more chronic conditions). Five percent of participants indicated they were caregivers of someone with a chronic condition. Within the minority populations (African-Americans, Latinos and Koreans) 83% identified having one or more chronic conditions (57% had 1-2, 20% had 3-4 6% had 5 or more). Fifty percent of minority participants rated their health as poor/fair compared to 19% of all participants, while 17% of the minority population rated their health as very good/excellent, compared to 26% of all participants.

**Target Population:**

Number: Total: 950

Age 65+: 850

African-Americans: 96

Hispanics: 80

Asians: 32

**Target Populations (Systemic)**

State and local health departments

Community-based organizations

Health Care Systems

**Population with Disparate Need**

Same as target population

**Evidence-Based Guidelines**

National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

National Council on Aging

**Role Under the National Health Objective**

Supplementing Funding

**Block Grant Funds for the National Health Objective**

Annual Base Current Year: \$146,252

10-49%: Partial Source of Funding

Other Sources of Funding for Current Year: \$547,000 (includes \$192,300 from U.S. Administration on Aging grant; \$130,000 from National Council on Aging Grant; and \$225,000 from Office of Minority and Multicultural Health) Plus match of staff salaries.

**Essential Services:**

**Inform and Educate**

Impact Objective: Between January 2009 and January 2010, the DHSS and its community partners will conduct CDSMP workshops for a total of 950 older adults including 850 aged 65+, African-Americans, 80 Hispanics, and 32 Asians.

Activities

1. By January 2010, DHSS will coordinate the local delivery of a minimum of 100 CDSMP workshops.

2. By January 2010, DHSS will provide technical assistance/training to local partners to foster program delivery, including a minimum of 2 face-to-face in-service sessions and 3 conference calls.

### **Mobilize Partnerships**

Impact Objective: Between January 2009 and January 2010, DHSS will expand the infrastructure for CDSMP workshop delivery, resulting in local capacity within each of the state's 21 counties.

#### Activities

1. By March 2009, DHSS will sponsor a master training course for 26 individuals from targeted community-based organizations, including minority community-based agencies.
2. By January 2011, DHSS will oversee the training of an additional 40 local peer leaders, including those representing African-American (10), Latino (8) and Asian (6) communities.

DRAFT

**Program Title: Immunizations/Vaccine Preventable Disease Program**

**Program Goal:** Reduce and eliminate the incidence of vaccine-preventable diseases affecting children, adolescents, and older adults through immunization.

**Program Health Priority:** Increase the immunization coverage levels in children two years old and younger through vaccination; decrease the burden of vaccine preventable diseases in designated pocket-of-need areas to achieve the Healthy People 2010 goal. Increase immunization awareness throughout the state in collaboration with internal and external partners.

**Primary Strategic Partners:**

**External**

Local Health Departments  
American Academy of Pediatrics (AAP)  
American Academy of Family Practices (AAFP)  
Health Officers Association  
Hospital Association  
Social Service Agencies

**Internal**

Maternal and Child Health Consortium  
Women, Child and Infant (WIC)

**Program Evaluation Methodology:** Health grantees will be required to submit progress reports on a quarterly and annual basis. The report must contain detailed information, supporting documents and evidences of immunization activities that they have conducted during the reporting periods. The Grant Evaluator will review all of the progress reports and other materials that have been submitted in detail, and provide feed-back and advice to each grantee accordingly.

**Program Setting or Site:** The program has identified the following sites for implementation: Business, corporations or industry, child care centers, community based organizations, community health centers, local health departments, medical or clinical sites and social services referral centers.

**Program FTE Allocation: Number of FTE's is: 0**

**Program National Health Objective:**

By December 31, 2009 reduce or eliminate indigenous cases of vaccine-preventable diseases by 10 percent.

**State Health Objective:**

1. Starting January 1, 2009, increase the percentage of two year old children receiving DTaP, polio, MMR, and varicella, vaccines separately and as part of the 4-3-1-3 -3-1 series, to 90.0 percent among all children 2 years and under by December 31, 2009

**Baseline data:** 2010 Target: 90 percent- NIS: 80.5 percent

**Data Source:** National Immunization Survey 2007.

2. By December 31, 2009 increase by 5 percent the number of children under 6 years of age that participate in the New Jersey Immunization Information System to 95 percent.

**Baseline data:** 95 percent- NJIIS: 90 percent

**Data Source:** New Jersey Immunization Information System 2007

3. By December 31, 2009 reduce or eliminate indigenous cases of the following vaccine-preventable diseases in New Jersey by 5 percent.

**Baseline data:** Pertussis among children under age 7 years

2007 Baseline: 10,454 - 2010 Target: 18

28 confirmed cases of Pertussis were reported in 2007

**Data Source:** (MMWR) Summary of Notifiable Diseases, United States, 2007

### **State Health Problem:**

**Health Burden:** 64 percent fewer confirmed and probable cases of pertussis occurred in 2007, due to better reporting, increased laboratory screening, improved specimen collection, development of disease guidelines for public reference and increased surveillance that helped identify case indicators of preventive health program success. According to the 2007 National Immunization Survey (NIS), New Jersey's vaccination rates for 4-3-1-3-3-1 series is 80.5 percent. That is 9.5 percent below the HP 2010 Objective of 90 percent for all two-year olds who are age-appropriately immunized. In the urban areas, where the majority of the State's minority and medically under-served children reside, some areas still have low rates. The purpose being to assess state progress toward meeting the HP 2010 Objective of 90 percent for all of the universally recommended childhood vaccines. In NJ varicella will be a reportable disease in 2009.

Several factors continue to contribute to slowly increasing immunization rates among children such as provider practices missing opportunities to vaccinate children and societal attitudes. In the urban areas, outreach workers have reported that in addition to the above factors, parents/guardians view immunization as a low priority when compared to food, housing, and safety issues. Vaccine cost however, does not appear to be a major barrier because of the Vaccines For Children Program, first dollar vaccine coverage law, and children's medical insurance programs such as NJ FamilyCare.

**Target Population:** 9,300 hard to reach racial/ethnic minority and medically under-served children two years of age and younger are the targets of the initiative cities of Vineland, Newark, Asbury Park/Long Branch, and New Brunswick in which it is estimated that 13,211 children two years of age and younger reside. The Target population for National Health Objective other than Chapter 23 is 13,211 which includes: Hispanic and non Hispanic, African American or Black, Native Hawaiian Pacific Is, American Indian/Alaskan Native, White and Asian from 0 to under 3 years.

Target population for National Health Objective Chapter 23 is 9,300 that relates to health problems include State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance and Health Care Systems.

**Population with Disparate Need:** The Vaccine Preventable Disease Program is a collaboration between the New Jersey Department of Health and Senior Services and agencies in four urban initiative cities throughout the state. Newark, New Brunswick, Asbury Park/Long Branch, and Vineland, represent pockets of need within our State. These agencies will be directly funded by the PHHSBG to raise the immunization level of racial/ethnic minority and medically under-served children in those cities between the ages of 0 months and 2 years to 90 percent. By identifying, offering, administering and referring children to a medical home for immunization services; providing immunization education and outreach to the area's hard-to-reach population; and increasing parental awareness of the need to have their children vaccinated on time every time. Categorical funding

cannot meet the needs of these Centers for Disease Control and Prevention designated pocket-of-need areas. The agencies establish liaisons with New Jersey FamilyCare, private providers, community-based organizations, and local health departments to ensure follow-up of immunization activities. The estimated number will be 9,300, which includes: Hispanic and non Hispanic, African American or Black, Native Hawaiian Pacific Islander, American Indian/Alaskan Native, White and Asian from 0 to under 3 years covering both urban and rural, males and females in primarily low income communities in Cumberland, Essex, Middlesex and Monmouth Counties.

**Data Source:** NJ Center for Health Statistics, US Census and New Jersey Immunization Information System (NJIS).

**Evidence Based Guidelines:**

1. MMWR Recommendations and Reports (Centers for Disease Control and Preventive Services)
2. CDC Recommends: The Prevention Guidelines System (CDC).

**Role Under the National Health Objective:** Supplemental Funding. Decreasing federal immunization 317 funds and limited state COLA dollars contribute to the health objectives in the four target cities/areas. PHHSBG funds supplement our statewide efforts.

**Block Grant Funds for the National Health Objective:**

Total prior year: \$225,000

Total current year: \$225,000

Amount to disparate population: \$225,000

Amount of money to local entities for health objectives: \$225,000

Block funds, no other state health department funds for this health objective: 75-99% Primary source of funding.

**Essential Service**

**Essential Service 1 – Monitor health status**

**Impact Objective:** By September 30, 2009, 9,300 of 13,211 or 80 percent of 2 year old children will be enrolled in the immunization registry of the four community action agencies in the target cities of Newark, Vineland, Asbury Park/Long Branch, and New Brunswick and age-appropriately immunized.

**Activity Objectives:**

1. Conduct tracking and follow-up to each 2 year old child to ensure age-appropriate immunizations
2. Ensure 2 year old is enrolled in immunization registry by conducting provider practice site audits
3. Educate the communities about importance of vaccination by coordinating with local health departments, WIC, NJ Family Care and other community based organizations to improve immunization rates in the pocket of needs areas.

**Essential Service 3 – Inform and Educate and 7 – Link people to services:**

**Impact Objective:**

By September 30, 2009 conduct direct, intensive outreach efforts by increasing awareness of immunization benefits for the target population in three venues in the target areas.

**Activity Objectives:**

By March 31, 2009, establish liaisons in the four (4) urban initiative cities to support the following outreach activities:

1. Between January 1, 2009 and September 30, 2009 identify, develop, and disseminate at least two immunization and health-related materials in each of the four (4) target areas that are literally and culturally appropriate for the target population.
2. Between January 1, 2009 and September 30, 2009 identify and collaborate with at least two existing community-based organizations in each of the four (4) urban initiative cities that agree to support immunization outreach activities.
3. By April 30, 2009 develop a work plan for a major immunization initiative in each community, identifying an event that is of cultural significance to the target population.
4. By August 30, 2009, sponsor a major outreach initiative for the target population in each community that has the support and participation of community members representative of the racial/ethnic minority target group.

**Program Title:** Mercer County Traumatic Loss Coalition

**Program Goals:** Reduce the death rate of suicide in males aged 15-19 through public awareness regarding suicide prevention, education targeting aged 15-19 to 4.8 per 100,000 population for New Jersey residents.

**Program Health Priority:** Health Promotion/Education

**Program Primary Strategic Partners:**

**Internal**

- DHSS, Child and Adolescent Health
- DHSS, Maternal Child and Community Health
- DHSS, Office of Women’s Health
- DHSS, Occupational Health
- DHSS, Public Employees Occupational Safety and Health (PEOSH)
- DHSS, Center for Health Statistics

**External**

- NJ Division of Mental Health
- NJ Dept. of Children and Families
- NJ Dept. of Education
- NJ Dept. of Human Services
- Central NJ Maternal Child Consortium

**Role of the Block Grant Funds:** The role of the Block Grant in this program is to provide funds to support the Traumatic Loss Coalition of New Jersey. Funds will pay the partial salary for Manager and Administrative Assistant. Funds will also be used to provide suicide prevention education intervention for FY2009.

**Program Evaluation Methodology:** The grantee submits quarterly program reports and expenditure reports. The Program Coordinator reviews the program reports and the fiscal unit reviews the expenditure reports. The Suicide Prevention Coordinator attend meeting of the PACNJ and its Coordinating Committee. In addition the Coordinator conducts annual site visit to the grantees place of business. Combine data from health and law enforcement sources to provide a clearer picture of the circumstances surrounding injury. Specific strategies are communication campaigns aimed at the general population and specific populations at risk throughout the state.

**Program Setting or Site:**  
County Health Department

**Program FTE Allocation: 0**  
No other existing funds.

**Program National Health Objective(s):** Adolescent Suicide Attempts

**State Health Objective(s):**

Reduce the rate of suicide attempts by adolescents.

**Data Source:** New Jersey Center for Health Statistics (2002)

### **State Health Problem**

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

### **Target Population:**

Adolescents: 1, 183, 311 (NJ Center for Health Statistics, 2002)

Age: 10-19

Race/Ethnicity: African Americans or Black, American India/Alaskan Native, Asian, Hispanic, Native Hawaiian/Other Pacific Islander, White, Other

Age: 4-12 years, 12-19 years, 20-24 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

### **Disparate Population:**

Black Male Adolescents: 110,039 (NJ Center for Health Statistics, 2002)

Age-Range: 10-19

Race/Ethnicity: African American or Black

Age: 4-11 years, 12-19 years, 20-24 years

Gender: Male

Geography: Rural and Urban

Primarily Low Income: No

### **Role Under the National Health Objective:**

#### **Block Grant Funds for the National Health Objective**

Annual Base Current Year: \$70,000

Annual Base Prior Year: \$70,000

### **Essential Services:**

### **Inform and Educate**

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

Activities:

1. By November, 2008 the New Jersey Department of Health and Senior Services will provide an Adolescent Health Institute with suicide prevention presentations.
2. By April, 2009 a revised edition of “Managing Sudden Traumatic Loss in Schools” will be in print and on-line.
3. By June, 2009 finalize suicide prevention/awareness curriculum in New Jersey schools (Assembly No. 3931).
4. By December, 2009 provide two presentations to staff to Mercer County schools “When the Worst Happens: How Schools Can Traumatic Loss.”
5. By November 2008 hold ten monthly Traumatic Loss meetings.
6. By December 2009, in collaboration with the New Jersey Department of Human Services, Division of Mental Health, provide technical assistance to the Traumatic Loss Coalitions in all 21 Counties.

**Program Title:** **New Jersey State Cancer Registry (NJSCR)**

**Program Goals:** Cancer surveillance strategies are aimed at identifying all newly diagnosed cancers in New Jersey. Data from these efforts are used in cancer control efforts, to monitor trends and evaluate public health programs, to conduct research and to contribute to our understanding of cancer on local, state, regional and national levels. Special efforts are made to identify all cancer cases in a timely manner and accurately record medical and demographic data. Special quality control efforts focus on properly identifying special populations so that information can be provided for minority and under-served populations. Cancer surveillance in New Jersey covers all racial and ethnic groups in a state well recognized for its diversity. Such data provide some of the most complete information on such groups in the country. PHHSBG funding is used to supplement funding from the state, the Centers for Disease Control and Prevention (National Program for Cancer Registries - NPCR) and the National Cancer Institute (Surveillance Epidemiology and End Results).

**Program Health Priority:** Identify all newly diagnosed cancer cases in NJ to monitor trends, enhance cancer control efforts, to evaluate public health programs, to conduct research and to understand the burden of cancer on local, state, and national levels.

**Program Primary Strategic Partners:**

Internal

NJ Office of Cancer Control  
NJ Commission on Cancer Research

External

CDC, National Program of Cancer Registries  
American Cancer Society

**Role of the Block Grant Funds:** PHHSBG funds are utilized to properly identify cancers in special populations so that information can be provided for cancer control efforts specifically targeting minority and underserved populations.

**Program Evaluation Methodology:**

- Report containing incidence and mortality data for various demographic groups including minorities will be published by 12/31/2008.
- Valid follow-up will be obtained on 95% of all cases by 12/31/2008.
- Obtain gold medal certification from North American Association of Central Cancer Registries by 6/2008.
- All contractual obligations will be met with CDC and NCI in 2008.
- NJSCR staff will have participated in 3 national workgroups to improve cancer surveillance activities.
- NJSCR will provide data to Office of Cancer Control by 12/2008 for incorporation into the Comprehensive Cancer Control Plan.
- NJSCR will have participated in at least 2 research studies using registry data by 12/2008.

**Program Setting or Site:**

Community- based organizations  
Local health departments  
Senior residences or centers

**Program FTE Allocation: 1**

**Program National Health Objective(s): HO 3-1 Overall Cancer deaths**

**State Health Objective(s):** The State Health Objectives, listed below are from the document "Healthy New Jersey 2010". By the Year 2010:

Reduce the age-adjusted death rate from female breast cancer per 100,000 female population to 17.0 for all females.

Increase the percentage of female breast cancers diagnosed in early (in situ/local) stage of disease to 67% in 2005.

Reduce the age-adjusted death rate from cervical cancer per 100,000 standard population to 1.0 for all females.

Reduce the age-adjusted incidence rate of invasive cervical cancer in females per 100,000 standard population to 6.9.

Reduce the age-adjusted death rate of males from prostate cancer per 100,000 standard population to 10.0 for total males.

Reduce the age-adjusted death rate from colorectal cancer per 100,000 standard population to 10.0 for the total population.

Reduce the age-adjusted incidence rate of cancer of the rectum and recto sigmoid per 100,000 standard population to 12.3 for the total population.

Reduce the age-adjusted death rate from lung cancer per 100,000 standard population to 28.5 for the total population.

Reduce the age-adjusted incidence rate of invasive melanoma per 100,000 standard population to 17.0 for the total population. (1970 standard)

Reduce the percentage of oral cancer diagnosed in the late regional and distant stages of disease to 67.0 percent for all males and 51% for females.

**Baseline and Data Source:**

**New Jersey Cancer Mortality Rates and Counts**

	2001-2005		2005	
	Rate	Count	Rate	Count
1) Female Breast	27.8	7,263	26.9	1,438
3) Female Cervical	2.7	665	2.6	132
5) Male Prostate	26.2	4,470	23.7	837
6) Both Sexes Colorectal	20.8	9,557	18.9	1,775
8) Both Sexes Lung	50.3	22,843	48.1	4,452

Rates are per 100,000 and age-adjusted to the 2000 US Std Population standard.

New Jersey cancer mortality data were obtained through the NCI's Surveillance, Epidemiology, and End Results (SEER) Program from the National Center for Health Statistics (NCHS) and tabulated using SEER\*Stat.

Underlying mortality data provided by NCHS ([www.cdc.gov/nchs](http://www.cdc.gov/nchs)).

### New Jersey Invasive Incidence Rates and Counts

	2001-2005		2005	
	Rate	Count	Rate	Count
4) Female Invasive Cervical	9.3	2,196	8.3	396
7) Both Sexes Invasive Rectum and Recto sigmoid	16.0	7,281	15.0	1,392
9) Both Sexes Invasive Melanoma	19.9	8,989	20.6	1,900

Rates are per 100,000 and age-adjusted to the 2000 US Std Population standard.

### New Jersey Invasive Incidence Rates and Counts

9) Both Sexes Invasive Melanoma	2001-2005		2005	
	Rate	Count	Rate	Count
	16.7	8,989	17.3	1,900

Rates are per 100,000 and age-adjusted to the 1970 US Std Million standard.

### New Jersey Percent Diagnosed in Early (In situ & Local) Stage

2) Female Breast	2001-2005		2005	
	Count	%	Count	%
	27766	69.7%	5472	69.1%

### New Jersey Percent Diagnosed in Late Stage (Regional & Distant)

10) Male Oral Cavity & Pharynx Female Oral Cavity & Pharynx	2001-2005		2005	
	Count	%	Count	%
Male Oral Cavity & Pharynx	1917	67.8%	398	69.8%
Female Oral Cavity & Pharynx	791	56.9%	155	56.8%

New Jersey cancer incidence data were taken from the January 2008 analytic file of the New Jersey State Cancer Registry. All the counts and rates were tabulated using SEER\*Stat Version 6.3 (<http://www.seer.cancer.gov/seerstat/>), a statistical software package distributed by the National Cancer Institute.

### State Health Problem

**Health Burden:** New Jersey has some of the highest cancer rates in the nation with 45,000 cases diagnosed annually. Cancer surveillance strategies are aimed at identifying all newly diagnosed cancers in New Jersey. Data from these efforts are used in cancer control efforts, to monitor trends and evaluate public health programs, to conduct research and to contribute to our understanding of cancer on local, state, regional and national levels. Special efforts are made to identify all cancer cases in a timely manner and accurately record medical and demographic data. Special efforts funded by PHHSBG focus on properly identifying cancers in special populations so that information can be provided for minority and under-served populations. Without these efforts, cancers in these groups would be under counted. Cancer surveillance in New Jersey covers all racial and ethnic groups in a state well recognized for its diversity. Such data provide some of the most complete information on

such populations in the country. PHHSBG funding is used to supplement funding from the state, the Centers for Disease Control and Prevention (National Program for Cancer Registries - NPCR) and the National Cancer Institute (Surveillance Epidemiology and End Results).

New Jersey has some of the highest cancer rates in the nation with 45,000 cases diagnosed annually. Cancer surveillance strategies are aimed at identifying all newly diagnosed cancers in New Jersey. Data from these efforts are used in cancer control efforts, to monitor trends and evaluate public health programs, to conduct research and to contribute to our understanding of cancer on local, state, regional and national levels. Special efforts are made to identify all cancer cases in a timely manner and accurately record medical and demographic data. Special efforts funded by PHHSBG focus on properly identifying cancers in special populations so that information can be provided for minority and under-served populations. Without these efforts, cancers in these groups would be under counted. Cancer surveillance in New Jersey covers all racial and ethnic groups in a state well recognized for its diversity. Such data provide some of the most complete information on such populations in the country. PHHSBG funding is used to supplement funding from the state, the Centers for Disease Control and Prevention (National Program for Cancer Registries - NPCR) and the National Cancer Institute (Surveillance Epidemiology and End Results). PHHSBG funds are used specifically to cover gaps in federal funding so that we may provide customized data and reports for local cancer control efforts targeting under served populations.

**Target Population:**

Entire population of New Jersey 8,414,350 (2000 census)

**Target Populations (Systemic)**

State and local health departments  
Community-based organizations  
Health Care Systems

**Population with Disparate Need**

In New Jersey, there are about 4 million members of minority and the medically under-served populations.

**Evidence-Based Guidelines**

New Jersey Department of Health and Senior Services, North American Association of Central Cancer Registries Standards for Cancer Registries, Volume II Data Standards and Data Dictionary, Eleventh Edition, Record Layout Version 11.1.

**Role Under the National Health Objective**

Supplementing Funding

**Block Grant Funds for the National Health Objective**

Annual Base Current Year: \$120,005  
Annual Base Prior Year: \$120,005  
100% Source of Funding

## **Essential Services:**

### **Inform and Educate**

1. Impact Objective: By December 31, 2008, publish at least one report of cancer burden including Incidence and mortality for various demographic groups including minorities.
2. By December 31, 2008, increase the percentage of cancer cases with valid follow up information to 95% or higher complete.

#### Activities:

1. In June 2008, obtain certification by the North American Association of Central Cancer Registries for the New Jersey State Cancer Registry for excellence in data quality, timeliness and completeness of cancer surveillance data.
2. Meet contractual obligations to the National Cancer Institute and cooperative agreement obligations to the Centers for Disease Control and Prevention in a timely and satisfactory manner.

### **Mobilize Partnerships**

Impact Objective: Participate in national workgroups to improve cancer surveillance.

#### Activities:

By December 2008, staff will have participated in at least three (3) national workgroups to improve cancer surveillance activities.

**Program Title: New Jersey Diabetes Prevention and Control Program (DPCP)**

**Program Goal(s):** The New Jersey Diabetes Prevention and Control Program (DPCP) is committed to reducing the burden of diabetes by increasing awareness of diabetes and its care and treatment among the general population, high risk groups, people with diabetes and providers.

**Program Health Priority:** To reduce the burden of diabetes, the Department of Health and Senior Services provides PHHSBG funding to the Southern Jersey Family Medical Center (SJFMC) to conduct the Diabetes Outreach and Education System (DOES) project which is targeted to a five-county area in southern New Jersey. The goal of the DOES project is to reduce the burden of diabetes in the region by increasing awareness of diabetes and its care and treatment among the general population, high risk groups, people with diabetes and providers. This initiative is in accordance with the Essential Services of the National Health Objective.

**Program Primary Strategic Partners:**

Internal

Tobacco Program  
Breast and Cervical Cancer Program  
Obesity and Nutrition Program  
Physical Activity Program  
Maternal and Child Health Division  
NJBRFSS

External

Local/District Health Departments  
American Diabetes Association  
Centers for Disease Control  
Southern Jersey Family Medical Centers  
Federally Qualified Health Centers  
NJ Diabetes Advisory Council  
OMMH Diabetes Grantees

**Program Evaluation Methodology:** Staff will develop an evaluation plan for each program project. The evaluation will include both process and outcome measures. An evaluation timeline model will be developed and monitored using a timeline form that was developed for other chronic disease programs. The DPCP will use CDC's six step method of evaluation i.e., engage stakeholders, describe the program, focus the evaluation design gather credible evidence, justify conclusions, ensure use and lesson learned.

Specific strategies are communications campaigns aimed at the general population and specific sub-populations, community **State Program: Chronic Disease Prevention and Control National Health Objective(s): 5-5, 19-1** seventy-six (76) interventions such as follow-up on a community assessment and planning intervention (Diabetes Today), implementation of the BPHC's Diabetes Collaborative at all SJFMC clinic sites, and educational efforts targeted to consumers and providers.

Program Setting or Site: Community health center, Medical or clinical site, Community based organization, and Community based organization

**Program FTE Allocation: .5 FTE**

**STATE HEALTH OBJECTIVE(s)**

Objective Description:

Start date: 07/2008

End date: 09/2010

1. By 2010, reduce the age-adjusted death rate from cardiovascular disease in people with diabetes to 15.2 per 100,000 standard population.  
Baseline Data: 19.0 data year 1999  
Data Source: New Jersey Vital Statistics
  
2. By 2010, reduce the incidence of lower extremity amputations to 6.0 per 1,000 persons with diagnosed diabetes.  
Baseline Data: 9.0 data year 1998  
Data Source: New Jersey Hospital Discharge data
  
3. By 2010, increase the percentage of persons 18 and over with diagnosed diabetes that reported having a glycosylated hemoglobin measurement at least once a year to 90 percent. (Note: BRFSS is the data source for rates of glycosylated hemoglobin testing.  
Baseline Data: 81.2% data year 2000.  
Data Source: New Jersey BRFSS

### **State Health Problem**

**Health Burden:** Diabetes is becoming more prevalent in New Jersey. The New Jersey Behavioral Risk Factor Survey data for 2004-2006, indicate that on average about 483,000 adults in New Jersey, or 7.3% of the population, had diagnosed diabetes. Percentages were higher for men (7.8%) than for women (6.9%). Rates also increased with age, with the highest percentages of diagnosed diabetes seen in the over 65 population (17.8%).

People with diabetes in New Jersey suffer from many diabetes-related complications or conditions. In 2006, these included over 500 new case of blindness, 2,779 lower extremity amputations, and 1,473 new cases of end-stage renal disease. In 2006, there were 211,117 diabetes-related hospitalizations, 190,045 of which also had a major cardiovascular disease listed as a diagnosis. In addition, diabetes was the underlying cause of death for 2,599 New Jerseyans in 2004, ranking fifth among the leading causes of death in the state. The over-65 age group and minorities were disproportionately affected, with higher rates of diabetes-related morbidity and mortality.

#### **Target Population**

6,662,131 all races/ethnicities

Ages 1-100

State and Local Health Departments; Boards, Coalitions, Task Forces, Community Planning, Policy Makers

**Population with Disparate Need** - 885,395 – Hispanic, African American or Black, American Indian/Alaskan Native, Asian; ages 12 and older; lower income; urban and rural; specific counties: Ocean, Cape May Cumberland, Salem, and Atlantic Counties.

**Data Source:** US Census Data

### **Evidence Based Guidelines**

The interventions for this state health objective follow one or more Evidence Based Guidelines/Best Practices:

- Best Practices Initiative (U.S. Department of Health and Human Services)
- National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

**Role Under the National Health Objective - Supplemental Funding**

**Block Grant Funds for the National Health Objective - \$205,000** of which \$140,000 are allocated to disparate populations

**ESSENTIAL SERVICE(s) - Monitor health status**

**Title of Impact Objective: Update Diabetes Surveillance Report**

**Time-bound:** start date: 07/2008 end date: 06/2009

**Who will perform the objective: Research Scientist**

**What will objective do (select only one):** increase

**What unit will be measured (select only one):** percent of individuals living with diabetes and its complications.

**Describe what will be measured:** By June 30, 2009, the "Burden of Diabetes in New Jersey: A Surveillance Report" and "Diabetes-Related Inpatient Hospital utilization in New Jersey" will be updated. The reports will include demographics, prevalence, diabetes and pregnancy, mortality, morbidity, health service utilization, and diabetes self-management data.

**What is the baseline:** 0% complete

**What is the target:** 100% complete

**Title of Activity: Burden of Diabetes Report**

**Time-bound:** start date: 07/2008 date: 03/2009

**Description of Activity that helps meet the target of Impact Objective:** By March 29, 2009, the updated demographics, prevalence, and diabetes and pregnancy, and prevention chapters of the "Burden of Diabetes in New Jersey: A Surveillance Report" will be revised and posted on the Program's web page.

**ESSENTIAL SERVICE(s) Inform and Educate**

**Title of Impact Objective: Increase Awareness of Diabetes**

**Time-bound:** start date: 07/2008 end date: 09/2009

**Who will perform the objective: DOES Program**

**What will objective do (select only one):** √ increase

**What unit will be measured** (*select only one*):  $\sqrt$  percent of individuals reached through screening, referral, and materials.

**Describe what will be measured:** By September 30, 2009, increase awareness of complications of diabetes and appropriate preventive measures (e.g. foot exams, hemoglobin A1C testing, and influenza and pneumococcal immunization).

**What is the baseline** (*must match the unit indicated above*): **Data Year 2001 foot exams – 63.2, flu shots – 55.2, eye exam – 75.3, A1c – 77.7, pneumococcal – 42.4**

**What is the target** (*must match the unit indicated above*): Foot 70%, flu 70%, eye 78%, A1c 80%, Pneu 50%

#### **Title of Activity 1: Fund the DOES Project**

**Time-bound:** start date: 07/2008      end date: 07/2009

#### **Description of Activity that helps meet the target of Impact Objective:**

By July 1, 2009, continue funding of the community interventions and health communications project (DOES) in the five-county south Jersey target area.

#### **Title of Activity 2: Disseminate Diabetes, Influenza, and Pneumococcal materials.**

**Time-bound:** start date: 07/2008      end date: 03/2009

#### **Description of Activity that helps meet the target of Impact Objective:**

By March 1, 2009, the DPCP Program and the DOES project will disseminate at least 45,000 diabetes related influenza brochures and 45,000 diabetes related pneumococcal brochures (English and Spanish) to providers and persons with diabetes.

#### **Title of Activity 3: Public Media Campaign on Diabetes and Influenza**

**Time-bound:** start date: 07/2008      end date: 03/2009

#### **Description of Activity that helps meet the target of Impact Objective:**

By March 1, 2009, the DPCP Program and the DOES project will place influenza and pneumococcal public service announcements and/or news articles in at least 10 media outlets.

#### **Title of Activity 4: DOES Project will conduct 5 community outreach events.**

**Time-bound:** start date: 07/2008      end date: 06/2009

#### **Description of Activity that helps meet the target of Impact Objective:**

By June 30, 2009, the DPCP Program and DOES project will conduct five (5) community outreach events.

#### **Title of Activity 6: DOES Provider Education Forum**

**Time-bound:** start date: 07/2008      end date: 06/2009

**Description of Activity that helps meet the target of Impact Objective:** By June 30, 2009, the DPCP Program and the DOES project will conduct a provider education program focused on preventing complications in the five county south Jersey target area.

**Title of Activity 7: DOES Continuing Education Program**

**Time-bound:** start date: 07/2008 end date: 06/2008

**Description of Activity that helps meet the target of Impact Objective:** By June 30, 2009, the DPCP Program and the DOES Project will conduct outreach and continuing education sessions with 50 providers in five (5) counties.

**Title of Activity 8: DOES Screenings**

**Time-bound:** start date: 10/2008 end date: 09/2009

**Description of Activity that helps meet the target of Impact Objective:** Between October 1, 2008 and September 30, 2009, seven hundred and fifty persons screened by the DEDD program for A1C and high blood pressure, will receive information on prevention of diabetes-related complications and referrals for care.

**ESSENTIAL SERVICE(s) *Develop Policies and Plans***

**Title of Impact Objective: Develop Quality of Care Intervention**

**Time-bound:** start date: 07/2008 end date: 09/2009

**Who will perform the objective: New Jersey Diabetes Advisory Council**

**What will objective do (select only one):**  develop

**What unit will be measured (select only one):**  percent of partnerships established in the stated timeframe.

**Describe what will be measured:** By September 30, 2009, established partnerships will implement at least one-statewide intervention to improve quality of care and to prevent complications of diabetes.

**What is the baseline (must match the unit indicated above):** 0% intervention

**What is the target (must match the unit indicated above):** 100% 1 intervention

**Title of Activity 1: New Jersey Diabetes Advisory Council (NJDAC) will conduct meetings**

**Time-bound:** start date: 07/2008 end date: 06/2009

**Description of Activity that helps meet the target of Impact Objective:** By June 30, 2009, the New Jersey Diabetes Advisory Council will conduct two (2) in-persons meetings of the full Council.

**Title of Activity 2: NJDAC PIP and Strategic Plan**

**Time-bound:** start date: 07/2008 end date: 03/2009

**Description of Activity that helps meet the target of Impact Objective:** By March 28, 2009, the DPCP Program will develop a performance improvement plan and a strategic plan.

ESSENTIAL SERVICE(s) *Link People to Services*

**Title of Impact Objective:** Link Persons with Diabetes to Medications

**Time-bound:** start date: 07/2008 end date: 12/2009

**Who will perform the objective:** The Diabetes Program with consultation and advice from NJDAC

**What will objective do (select only one):**  increase

**What unit will be measured (select only one):**  percent of individuals referred with ESRD to access for medication.

**Describe what will be measured:**

By December 2009, increase the number of low income, persons with end stage renal disease who are linked to medication and nutritional sources.

**What is the baseline (must match the unit indicated above):** 0% Transatlantic Renal Council annual report 2008

**What is the target (must match the unit indicated above):** 10% increase of individuals accessing medication

**Title of Activity:** Assist people with End Stage Renal Disease

**Time-bound:** start date: 07/2008 end date: 09/2009

**Description of Activity that helps meet the target of Impact Objective:** By September 30, 2009, 1,100 low-income individuals identified as having end stage renal disease and need for a source of medications and/or nutritional supplements will receive assistance.

ESSENTIAL SERVICE(s) *Evaluate health programs*

**Title of Impact Objective:** Evaluate HP 2010 Progress

**Time-bound:** start date: 07/2008 end date: 09/2009

**Who will perform the objective:** New Jersey Center for Health Statistics

**What will objective do (select only one):**  evaluate

**What unit will be measured (select only one):**  percent of indicators met for the program.

**Describe what will be measured:** By September 30, 2009, progress toward Healthy New Jersey 2010 objectives will be measured.

**What is the baseline** (*must match the unit indicated above*): Original Baselines of each objective

**What is the target** (*must match the unit indicated above*): The percent of objectives targets met.

**Title of Activity 1: Evaluation plan of DPCP program**

**Time-bound:** start date: 07/2008 end date: 06/2009

**Description of Activity that helps meet the target of Impact Objective:** By June 30, 2009, an evaluation plan of all DPCP Program interventions will be established.

**Title of Activity 2: Evaluation of the DOES project**

**Time-bound:** start date: 07/2008 end date: 12/2009

**Description of Activity that helps meet the target of Impact Objective:** By December 2009, an evaluation of the DOES project will be complete.

**Title of Activity 3: Evaluation plan of DPCP program**

**Time-bound:** start date: 07/2008 end date: 12 /2009

**Description of Activity that helps meet the target of Impact Objective:** By December 2009, progress toward preventive services objectives (hemoglobin A1c testing) specified in Healthy New Jersey will be re-evaluated.

**PROGRAM NATIONAL HEALTH OBJECTIVE(S): HO 5-13 Annual dilated eye examinations**

**STATE HEALTH OBJECTIVE(S)**

Objective Description: Increase the percentage of persons 18 and over with diagnosed diabetes that have had a dilated eye exam within the past year.

**Start date: 07/2008 End date: 09/2010**

Baseline Data: 71.6% Year 1998 data

Data Source: New Jersey BRFSS

**State Health Problem**

**Health Burden:** Minority groups with diabetes in New Jersey had disproportionately high age adjusted rates of the disease. About 6.0% of non-Hispanic whites had a diagnosis of diabetes as compared to 11.3 % of non-Hispanic Blacks and 10.3 of Hispanics. National data suggests that the Hispanic figure probably underestimates the magnitude of diabetes among persons of that ethnicity. An additional 193,000 New Jerseyans are believed to have diabetes but are unaware that they have it. In 2004, the American Diabetes Association identified pre-diabetes as a condition of individuals with

either a fasting glucose test of greater or equal to 100 mg/dl, but less than 120 mg/dl and an oral glucose tolerance test of greater or equal to 140 mg/dl but less than 200 mg/dl. It is estimated that 40 percent of the population 40-74 years of age has pre-diabetes.

People with diabetes in New Jersey suffer from many diabetes-related complications or conditions. In 2006, these included over 500 new case of blindness, 2,779 lower extremity amputations, and 1,473 new cases of end-stage renal disease. In 2006, there were 211,117 diabetes-related hospitalizations, 190,045 of which also had a major cardiovascular disease listed as a diagnosis. In addition, diabetes was the underlying cause of death for 2,599 New Jerseyans in 2004, ranking fifth among the leading causes of death in the state. The over-65 age group and minorities were disproportionately affected, with higher rates of diabetes-related morbidity and mortality. For example, in 2003, the rate of hospital discharges with any mention of diabetes was 1072.5 per 10,000 population for persons 65 and over compared to 323.5 for persons 45-64. The age adjusted rate of end stage renal disease and diabetes per 10,000 standard population in blacks was nearly than four times that of whites. The age adjusted rate of lower extremity amputations in blacks was nearly than three times that of whites. In 2004, the age-adjusted death rate from diabetes per 100,000 standard population was 55.0 for blacks as compared to 25.0 for whites. A five county area in the southern portion of the state has among the highest percentages of at risk population sub-groups in the state. The burden of diabetes in terms of prevalence rates, morbidity rates, and mortality rates were particularly high in this region.

Target Population for National Health Objective other than Chapter 23 - 6,662,131

Target Population

6,662,131 all races/ethnicities

Ages 1-100

State and Local Health Departments; Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Population with Disparate Need - Hispanic, African American or Black, American Indian/Alaskan Native, Asian; ages 12 and older; lower income; urban and rural; specific counties: Ocean, Cape May Cumberland, Salem, and Atlantic Counties.

ESSENTIAL SERVICE(s) - Diagnose and Investigate

**Title of Impact Objective: Screen and Diagnose Diabetic Eye Disease**

**Time-bound:** start date: 07/2008 end date: 06/2009

**Who will perform the objective: New Jersey Commission of the Blind and Visually impaired**

**What will objective do (select only one):**  $\sqrt$  increase

**What unit will be measured (select only one):**  $\sqrt$  percent of individuals screened for eye exams.

**Describe what will be measured:**

By 2009, increase availability by 750 the number of screening for diabetic eye disease among low income, uninsured persons with diabetes.

**What is the baseline** (*must match the unit indicated above*): **0 data year 2000**

**What is the target** (*must match the unit indicated above*): 100% 750 individuals of low income screened

**Title of Activity: DEDD Screenings**

**Time-bound:** start date: 07/2008 end date: 03/2009

**Description of Activity that helps meet the target of Impact Objective:** By September 30, 2009, seven hundred and fifty (750) low-income, uninsured people with diabetes in need of annual eye screening services will receive dilated eye exams through the DEDD Program.

ESSENTIAL SERVICE(s) - *Inform and Educate*

**Title of Impact Objective: Increase Awareness**

**Time-bound:** start date: 07/2008 end date: 06/2009

**Who will perform the objective: Commission for the Blind and Visually Impaired**

**What will objective do** (*select only one*): √ increase

**What unit will be measured** (*select only one*): √ percent of people with diabetes screened for eye exams

**Describe what will be measured:**

By September 30, 2009, increase awareness of complications of diabetes and appropriate preventive measures (e.g. eye exams).

**What is the baseline** (*must match the unit indicated above*): **0 data year 2000**

**What is the target** (*must match the unit indicated above*): 100% of 750 people informed of prevention of complications

**Title of Activity 1: DEDD Education**

**Time-bound:** start date: 10/2008 end date: 09/2009

**Description of Activity that helps meet the target of Impact Objective:** Between October 1, 2008 and September 30, 2009, seven hundred and fifty persons screened by the DEDD program will receive information on prevention of diabetes-related complications.

**Title of Activity 2: Screen for Hypertension**

**Time-bound:** start date: 07/2008 end date: 03/2009

**Description of Activity that helps meet the target of Impact Objective:** By September 30, 2009, seven hundred and fifty persons screened by the DEDD program will be screened for hypertension.

**State Program Title: New Jersey Division on Women (DOW) Rape Care and Prevention Program**

**State Program Strategy:**

**Goal:** All PHHSBG funded Sexual Violence Programs will engage in individual and organizational capacity building and comprehensive primary prevention program planning for sexual violence.

**Priorities:** Sexual violence is a serious public health concern in the state of New Jersey. The 2003 report, “*Rape in New Jersey: A Report to the State*” by Kilpatrick and Ruggiero, estimated that 9.9% of adult women in New Jersey, or one in ten women, had been victims of ‘forcible rape’ during their lifetime. The “*New Jersey Student Health Survey of High School Students*” conducted by the NJ Department of Education in 2003 indicated that 12% of the girls and 7% of the boys had experienced sexual contact against their will. The 2007 New Jersey Uniform Crime Report indicated that 1,029 women reported rape or attempt to rape to law enforcement authorities that year. During the same reporting period, the state’s Rape Prevention and Education (RPE) funded Sexual Violence Programs provided services to 4,091 new victims of sexual assault victims; over three times the number of victims who reported to law enforcement. While definitions and timeframes differ, these data sources all suggest that sexual violence is prevalent in New Jersey.

In a committed effort to reduce sexual violence in New Jersey, the DOW Rape Care and Prevention Program, housed in the New Jersey Department of Community Affairs and in partnership with the New Jersey Department of Health and Senior Services, is proposing to conduct individual and organizational capacity building and comprehensive primary prevention program planning of sexual violence over the next several years. These efforts will seek to facilitate the shift from current prevention activities that focus on awareness/risk reduction to a primary prevention focus utilizing a social ecological approach.

**Primary Strategic Partnerships**

**Internal**

DOW Rape Care & Prevention Program  
Dept. of Community Affairs  
Dept. of Health and Senior Services  
Dept. of Law and Public Safety  
NJ Division of Criminal Justice  
NJ Division of Mental Health Services  
NJ State Police  
Dept. Of Education  
Dept. of Human Services  
Dept. of Children and Families

**External**

New Jersey Coalition Against Sexual Assault  
County Sexual Violence Programs  
Prevention Non-profits  
Local Law Enforcement  
NJ School Board Association  
Catholic Charities  
Child Assault/Abuse Prevent Non-profits  
Sexual Assault Nurse Examiner Programs  
Rutgers University

**Role of the PHHSBG Funds:** The role of the Block Grant in this program is to provide funds to assist in increasing individual and organizational capacity building and comprehensive primary prevention program planning regarding sexual violence.

**Evaluation Methodology:** All Sexual Violence Programs subgrantees are required to submit various quarterly programmatic and fiscal monitoring reports as listed below. All reports are reviewed by the DOW Rape Care and Prevention Program staff. Included with these reports are summaries of each subgrantees’ efforts to evaluate their educational presentations. Other methods of program evaluation

include site visits and technical assistance meetings and trainings. The program manager will summarize and analyze data from these reports to document progress.

**FTE's (Full Time Equivalents):** There are no full time equivalents funded with PHHS Block Grant Funds

**National Health Objective: HO 15-35 Rape or attempted rape**

**State Health Objective(s):**

No objective listed in Healthy New Jersey 2010.

**State Health Problem:**

**Health Burden:** An alarming number of women, men and children become victims of sexual violence, including rape, each year. Based on a limited definition of rape, the New Jersey Uniform Crime Report states that there were 1,029 rapes in 2007, the last year for which information is available. In contrast, New Jersey Rape Care Centers funded by PHHSBG funds provided services to 4,091 new victims age 12 and older in 2007. New Jersey receives \$206,051 for the DOW Rape Care and Prevention Program to address this issue; these funds are granted to county-based Sexual Violence Programs to impact the prevalence of sexual violence by increasing individual and organizational capacity building and comprehensive primary prevention program planning regarding sexual violence.

**Cost Burden:** According to the Journal of Interpersonal Violence (July, 2002), sexual violence is the most costly crime in the nation. Based on the Journal of Interpersonal Violence's analysis that estimates each sexual assault to cost \$110,000, this translates into \$450,010,000 for New Jersey in 2007. (4,091 new victims @ \$110,000=\$450,010,000)

Based on these findings, the tangible costs in New Jersey for 2007 were:

- \$2,045,500 for short term medical care
- \$9,818,400 for mental health services
- \$9,000,200 for lost economic productivity

Insurance administrative costs, police investigations, criminal prosecutions, costs associated with the correctional system and victims' risk reduction activities are not factored into any of these costs, thus potentially making the cost burden much higher.

Based on Journal of Interpersonal Violence's cost analysis, pain and suffering is estimated to have cost New Jersey \$104,900 in 2007. This total took into consideration the following facts:

1. Up to half of all victims suffer from at least one symptom or rape trauma syndrome
2. Rape victims are four times more likely to have an emotional breakdown than are non-victims
3. 25%-50% of sexual assault victims are likely to seek mental health services and victims often suffer from lifelong physical manifestations of sexual trauma (national Institute of Justice, Economic Costs of Sexual Assault)

**Target Population:** 8,625,920

**Race/Ethnicity:** African America or Black, American Indian, Alaskan Native, Asian, Native

Hawaiian and Other Pacific Islanders, White, Multi-Racial and Hispanic (any race)

Age: 0-4 years, 5-9 years, 10-14 years, 15-19 years, 20-24 years, 25-34 years, 35-49 years , 50-64 years, 65 years and older

Gender: Female and Male

Geography: Urban, Suburban and Rural

Primarily Low Income: No

Primary Prevention will target a universal population therefore there is no data included for disparate population.

**Evidence Based Guidelines and Best Practices:**

Nine Principles of Effective Prevention Planning (Wasserman)

Getting to Outcomes (CDC, USC, Wasserman)

Creating Safer Communities: The Underlying Theory of the Rape Prevention and Education Model of Social Change

Creating Safer Communities: Rape Prevention Education Model of Community Change

Activities Model for Primary Prevention of Sexual Violence

Annotated Bibliography for Empirical Studies including meta-analyses, qualitative studies, quantitative studies, instrument development

**Healthy Stages of Life (CDC Life Stage Goals):**

Infants and Toddlers, Children, Adolescents, Adults, Older Adults

**Healthy Places:** Communities, Homes, Schools, Institutions

**Funds Allocated and Block Grant Role in Addressing this Health Objective:**

Total Funds Allocated to Health Objective: \$206,051

Funds Allocated to Disparate Populations: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other Funds for this HO: 19-36%- Primary Source of Funding, with the average if 21.92%

**ESSENTIAL SERVICES-OBJECTIVES-ANNUAL ACTIVITIES**

**Essential Service 5 – Develop policies and plans:**

**Impact Objective 1: Develop a primary prevention planning committee**

From October 1, 2008 to September 30, 2009, each PHHSBG subgrantee will begin to develop a primary prevention planning committee to address individual county needs in the area of prevention and engage essential stakeholders.

**Annual Activities:**

**1. Perform needs assessment**

From October 1, 2008 to September 30, 2009 each PHHSBG subgrantee will work with consultants from Vera Institute to perform a needs assessment.

**2. Identify primary prevention planning committee members**

From October 1, 2008 to September 30, 2009 each PHHSBG subgrantee will select key stakeholders from their county and ask for commitment to become a part of the primary prevention planning committee.

**Essential Service 8 – Assure competent workforce:**

**Impact Objective 1: Technical assistance training to Increase Individual and Organizational Capacity Building**

From October 1, 2008 to September 30, 2009, each PHHSBG subgrantee will attend meetings to develop individual and organizational capacity building involving primary prevention.

**Annual Activities:**

**1. Attend meetings with Vera Institute Consultants**

From October 1, 2008 to September 30, 2009 each PHHSBG subgrantee will attend monthly meetings with consultants from Vera Institute who will provide individual and organizational capacity building technical assistance specific to that agency and the county where they are located.

**2. Attend regularly scheduled technical assistance training provided by the DOW Rape Care and Prevention Program**

From October 1, 2008 to September 30, 2009 each PHHSBG subgrantee will attend regularly scheduled technical assistance meetings that will address key areas to increase individual and organizational capacity building in the area of sexual violence

**Program Title: New Jersey Heart Disease and Stroke Prevention (NJHDSP) Program**

**Program Goal(s):** The New Jersey Heart Disease and Stroke Program (HDSP) is committed to reducing the burden of heart disease and stroke by increasing awareness of diabetes and its care and treatment among the general population, high risk groups, people with heart disease and stroke and providers.

**Program Health Priority:** 12-2 Knowledge of symptoms of heart attack and importance of calling 911

**Program Primary Strategic Partners:**

Internal

Obesity  
Diabetes  
Cancer Education and Early Detection (NJCEED)  
Centers for Primary Health Care  
Tobacco Control/Tobacco Dependence Treatment Program  
Emergency Medical Services  
Office of Public Infrastructure  
Certificate of Need  
Office of Women’s Health  
Office of Aging and Community Service

External

EMS  
Medicaid  
American Heart Association  
NJ Hospital Association  
NJ Health Institute  
Stroke Association  
Blue Cross Blue Shield  
Office of Primary Care  
FQHC  
Preventive Cardio Nurse

**Program Evaluation Methodology:** Staff will develop an evaluation plan for each program project. The evaluation will include both process and outcome measures. Each evaluation plan will be implemented as the work plans are also being developed. An evaluation timeline model will be developed and monitored using a timeline form that was developed for other chronic disease programs. The HDSP will use CDC’s six step method of evaluation i.e., engage stakeholders, describe the program, focus the evaluation design gather credible evidence, justify conclusions, ensure use and lesson learned. The Wellness and Prevention Control Program has staff that is experienced in the six step evaluation method. Staff has recently attended CDC’s Evaluation Institute and it is the method of choice in New Jersey’s Diabetes Prevention and Control and Asthma Education and Prevention programs.

**Program Setting or Sites:** Community health centers; Senior residence or centers; Community based organizations; homes; worksites; and, medical/clinic sites.

**Program FTE Allocation:** .5 FTE

**PROGRAM NATIONAL HEALTH OBJECTIVE(s): HO 12-2 Knowledge of symptoms of heart attack and importance of calling 911**

**STATE HEALTH OBJECTIVE(s)**

**Objective Description:** Reduce the age-adjusted death rate from coronary heart disease to 165 per 100,000 standard population.

Start date: 09/2008

End date: 09/2010

**Baseline Data: 213.7 Populations 1998 Baseline Data**

**Data Source:** New Jersey Department of Health and Senior Services, Center for Health Statistics

State Health Problem

Health Burden: Heart disease remains the leading cause of death in the United States as a whole and in New Jersey, where it accounted for over 23,000 deaths in 1998, 32.4 percent of all deaths. It is estimated that nationally one in five people has some form of cardiovascular disease including coronary heart disease. Coronary artery disease is the most common form of heart disease and remains the number one cause of death for both men and women. This type of heart disease is caused by a narrowing of the coronary arteries that supply blood to the heart.

From 1985 to 1998 the age-adjusted death rate in New Jersey from coronary heart disease fell by 43.0 percent, mirroring the decline nationally. The decrease in death rates occurred for minorities as well, although gaps still persist.

**Target Population:** 6,622,131 (all races/ethnicities ages 20 and older).

**Population with Disparate Need:** 882,768 African American or Black ages 20 years and older.

Data Source: US Census data

Evidence Based Guidelines

- Guide to Community Preventive Services (Task Force on Community Preventive Services)
- Guide to Community Preventive Services (Task Force on Community Preventive Services)
- Best Practices Initiative (U.S. Department of Health and Human Services)

Block Grant Role Under the National Health Objective: Supplemental Funding

Block Grant Funds for the National Health Objective: 89,961

ESSENTIAL SERVICE(s)

**Title of Impact Objective:** Maintain Surveillance Data Collection

**Time-bound:** start date: 10/2008      end date: TBD

**Who will perform the objective:** Research Scientist

**What will objective do** (*select only one*): ✓

**What unit will be measured** (*select only one*): ✓ percent of individuals having experienced heart disease and stroke incidence.

**Describe what will be measured:** By September 30, 2009, monitor the cardiovascular health status of New Jersey adults and create cardiovascular fact sheet.

**What is the baseline** (*must match the unit indicated above*): 0%

**What is the target** (*must match the unit indicated above*): 100% monitored and collected data and created cardiovascular fact sheet

**Title of Activity 1: Surveillance**

**Time-bound:** start date: 07/2008 end date: 01/2009

**Description of Activity that helps meet the target of Impact Objective:** By January 31, 2009, identify data needs for defining wellness and health risks of New Jersey adults.

4.4.6.1.1. **Title of Activity 2: Identify data sources New Jersey BRFSS**

**Time-bound:** start date: 07/2008 end date: 03/2009

**Description of Activity that helps meet the target of Impact Objective:** By March 31, 2009, identify sources of data to define wellness and health risk behaviors of New Jersey residents, including requesting 2005 through 2007 aggregated BRFSS data on BMI, physical activity, and nutrition, and other wellness/risk indicators, as available.

**Title of Activity 3: Develop a Plan**

**Time-bound:** start date: 07/2008 end date: 09/2009

**Description of Activity that helps meet the target of Impact Objective:** By September 30, 2009, produce a written plan for reducing wellness and health risks of New Jersey residents.

**Title of Activity 4: Increase the BRFSS Sample Size**

**Time-bound:** start date: 07/2008 end date: 012/2008

**Description of Activity that helps meet the target of Impact Objective:** By December 31, 2008, allocate funding to the Center for Health Statistics to increase the sample size and to potentially add questions to the Behavioral Risk Factor Survey (BRFSS) to collect data concerning the various chronic diseases inclusive of CVD, stroke, diabetes, asthma, etc.

ESSENTIAL SERVICE(S)

**Title of Impact Objective: Inform and Educate**

**Time-bound:** start date: 10/2008 end date: 09/2010

**Who will perform the objective: Program Staff**

**What will objective do** (*select only one*): √ increase

**What unit will be measured** (*select only one*): √ percent of partnerships established to raise awareness in affected communities.

**Describe what will be measured:** By September 2009, partnerships will be for the developed with racial/ethnic minority community-based organizations (MCBOs) in New Jersey to promote awareness of healthy lifestyles.

**What is the baseline** *(must match the unit indicated above): 0 partners*

**What is the target** *(must match the unit indicated above): 5 partners*

**Title of Activity 1: Infrastructure**

**Time-bound:** start date: 07/2008 end date: 03/2009

**Description of Activity that helps meet the target of Impact Objective:** By March 31, 2009, provide support for a coordinated wellness education program infrastructure.

**Title of Activity 2: Worksite program**

**Time-bound:** start date: 07/2008 end date: 06/2009

**Description of Activity that helps meet the target of Impact Objective:** By June 2009 collaborate with a local entity to implement a workplace wellness project.

**Title of Activity 3: Evidence based Intervention for African Americans**

**Time-bound:** start date: 07/2008 end date: 09/2009

**Description of Activity that helps meet the target of Impact Objective:** By September 30, 2009, develop and implement a strategy for science-based nutrition and physical activity health communications intervention targeted to the African American population in New Jersey.

**PROGRAM(s)**

State Program Strategy

**Program Title:** The New Jersey Heart Disease and Stroke Program (HDSP) is committed to reducing the burden of heart disease and stroke by increasing awareness of diabetes and its care and treatment among the general population, high risk groups, people with heart disease and stroke and providers.

**Program Health Priority:** 12-2 Knowledge of symptoms of heart attack and importance of calling 911

**Program Primary Strategic Partners:**

Internal

Obesity  
Diabetes  
Cancer Education and Early Detection (NJCEED)  
Centers for Primary Health Care  
Tobacco Control/Tobacco Dependence Treatment Program  
Emergency Medical Services

External

EMS  
Medicaid  
American Heart Association  
NJ Hospital Association  
NJ Health Institute  
Stroke Association

Office of Public Infrastructure  
Certificate of Need  
Office of Women's Health  
Office of Aging and Community Service

Blue Cross Blue Shield  
Office of Primary Care  
FQHC  
Preventive Cardio Nurse

**Program Evaluation Methodology:** Staff will develop an evaluation plan for each program project. The evaluation will include both process and outcome measures. Each evaluation plan will be implemented as the work plans are also being developed. An evaluation timeline model will be developed and monitored through the use of a timeline form that was developed for other chronic disease programs. The HDSP will use CDC's six step method of evaluation i.e., engage stakeholders, describe the program, focus the evaluation design gather credible evidence, justify conclusions, ensure use and lesson learned. The Wellness and Prevention Control Program has staff that is experienced in the six step evaluation method. Staff has recently attended CDC's Evaluation Institute and it is the method of choice in New Jersey's Diabetes Prevention and Control and Asthma Education and Prevention programs.

Program Setting or Sites: Senior residence or centers; Community health center; Community based organizations; Homes; Work site; and, Medical or clinical sites.

**PROGRAM NATIONAL HEALTH OBJECTIVE(s): HO 12-8 Knowledge of early warning symptoms of stroke**

**STATE HEALTH OBJECTIVE(s) (Modified)**

**Objective Description:** To strengthen prevention efforts through increased awareness and education about risk factor and lifestyle changes that affect high blood pressure, high cholesterol, diabetes, and smoking.

To utilize population-based public health approaches to increase public awareness of the urgency of addressing CVD, the signs and symptoms of heart disease and stroke, and the need to call 9-1-1.

Start date: **09/2008**      End date: *09/2010*

Baseline Data: Populations 1998 Baseline Data - Target/Preferred 2010 Endpoint

Data Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

**State Health Problem (Modified)**

Health Burden: The burden of cardiovascular disease in New Jersey has been well defined. New Jersey Behavioral Risk Factor Survey (NJBRFS) data for 2005-2007 indicate an estimated 6.3 percent of New Jersey's population 18 years of age and over, or 427,000 people, have a history of myocardial infarction (MI), angina/coronary heart disease (CHD). Also, an estimated 2.2 percent of New Jersey's population 18 years of age and over, or 148,000 people, have had a history of a stroke.

The minority residents are more likely to have heart disease and stroke. About 6.8 percent of black non-Hispanic adults (48,000 people) have a history of myocardial infarction (MI), angina/coronary heart disease (CHD). For non-Hispanic whites, the estimated percentage of adults with a history of myocardial infarction (MI), angina/coronary heart disease (CHD) is 5.8 percent or 287,000 people.

About 11,000 non-Hispanic Asian adults have a history of myocardial infarction (MI), angina/coronary heart disease (CHD), and accounting for about 5.1 percent of that population. For Hispanics, the estimated percentage of adults with a history of myocardial infarction (MI), angina/coronary heart disease (CHD) is 7.6 percent or 64,000 people. About 4.2 percent of black non-Hispanic adults (13,000 people) have a history of stroke. For non-Hispanic whites, the estimated percentage of adults with a history of stroke is 2.3 percent or 45,000 people. About 2,000 non-Hispanic Asian adults have a history of stroke, accounting for about 1 percent of that population. For Hispanics, the estimated percentage of adults with a history of stroke is 1.1 percent or 6,000 people.

Mortality data indicate that slight progress has been made in New Jersey in reducing the age-adjusted rate of heart disease and stroke. In 1999, the age-adjusted death rates for heart disease and stroke were 281.0 and 49.3 per 100,000 respectively. In 2003 the rates decreased to 255.2 for heart disease and 45.9 per 100,000 for stroke. Data indicate that there are disparities in race and ethnic populations where heart disease and stroke are listed as the leading cause of death. For deaths caused by heart disease, in New Jersey in 2003, the black population had an age-adjusted rate of 269.5 per 100,000 population compared to 237.1 for the white population and 133.4 for the Hispanic population and 102.6 for Asian and Pacific Islander. Likewise, for deaths caused by stroke, the black population had an age-adjusted rate of 62.7 per 100,000 population compared to 56.6 for the white population and 24.8 for the Hispanic population and 30.0 for Asian and Pacific Islander.

The trend indicating the increasing rates of two major risk factors, obesity and diabetes, may impact the rates of incidence and prevalence of cardiovascular disease in the future. Obesity rates, as estimated by the BRFSS, went from 9.9% of the New Jersey population in 1991 to 21.8% in 2005, a 120.0% increase in the rate of obesity. Nationally, the median obesity rate went from 12.6% to 23.9%, an increase of 96.8%. (2) National BRFSS diabetes data show that the crude rate of diagnosed diabetes in New Jersey's population 18 years and older went from 4.3% in 1991 (the first year the BRFSS was administered in New Jersey) to 7.7% in 2005; a 79.1% rate increase. Median rates of diabetes for the nation as a whole for those years were 4.8% and 7.3%, respectively; a 52.1% increase. This comparison suggests a greater increase of diabetes rates in New Jersey than in the nation as a whole.

**Target Population:** 6,542,820 (all races/ethnicities ages 20 and older)

**Population with Disparate Need:** 880,000 African American or Black ages 20 years and older.

**Data Source:** US Census data

**Evidence Based Guidelines:**

- Guide to Community Preventive Services (Task Force on Community Preventive Services)
- Guide to Community Preventive Services (Task Force on Community Preventive Services)
- Best Practices Initiative (U.S. Department of Health and Human Services)

**Block Grant Role Under the National Health Objective:** Supplemental Funding

**Block Grant Funds for the National Health Objective:** \$ 176,982

**ESSENTIAL SERVICE(s) -*Inform and Educate***

**Title of Impact Objective: Increase Awareness**

**Time-bound:** start date: 09/2008 end date: 09/2009

**Who will perform the objective: Program staff**

**What will objective do (select only one):**  increase

**What unit will be measured (select only one):**  percent of individuals that receive information about the warning signs and symptoms of heart disease and stroke.

**Describe what will be measured:** By September 30, 2009, increase the awareness of the warning signs of heart disease and stroke in both the general public and at-risk racial-ethnic minority populations.

**What is the baseline (must match the unit indicated above):** 40%

**What is the target (must match the unit indicated above):** 60%

**Title of Activity 1: Awareness Campaign**

**Time-bound:** start date: 09/2008 end date: 09/2009

**Description of Activity that helps meet the target of Impact Objective:** By September 30, 2009, sponsor public awareness campaigns to raise awareness about signs and symptoms of heart disease and stroke and the importance of calling 9-1-1 when such symptoms appear.

**State Program Title: New Jersey Nutrition, Physical Activity & Obesity Prevention Program**

**Program Goal:** To prevent and control obesity through healthful eating and physical activity

**Program Health Priority:** New Jersey has the nation's second highest obesity rate for WIC children (of those states and US territories that report this data). The prevalence of obesity among Hispanic children exceeds national rates. In addition, the 2005 New Jersey Student Health Survey, based on self reported information, indicated that about three in 10 middle- and high-school students were either overweight or at-risk of being overweight based on their calculated Body Mass Index (BMI).

In 2003-2004 academic school year, the Department of Health and Senior Services in collaboration with the Department of Education conducted a retrospective records survey to establish a baseline estimate of weight status of school-aged children. The study analyzed 2,393 sixth grade student health records from 40 randomly selected schools from varying socioeconomic strata. Results show that a total of 38% of New Jersey youth were either obese (20%) or overweight (18%).

**Program Strategic Partners:**

**Internal**

Maternal, Child and Community Health Program - Child and Adolescent Health  
Office of Public Health Infrastructure  
Office of Cancer Control and Prevention  
WIC - Fruit and Vegetable Program

**External**

Department of Agriculture  
Department of Education  
Department of Transportation

**Program Evaluation Methodology:** Community Partnership for Healthy Adolescents grantees addressing physical activity and nutrition are monitored quarterly by the Program Officer for progress toward meeting the objectives identified in their Adolescent Health Plans. Improvements to the physical activity and nutrition initiatives will be made by the incorporation of "best practices" or use of "model" programs.

**Program Setting:** Child care center, Schools or school district, Community based organization

**Program FTE Allocation 2 FTE**

**National Health Objective:** HO 19-3 Overweight or obesity in children and adolescents

**State Health Objective(s):** None applicable.

**Baseline: 1996-99 Overweight but not Obese = 36.7; Obese = 15.5**

**Data Source:** NJDHSS, Center for Health Statistics

**State Health Problem:**

**Health Burden:** Obesity is a growing, global public health crisis and New Jersey is not exempt. Physical activity and overweight/obesity are two of the 10 top leading indicators of health identified in Healthy People 2010. Excess weight is the nation's second leading cause of death, after smoking. Obesity increases blood pressure and cholesterol levels placing children at risk for early heart disease. Excess body fat increases resistance to insulin causing Type II diabetes in children. Other physical health problems may include asthma, sleep apnea, menstrual abnormalities, orthopedic problems and risk for certain cancers. In addition to physical health problems, there are emotional and social consequences including depression, suicide ideation, bullying, discrimination and poorer academic performance.

Since eating and exercise habits established in childhood and adolescence influence life-long patterns of behavior, the problem of childhood overweight is known to persist into adulthood. The 2006 New Jersey Behavior Risk Factor Surveillance System (BRFSS) reported 59.9% for combined rates of obese and overweight in adults. Thus, early intervention is needed so that obese children do not become obese adults which ultimately impacts the quality of their adult life.

**Cost Burden:** The US Department of Health and Human Services estimates that 20% of children and youth in the United States will be obese by 2010. According to one estimate, insured children treated for obesity are approximately three times more expensive than the insured child without obesity, costing the US approximately \$750 million per year. For adults in 2003, obesity-related health conditions cost the nation \$75 billion a year in medical expenses, with taxpayers paying half those costs through the Medicare and Medicaid programs. New Jersey's share of the national total was estimated to be \$2.3 billion.

**Target Population:**

Ethnicity/Race: All

Gender: Female and Male

Age: Toddlers, Children, Adolescents, Adults

**Disparate Population:**

Ethnicity/Race: All

Gender: Female and Male

Age: Toddlers and Children

Geography: Rural and urban

Income: Primarily Low

Location: Statewide

WIC PedNSS 2006 Data; NJDHSS Center for Health Statistics

**Evidence Based Guidelines: MMWR Recommendations**

Guidelines for School Health Programs to Promote Lifelong Healthy Eating

[www.cdc.gov/mmwr/preview/mmwrhtml/00042446.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/00042446.htm) or

[www.cdc.gov/nccdphp/dash/publications/index.htm#guidelines](http://www.cdc.gov/nccdphp/dash/publications/index.htm#guidelines)

Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health (DASH) [www.cdc.gov/nccdphp/dash/index.htm](http://www.cdc.gov/nccdphp/dash/index.htm)

Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young

People

[www.cdc.gov/mmwr/preview/mmwrhtml/00046823.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/00046823.htm) or  
[www.cdc.gov/nccdphp/dash/publications/index.htm#guidelines](http://www.cdc.gov/nccdphp/dash/publications/index.htm#guidelines)

Promoting Physical Activity: A Guide for Community Action  
[www.cdc.gov/nccdphp/dnpa/pahand.htm](http://www.cdc.gov/nccdphp/dnpa/pahand.htm)

Effective Population Level Strategies to Promote Physical Activity  
[www.cdc.gov/nccdphp/dnpa/physical/recommendations.htm](http://www.cdc.gov/nccdphp/dnpa/physical/recommendations.htm)

Promoting Better Health for Young People Through Physical Activity and Sports  
[www.cdc.gov/nccdphp/dash/physicalactivity/promoting\\_health/index.htm](http://www.cdc.gov/nccdphp/dash/physicalactivity/promoting_health/index.htm)

Physical Activity Guidelines – October 7, 2008  
[www.health.gov/paguidelines](http://www.health.gov/paguidelines)

USDA, The Power of Choice - Helping Youth Make Healthy Eating and Fitness Decisions - A Leader's Guide (ages 11-13) [www.fns.usda.gov](http://www.fns.usda.gov)

USDA, Changing the Scene: Improving the School Nutrition Environment  
[www.fns.usda.gov/tn/healthy/index.htm](http://www.fns.usda.gov/tn/healthy/index.htm)

NAPSACC Nutrition and Physical Activity for Child Care, [www.napsacc.org](http://www.napsacc.org)

### **Role Under the National Health Objective**

Role of Block Grant Dollars: Supplemental Funding

Annual Basic Current Year: \$198,353

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Block Funds Vs. Other State Department Funds for this HO: 50%

### **ESSENTIAL SERVICES- OBJECTIVES-ANNUAL ACTIVITIES**

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are Evidence-based and Best Practices.

Monitor Health Status

Inform and Educate

Mobilize Partnerships

Develop policies and plans

### **Essential Service 1 - Monitor health status**

**Impact Objective:** By September 2009, the ONF will monitor the change in BMI and other NPA self-reported behaviors by students.

**Annual Activity Objective:** By March 2009, the ONF will have reviewed and identified appropriate nutrition and physical activity questions for use in the 2009 Student Health Survey (SHS).

### **Essential Service 3 - Inform and Educate**

**Impact Objective:** By September 2010, increase the number of policies that encompass environmental change that supports physically active and healthy communities and NJ public schools.

#### **Annual Activities:**

1. By May 2009 collaborate with the NJ Council on Physical Fitness and Sports to offer state-wide Healthy Community Development trainings for communities aimed at increasing physical activity opportunities.
2. By January 2010, collaborate with DOE CSHP to develop new initiatives aimed at decreasing obesity (i.e. pedometer projects, gardening, library and chefs in the classroom programs).
3. By September 2009, collaborate with DOE CSH to conduct trainings on the School Health Index to assist schools in assessing current school policies and practices in 8 areas of health.

### **Essential Service 4 - Mobilize partnerships:**

**Impact Objective:** Annually, provide oversight of the Community Partnership for Healthy Adolescents grantees in three New Jersey communities that have identified nutrition and physical activity as a priority adolescent health issue to address.

**Annual Activity:** By July 2009, monitor reports for three Community Partnership for Healthy Adolescents grantees.

**Impact Objective:** By October 2009, collaborate with DOE CSHP BMI workgroup to determine the feasibility of collecting and tracking height and weight measurements of NJ school aged youth.

#### **Annual Activities:**

1. By January 2009, convene the BMI workgroup.
2. By June 2009, reach consensus on ht/weight collection in schools.
3. By September 2009, secure the necessary approval if plan is determined to be feasible.

### **Essential Service 5 – Develop policies and plans**

**Impact Objective:** By September 2009, print and disseminate the revised NJ Obesity Action.

**Annual Activity:** By July 2009, revise the NJ Obesity Action Plan to meet CDC State Obesity Plan index criteria.

**State Program Title: Public Health Workforce Development**

**Program Goals:** To strengthen New Jersey's local public health system and improve the performance and practice of local health departments. This is accomplished by:

- Licensing Health Officers and Registered Environmental Health Specialists.
- Promoting the efficiency and effectiveness of local health departments through consultation and technical assistance.
- Developing the core competencies and capabilities of the public health workforce through credentialing, accreditation and promotion of training and continuing education opportunities.
- Administering Public Health Priority Funding and other grant funding to eligible local health agencies to support the provision of priority health services and the core functions of public health.
- Researching scientifically-based best practices in public health.

**Program Health Priority:** Increase from 75 percent to 90 percent the number of local health department staff and local boards of health members who have participated in competency-building training by the end of 2009.

**Program Primary Strategic Partners:**

**Internal:** Health Infrastructure Preparedness and Emergency Response  
Infrastructure Preparedness and Emergency Response Policy

**External:** NJ Health Officer's Association  
NJ Environmental Health Association  
Rutgers University, Cook College

**Program Evaluation Methodology:** Adoption of revised licensing rules, *N.J.A.C. 8:7*; review of the NJLMN database for course completion by members of the public health workforce; update curriculum for the *Environment and Public Health* course; issue a summary report of the REHS and HO licensing examinations including any revisions deemed necessary.

**Program Setting:** Local and county health departments.

**Program FTE Allocation: 6 FTE**

**Program National Health Objectives:** HO 23-8 Increase the proportion of Federal, Tribal, State, and local health agencies that incorporate specific competencies in the essential public health services into personnel systems.

**State Health Objective:**

1. By June 2009 draft new rules at *N.J.A.C. 8:7, Licensure of Persons for Public Health Positions*, which will serve as the administrative core to the Department's public health workforce agenda.
2. Increase the marketing and use of New Jersey's Learning Management Network (NJLMN) from a baseline estimate of 80 percent to 95 percent by the end of 2009.
3. Increase from 80 percent to 95 percent the number of local health department staff and local boards of health members who have participated in competency-building training by the end of 2009.
4. Pursuant to the provisions of *N.J.A.C. 8:7, Licensure of Persons for Public Health Positions*, by February 2009, review continuing education credits and, if appropriate and adequate, issue license

renewals for Health Officers and Registered Environmental Health Specialists and update licensing databases.

5. Collaborate with and provide technical support to Cook College, Office of Continuing Professional Education in updating the Environment and Public Health (EPH) course. This course serves as one means of entrée to sit for the Registered Environmental Health Specialist (REHS) examination. Curricula will be updated as dictated by public health policy and rules and by the changing landscape of public health issues in time for the start of the next session which begins in June 2009.
6. Begin a review of the licensing examination which is used for Registered Environmental Health Specialists (REHS). The examination is given three times per year and the questions must be updated to reflect the current state of the art and state of the science. Review and revisions will be completed by October 2009.
7. Begin a review of the licensing examination which is used for Health Officer (HO). The examination is given three times per year and the questions must be updated to reflect the current state of the art and state of the science. Review and revisions will be completed by October 2009.

### **State Health Burden**

**Health Burden:** New Jersey has 111 local health departments that provide services to more than eight million people. A survey conducted by the Department demonstrated that there are great inconsistencies in the depth and breadth of skills, expertise, and competence among public health professionals employed in the local government public health system. Policy-making local boards of health members do not have a broad enough understanding of the local public health system to assure decision-making which positively impacts health outcomes.

**Target Population:** State and Local Health Departments

### **Block Grant Funds for the National Health Objective:**

Total Funds Allocated to Health Objective: \$ 804,759

Funds Allocated to Disparate Populations: \$ 0

Role of Block Grant Dollars: Program staff salaries

Per cent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% Funding

### **Essential Health Services:**

3. Inform and Educate
5. Develop Plans and Policies
6. Enforce Laws and Regulations
8. Assure Competent Workforce

**Impact Objectives:** By December 2009, increase the percentage of local health departments that satisfy staff expertise/competencies as defined in Department public health performance standards from 75.0 to 90.0 percent.

**Program Goals:** To strengthen New Jersey's local public health system and improve the performance and practice of local health departments. This is accomplished by:

- Providing a legal framework for the operation of local public health agencies through the *Public Health Practice Standards of Performance for Local Boards of Health in New Jersey* (N.J.A.C 8:52).
- Evaluating the performance of local health departments and regional systems to assure the provision of quality public health services and programs in accordance with the *Public Health Practice Standards*.
- Promoting the efficiency and effectiveness of local health departments through consultation and technical assistance.
- Supporting regional public health systems that promote collaboration and coordination among local public health departments and other community partners.
- Administering Public Health Priority Funding and other grant funding to eligible local health agencies to support the provision of priority health services and the core functions of public health.
- Responding to the public's interest and need for information about the responsibilities of, and services available from, local health departments in New Jersey.
- Researching scientifically-based best practices in public health

**Program Health Priority:** By September 30, 2009, increase the percentage of local health departments performing core public health functions, *i.e.*, assessment, policy development, and assurance to 85 per cent.

**Program Primary Strategic Partners:**

**Internal:** Health Infrastructure Preparedness and Emergency Response  
Infrastructure Preparedness and Emergency Response Policy

**External:** NJ Health Officer's Association  
NJ County Health Officer's Association  
NJ Local Boards of Health Association  
Governmental Public Health Partnerships  
Community Public Health Partnerships  
Local Boards of Health

**Program Evaluation Methodology:** On-site performance evaluation of local health agencies; intake, review, and processing of Public Health Priority Funding applications; review attendance records and minutes from meetings of public health collaborative efforts; revision and readoption of *Practice Standards*.

**Program Setting:** Local and county health departments.

**Program National Health Objectives:** HO 23-11 Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

**State Health Objective:**

1. By September 2009 increase site visits to evaluate performance in the three essential public health service areas and provide technical assistance to local health departments and to Governmental Public Health Partnerships from 60 percent to 100 percent.
2. By September 2009, increase the percentage of local health departments that have participated in the development of a county-wide plan to address chronic disease prevention and improved access

to care, as identified in twenty-one county-wide community health improvement plans (CHIP), from 86 to 100 percent.

3. By September 2009 increase the number of CHIP Action Teams across the State which have obtained resources to support and sustain their work in preventing chronic diseases and improving access to care from 00.0 percent to 35.0 percent.
4. By September 2009 evaluate the performance standards for local health department in New Jersey against the national standards for the accreditation of local health departments.
5. By January 2009, distribute over \$2.4 million to local health departments in the form of Public Health Priority Funding. These funds are used to build public health infrastructure through organization capacity assessment and development. These funds also support local health department responsibilities for communicable disease control, chronic disease prevention, access to care, environmental health, maternal and child health, adult health services, and administration.

### **State Health Burden**

**Health Burden:** New Jersey has 111 local health departments that provide services to more than eight million people. Inconsistencies in the capacity of the local government public health system to meet national performance standards continue to exist, although not as dramatically as in previous years. The development of partnerships between local health departments (Governmental Public Health Partnerships) and broader health partnerships (Community Public Health Partnerships) in every county for the purpose of assuring improved health outcomes, with a special emphasis on preventing chronic disease and improving access to care, are important developments in meeting national performance standards and accelerating our ability to improve population health. These initiatives require the support and attention of the Department to ensure their sustainability and success.

**Target Population:** State and Local Health Departments

### **Essential Health Services:**

3. Inform and Educate
5. Develop Plans and Policies
6. Enforce Laws and Regulations
7. Assure Competent Workforce

### **Impact Objectives:**

1. By September 2009, increase site visits to evaluate performance in the three essential public health service areas and provide technical assistance to local health departments and to Governmental Public Health Partnerships from 60 percent to 100 percent.
2. By September 2009, increase the percentage of local health departments that have participated in the development of a county-wide plan to address chronic disease prevention and improved access to care, as identified in twenty-one county-wide community health improvement plans (CHIP), from 86 to 100 percent.
3. By September 2009, increase the number of CHIP Action Teams across the State which have obtained resources to support and sustain their work in preventing chronic diseases and improving access to care from 00.0 percent to 35.0 percent.
4. By September 2009, evaluate the performance standards for local health department in New Jersey against the national standards for the accreditation of local health departments.

5. By January 2009, distribute over \$2.4 million to local health departments in the form of Public Health Priority Funding. These funds are used to build public health infrastructure through organization capacity assessment and development. These funds also support local health department responsibilities for communicable disease control, chronic disease prevention, access to care, environmental health, maternal and child health, adult health services, and administration.

DRAFT

**State Program Title: Quality Emergency Medical Services Care**

**State Program Strategy:**

**Goal:** To reduce mortality and morbidity for those individuals cared for by the EMS system, who fall victim to injuries or suffer from chronic or acute illness.

**Quality Emergency Medical Services Care (HO-1-11):** \$476,164 of this total will be utilized by the Office of Emergency Medical Services (OEMS) to strengthen the quality of prehospital EMS providers through basic and continuing medical education, and to define operating guidelines and minimum standards for all prehospital agencies, personnel, and vehicles.

**Program Health Priorities:** When primary and secondary prevention efforts fail and people become victims of illness or injury, they enter the state's EMS system. EMS is defined as services used in responding to an individual's perceived need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury.

It is estimated that New Jersey's population in 2005 was 8,703,150. It is also estimated that the state's EMS system responds to over 800,000 requests annually. In 2005, the advanced life support (ALS) component of the state's EMS system responded to over 388,000 requests for assistance and rendered care for 163,944 patients. Of these patients, over 39,000 patients were treated for heart ailments and 37,939 were treated for respiratory distress.

Maintaining evidence-based treatment guidelines, including minimum staffing, equipment criteria, and the use of nationally recognized data elements for patient medical records is essential in helping to ensure quality prehospital care for every patient encounter.

**Primary Strategic Partners:**

**Internal**

Health Infrastructure Preparedness and Emergency Response  
Center for Health Statistics  
Center for Injury Surveillance and Prevention  
Family Health Services  
Public Occupational Safety and Health

**External**

NJ EMS Council  
NJ Air Medical Council  
NJ EMS for Children Advisory Council  
NJ Poison Information and Education System (NJPIES)  
NJ Department of Education  
NJ Department of Children and Families  
NJ Department of Law and Public Safety (Office of Homeland Security and Preparedness, NJ State Police – Office of Emergency Management)  
Brain Injury Council  
Spinal Cord Injury Council  
NJ Trauma Center Council

**Role of PHHSBG Funds:** The role of the Block Grant in this program is to provide funds to support four (4) staff positions in the Office of Emergency Medical Services (Education Section and Regulatory Officer).

**Evaluation Methodology:** Basic and continuing education programs for Emergency Medical Technician-Basics are required to be submitted to the Office of Emergency Medical Services for review and approval. All programs approved are posted on a web-based learning management system, and are available to all prospective and current EMS personnel. Staff from OEMS will conduct unannounced site visits to monitor the quality of the educational programs offered by nearly 1,000 agencies and/or instructors across the state. Peer review of educational programs in conjunction with published regulations provides a framework for objective monitoring by OEMS staff. Operational regulations which include minimum staffing and equipment, as well as clinical treatment protocols are maintained by OEMS in accordance with nationally recognized, evidence based standards of care.

**Program Setting:** State Health Department

**FTE's (Full Time Equivalents):** 4 FTE

**National Health Objective:** HO 1-11 Emergency Medical

**State Health Objective:**

There are no specific EMS-related objectives in Healthy New Jersey 2010.

**Baseline:** 8,703,150 state population

**Data Source:** NJ Department of Health and Senior Services – Center for Health Statistics

**State Health Problem**

**Health Burden:** When primary and secondary prevention efforts fail, and people become victims of illness, intentional or unintentional injury, they enter the state's emergency medical services (EMS) system. EMS responds to all requests for prehospital medical assistance, including trauma, cardiac and medical emergencies, which can affect persons of all age groups and socio-economic status. A properly organized EMS system contains many components working in a coordinated manner.

The prevalence of chronic illness in ethnic and low socioeconomic populations as well as those at either extreme of the life cycle has been well documented from a national perspective. A New Jersey's population ages, the requests for medical assistance will only increase. The Emergency Department, which serviced 3,370,670 patients in 2007, and the EMS system remain as the safety net for the entire healthcare system.

It is also estimated that the state's EMS system responds to over 800,000 requests annually. In 2005, the advanced life support (ALS) component of the state's EMS system responded to over 388,000 requests for assistance and rendered care for 163,944 patients. Of these patients, over 39,000 patients were treated for heart ailments and 37,939 were treated for respiratory distress.

**Cost Burden:** As with most public health programs, it is difficult to qualify the cost savings to each patient cared for by the EMS system. Intuitively, we expect that a patient who receives pre-hospital care spends less time as hospital patient, however, data supported evidence is absent. EMS providers often take advantage of a "teachable moment" when in someone's home and we speak to the

importance of making safety changes (i.e. removal of scatter rugs), or maintaining a prescribed regiment for medication administration. The proper immobilization of the injured spine of a motor vehicle crash victim can make the difference between resumption of normal daily activities and a permanent disability.

**Target Population:**

Number: 8,703,150  
Race/Ethnicity: Hispanic and Non-Hispanic  
Age: Under 1 year through and including 65 years and older  
Gender: Male and Female  
Geography: Urban  
Primarily Low Income: No  
Location: State of New Jersey

**Disparate Population:** In so much as injury and illness holds no special regard for race, ethnicity, age, gender or income level there is no disparate population being served. EMS responds to requests from residents and visitors to New Jersey alike. Target and Disparate Data Sources: NJ DHSS, Center for Health Statistics

**Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**

Emergency Medical Services Education Agenda for the Future (National Highway Traffic Safety Administration, Department of Transportation)

**Healthy Stages of Life (CDC Life Stage Goals):** Infants through and including older adults

**Healthy Places:** Communities

**Funds Allocated and Block Grant Role in Addressing this Health Objective:**

Total Funds Allocated to Health Objective \$398,682  
Funds Allocated to Disparate Populations: \$0  
Role of Block Grant Dollars: Supplemental Funding  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Primary source of funding

**ESSENTIAL SERVICES –OBJECTIVES-ANNUAL ACTIVITIES**

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

**Essential Service 3 – Inform and Educate**

**Impact Objective 1**

**Increase the number of qualified prehospital providers**

Between 10/2008 and 09/2009, OEMS will increase the number of EMT-B instructors by 5% over the 2008 instructional cadre.

**Annual Activities:**

**Increase the number of qualified prehospital providers**

1. Between 11/2008 and 04/2009, OEMS will conduct a multi-day instructor training institute for prospective EMT-B instructors.
2. Between 12/2008 and 02/2009, OEMS will evaluate the hybrid distance learning/traditional EMT-Basic program conducted by Camden County College, for promotion statewide
3. Between 01/2009 and 07/2009, OEMS will institute a streamlined, web-based process to facilitate the recertification of current EMT-B personnel.
4. Between 11/2008 and 12/2008, OEMS will develop an objective audit process for both EMT-B basic and continuing education programs.
5. Between 01/2009 and 08/2009, OEMS will conduct on-site audits of 10% of all EMT-B basic and continuing education programs.

### **Impact Objective 2**

Between 11/2008 and 04/2009, the DHSS will adopt a comprehensive set of certification and operational regulations to reflect current national clinical practices for the NJ EMS system.

### **Annual Activities**

#### **Adopt comprehensive certification and operational regulations for the EMS system.**

1. Between 11/2008 and 12/2008, OEMS to complete the responses received during the open public comment period on the proposed certification and recertification regulations.
2. Between 01/2009 and 02/2009, OEMS to prepare the revised certification and recertification regulations for adoption.
3. Between 03/2009 and 06/2009, OEMS to prepared the amended operational regulations for publication as a proposal.
4. Between 06/2009 and 09/2009, OEMS to receive written comments in response to the open public comment period on the proposed operational regulations.