

Annual Report 2006

Family Health Services



Jon S. Corzine
Governor



Fred M. Jacobs, M.D., J.D.
Commissioner

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New Jersey Department of Health and
Senior Services

Division of Family Health Services

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Introduction

The Division of Family Health Services, within the Public Health Services Branch of the New Jersey Department of Health and Senior Services works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. The Division of Family Health Services encompasses a broad range of programs and services that focus on the health and well-being of families and communities in New Jersey. Our goal is to promote and protect the health of individuals throughout the life span, from the prenatal period, to mothers and newborns, infants, children and adolescents, to adult women and men, and even to seniors. Ultimately we work to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

We accomplish this by administering funding for and overseeing a wide variety of family centered, culturally competent programs and initiatives in the community, including preventive and primary care services. A description of the Division's programs and services and 2006 accomplishments follows. The organizational structure of the Division is discussed separately and should not be confused with the continuum of programs and services that are described in this report based on the primary population served.

The Division also oversees and administers a number of task forces, boards and councils, which fulfill legislative intent and mandate.

The Division of Family Health Services is supported by State and federal funding. The combination of funds supports population based public health surveillance, public health screening and early detection programs, enabling programs to support high risk or special needs families, and direct services to specific populations. The Division administers over 500 health service grants or letters of agreement with community based agencies to provide this array of public health services.

State Funding – \$158,893,000

Federal Funding – \$140,670,000

Federal funding is provided through over twenty grants to the Department/Division including but not limited to:

U.S. Department of Agriculture (USDA)

- ❖ Breastfeeding Peer Counseling;



- ❖ Farmers Market;
- ❖ Senior Farmers Market; and
- ❖ Women, Infants and Children Special Supplemental Nutrition Program (WIC).

U.S. Department of Health and Human Services

- ❖ Abstinence Education (AFC);
- ❖ Asthma (CDC);
- ❖ Birth Defect Surveillance (CDC);
- ❖ Breast and Cervical Cancer Initiative (CDC);
- ❖ Childhood Lead Poisoning Prevention (CDC);
- ❖ Diabetes (CDC);
- ❖ Early Childhood Comprehensive System (HRSA);
- ❖ Early Hearing Identification and Detection (CDC);
- ❖ Healthy Start – Eliminating Disparities in Perinatal Health (HRSA);
- ❖ Maternal and Child Health Block Grant (HRSA);
- ❖ Newborn Hearing (HRSA);
- ❖ Pregnancy Risk Assessment Monitoring System (CDC);
- ❖ Preventive Health and Health Services Block Grant (CDC);
- ❖ Primary Care Cooperative Agreement (HRSA);
- ❖ Ryan White Title IV (HRSA);
- ❖ State Office of Rural Health (HRSA);
- ❖ State Systems Development Grant (HRSA); and
- ❖ Title X – Family Planning (OPA).

AFC – Agency for Children and Families

CDC – Centers for Disease Control and Prevention

HRSA - Health Resources and Services Administration

OPA – Office of Population Affairs

U.S. Department of Education

- ❖ Early Intervention Part C of IDEA.

The Division of Family Health Services is comprised of four major service units, and four offices.

The service units are:

- ❖ Chronic Disease Prevention and Control (CDPC);
- ❖ Maternal, Child and Community Health (MCCH);
- ❖ Special Child Health and Early Intervention Services (SCH-EIS); and
- ❖ Women, Infants and Children (WIC).

The offices are:

- ❖ Office of the Medical Director, Maternal and Child Health Epidemiology;
- ❖ Office of Primary Health Care;
- ❖ Office of Procedural Safeguards for Early Intervention; and
- ❖ Office of Women's Health.

Chronic Disease Prevention and Control (CDPC)

This unit provides support for outreach, education, preventive services including screening for early detection for people with or at risk for cancer, diabetes, asthma, and other chronic diseases.

Maternal, Child and Community Health (MCCH)

This unit supports programs and services to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low income and special populations. Family planning, prenatal care, and perinatal risk reduction services for women and their partners, to children and adolescent programs that focus on preventive initiatives in the areas of asthma, child care, early childhood systems development, lead poisoning, immunization, injury prevention, oral health, nutrition and physical fitness and teen pregnancy prevention are all part of the MCCH effort.

Special Child Health and Early Intervention Services (SCH-EIS)

This unit supports programs and services to ensure that children with special health needs and their families have access to comprehensive, community-based, culturally competent and family-centered care. SCH-

EIS works with parent groups, specialty medical, educational, and social service providers and a statewide network of case managers to provide coordinated care for children with special health care needs and facilitate the development of community-based services for such children and their families.

Women, Infants and Children (WIC)

This unit provides eligible participants with nutrition assessment and education, supplemental foods, breastfeeding education and support, referrals to healthcare, immunization screening and other support services. The program also serves as a gateway to preventive health during critical times of growth and development in order to prevent health problems and improve health status of vulnerable populations.

Office of the Medical Director, Maternal and Child Health Epidemiology (MCH – EPI)

This unit promotes the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and facilitates efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and execution of applied research projects.

Office of Primary Health Care (OPC)

This Office strives to increase access to quality comprehensive preventive and primary health care for the State's underserved and uninsured population. Through support of community health centers and recruitment and retention of health professionals, the unit seeks to improve the health status of New Jerseyans, to decrease health disparities among sub-groups of the population being served and to decrease reliance on hospital emergency department services for non-emergent conditions.

Office of Procedural Safeguards for the Early Intervention System

This Office ensures the resolution of disputes within New Jersey's Early Intervention System, providing families due process in accordance with the provisions of Part C of the federal Individuals with Disabilities Education Act.

Office of Women's Health

This Office was established through legislation (P.L. 2001, Chapter 376) and signed into law on January 8,

Organization

2002, and serves as an information and resource center for women's health information and data, and advocates for the implementation of effective strategies to improve women's health. The Office coordinates efforts with other state departments whose services impact in this area, as well as non-governmental providers and community organizations.

Resource and Referral Information – The Family Health Line

The Family Health Line operates a 24/7 toll-free 1-800-328-3838 number for New Jersey residents providing resource and referral information on services for women, infants, children, adolescents and adults with chronic disease.

In State Fiscal Year (SFY) 2006, the Family Health Line responded to 11,571 calls and made 14,427 referrals. Of the total referrals made, 3,636 were Women, Infants and Children (WIC), 967 were Postpartum Depression (PPD), and 623 were Federally Qualified Health Centers (FQHC) referrals.

As of July 1, 2006, the Family Health Line has received a total of 1,392 Postpartum Depression (PPD) related calls of which 1,015 were referred to UMDNJ University Behavioral HealthCare (UBHC) for screening, assessment and treatment. The remaining 377 callers received PPD education information.



Major Boards and Councils within the Division

Major Boards and Councils within the Division of Family Health Services

Advisory Council on Adolescent Pregnancy

There are more than 7,000 births to teens in New Jersey each year. Teenage childbearing has ramifications not only for the teen mother and her child, but also for our society. P.L. 1997, Chapter 229, established the Council as a permanent body to coordinate and improve services of state and local government, private and voluntary agencies, community organizations, and schools which seek to serve adolescents at high risk of pregnancy, pregnant adolescents, adolescent parents, and their families.

Newborn Screening Advisory Panel

Advances in screening technologies coupled with public advocacy and demand for expanded newborn screening led the Commissioner of Health and Senior Services to convene this Panel. The Panel assessed the appropriateness of mandating screening for additional disorders. As a result of the Panel's recommendations, New Jersey moved from screening for four biochemical disorders to 20 by SFY 2004. The Panel meets at least annually to review current practice and make recommendations for improving New Jersey's newborn screening program.

New Jersey Council on Physical Fitness and Sports

In 1999, legislation was enacted to create the New Jersey Council on Physical Fitness and Sports (N.J.S.A. 26:1A-37.5 et seq.). The Council aims to improve the health and fitness of New Jersey's citizens by:

- ❖ Providing and supporting quality educational opportunities;
- ❖ Disseminating accurate information about health, fitness, recreation and sports;
- ❖ Facilitating and reporting on relevant research initiatives; and
- ❖ Advocating for health enhancing policies and legislation.

New Jersey WIC Advisory Council

The WIC Advisory Council is appointed by the Commissioner of Health and Senior Services. The

Council brings together representatives from statewide organizations and constituencies that have an interest in the nutritional status of mothers and children to collaborate and advise New Jersey WIC Services to promote the delivery of quality services to WIC clients. During the past year the Council has focused attention on strategic partnerships and outreach.

New Jersey Cancer Education and Early Detection (NJCEED) Statewide Coalition

The New Jersey Cancer Education and Early Detection (NJCEED) Statewide Coalition is an advisory body to the NJCEED Program and consists of approximately 150 stakeholders. There are six subcommittees: Medical Advisory, Public and Professional Education, Legislative, Advocacy, and Surveillance.



New Jersey Diabetes Council

The New Jersey Diabetes Council is an advisory body to the Department of Health and Senior Services' Diabetes Prevention and Control Program. The Council has over 100 members and meets on a semi-annual basis. The membership is composed of professionals and consumers from around the state with a keen interest in diabetes and the people that it affects. A Coordinating Committee, which meets at least quarterly, is the governing body of the Council. The Council's ten task forces address issues such as clinical practices, primary prevention, surveillance, quality improvement, etc. The Council is currently developing a strategic plan for diabetes in New Jersey.

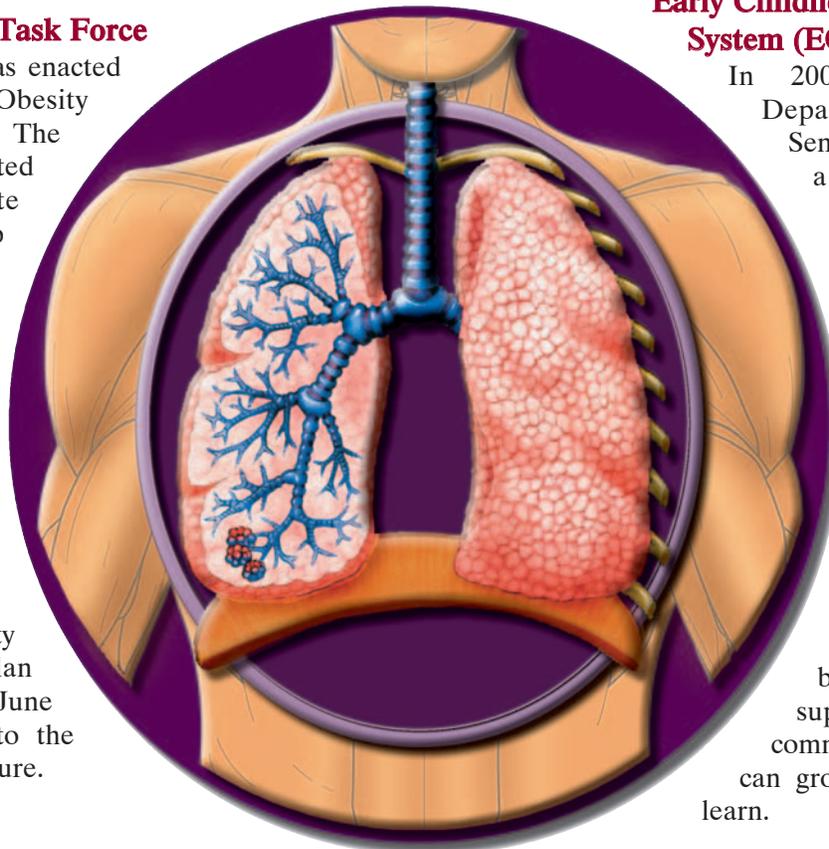
Major Boards and Councils within the Division

Interdepartmental Asthma Committee

Asthma represents a serious and compelling public health problem in New Jersey; it is a complex disease which requires a comprehensive and coordinated response including efforts directed at health care delivery systems, environmental assessment and intervention, education, and health policy review. State government recognized the significant challenge of addressing asthma in the State and the need to adopt a broad, multi-departmental approach. In order to establish an understanding of current internal efforts and to develop a means of communication to ensure coordination and to eliminate fragmentation, the DHSS created the Interdepartmental Asthma Committee (IAC). The IAC is comprised of representatives from multiple divisions and programs within DHSS and the Departments of Environmental Protection, Education, and Human Services. The IAC strives to coordinate, communicate, and ensure a comprehensive response to asthma in New Jersey. In recognition of asthma as a significant public health issue and the multifaceted approach required to address asthma, the IAC developed the "Interdepartmental Report and Strategic Plan for Asthma." The Strategic Plan provides goals, objectives, and strategies to reduce unnecessary illness and death associated with asthma.

Obesity Prevention Task Force

In 2004, legislation was enacted to create an Obesity Prevention Task Force. The Task Force was directed to study and evaluate and develop recommendations related to, specific actionable measures to support and enhance obesity prevention among residents of the State, with particular attention to children and adolescents. The Task Force developed a New Jersey Obesity Prevention Action Plan which was finalized in June 2006 and presented to the Governor and Legislature.



Statewide Interagency Coordinating Council for Early Intervention Services

The State Interagency Coordinating Council (SICC) provides advice and assists the Department of Health and Senior Services, which is the designated lead agency in New Jersey for early intervention services, in the development and implementation of policies that support the statewide system. The SICC, comprised of Governor-appointed members representing parents, service providers, various agencies, lawmakers and the community, provides a forum for the stakeholders to meet and share information and ideas for enhanced and improved coordinated services to infants and toddlers with disabilities and their families.

The SICC, established under federal (Part C, Individuals with Disabilities Education Act) and state law, meets every other month. It also forms standing and interim committees that address different issues that arise within the statewide system of providing services and supports for infants and toddlers with disabilities. The SICC prepares and submits an annual report to the Governor and to the U.S. Secretary of Education on the status of early intervention programs within the State.

Early Childhood Comprehensive System (ECCS) Team

In 2003, the New Jersey Department of Health and Senior Services was awarded a planning grant from the Health Resources and Services Administration, State Maternal and Child Health Early Childhood Comprehensive Systems Grant Program (SECCS). These grants were made available nationwide requiring each state to develop plans that when implemented would build systems which support families and communities so that children can grow healthy and ready to learn.

Major Boards and Councils within the Division

New Jersey's ECCS grant team includes representatives from the State Departments of Health and Senior Services, Human Services, Education, Labor and Workforce Development, Environmental Protection, Community Affairs, as well as the Juvenile Justice Commission, non-governmental providers, community organizations and parents—all of which impact the lives of young children and their families. ECCS has also joined with other major early childhood systems building efforts—Build New Jersey Partners for Early Learning administered by the Association for Children of New Jersey, the Head Start-State Collaboration Project, the newly established Department of Children and Families, Division of Prevention and Community Partnerships, and the Governor's Office.

Women and Bleeding Disorders Task Force

By Executive Order, a Women and Bleeding Disorders Task Force was established to ensure that women with bleeding disorders are appropriately diagnosed and treated. The Task Force, appointed by the Governor, is to

- ❖ Review current information and data describing the problem of undiagnosed bleeding disorders in women – with or without menorrhagia;

- ❖ Define the need for appropriate testing, diagnosis, and access to treatment options for women with bleeding disorders; and
- ❖ Make recommendations to address identified problems/concerns including, but not limited to, education of targeted medical and consumer communities.

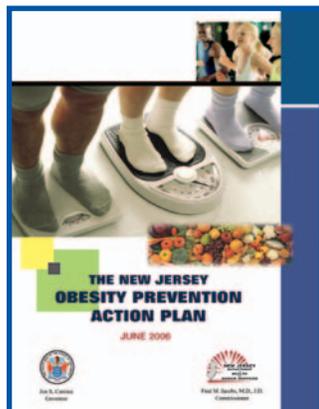
The Task Force was required to report its findings and recommendations to the Governor and Legislature no later than one year from convening. The first meeting of the Task Force was held in November 2004. In 2006, the report was submitted to the Governor and Legislature.

Women's Health Commission

The Women's Health Advisory Commission is to be a nine member, governor-appointed board, established by statute. Appointment of members is currently pending. This Commission will serve in an advisory capacity to the Office of Women's Health reviewing and making recommendations concerning needs, priorities, programs and policies that affect the health of women. Commission appointments are pending.

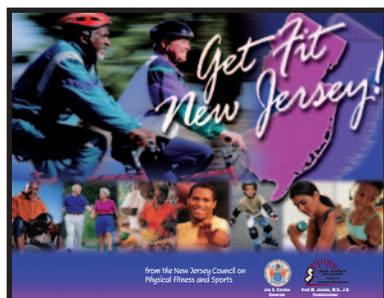
Publications 2006

The New Jersey Obesity Prevention Action Plan was created by a 27-member Task Force appointed by the Legislature in 2004. The Task Force was charged with recommending ways to improve New Jersey's obesity prevention efforts, with a special focus on children and adolescents. The Action Plan is a comprehensive report addressing all aspects of obesity prevention from seven major themes; infrastructure, public/professional awareness, communities, schools, workplace, health care system, and disparities. The report was submitted to Governor Jon Corzine and the Legislature in June 2006. Full report can be accessed at http://nj.gov/health/fhs/documents/obesity_prevention.pdf



Bleeding Disorders in Women: Report and Recommendations was submitted to Governor Corzine and the Legislature in November 2006. Bleeding disorders in women is a common, but hitherto neglected problem with substantial medical, psycho-social and financial implications for affected women and public health impact for the State of New Jersey. The report identifies the problem and includes recommendations for professional and consumer education, and development of screening and referral criteria for women who may be affected by a bleeding disorder. Full report can be accessed at http://nj.gov/health/fhs/owh/bleeding_disorders.shtml#bd

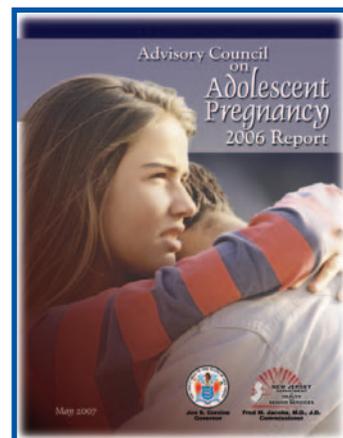
Get Fit New Jersey! A User's Guide to Better Health and Fitness for People of All Ages This publication is a project of the Council on Physical Fitness and Sports. This publication consists of 21 chapters, which were written by a



Council member or resource member. The publication was released at the Inaugural Leaders' Academy for Healthy Community Development on May 12, 2006. The book is available in print or CD format. Individual chapters of the book may be downloaded from the New Jersey Department of Health and Senior Services web site at <http://www.state.nj.us/health/fhs/njcpfs/getfit.shtml>

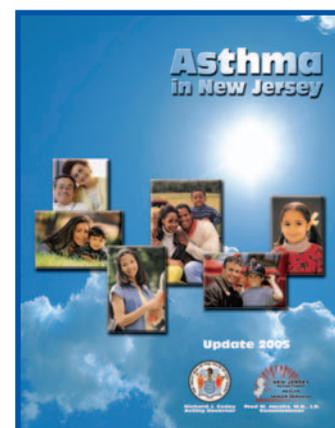
Advisory Council on Adolescent Pregnancy 2006 Report

The purpose of this report is to advise the Governor and Legislature of the activities of the Advisory Council on Adolescent Pregnancy, including its findings, recommendations for legislation, administrative action or other methods for preventing adolescent pregnancy, reducing out-of-wedlock births among adolescents and improving services related to adolescent pregnancy. The report also contains a review of the responsibilities of the Advisory Council on Adolescent Pregnancy, the activities the Council has undertaken to fulfill its duties, the recommendations of the Council, future activities, and additional data on teen pregnancy. This year the primary focus of the council was on bringing the National Exhibit, *Children of Children, Portraits and Stories of Teenage Parents* to New Jersey. Full report can be accessed at <http://nj.gov/health/fhs/children/documents/pregnancy06report.pdf>



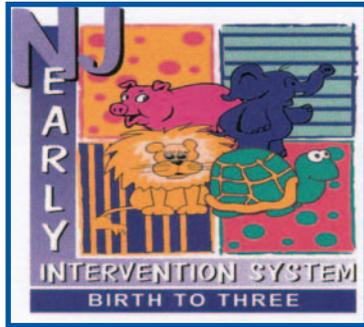
Asthma in New Jersey-update 2006

This report presents the most recent statewide data on asthma. It is the third in a series of planned annual updates to the information and data first presented in the report, *Asthma in New Jersey*. This updated report is divided into two sections. Part 1 presents data on asthma prevalence, risk factors, health care utilization, disease burden, morbidity and mortality. This data represents the efforts of the New Jersey Department of Health and Senior Services (NJDHSS) staff working under the Centers for Disease Control and Prevention cooperative agreement, "Addressing Asthma from a Public Health Perspective." Part 2 of this report presents occupational asthma data that was collected by NJDHSS staff within the Occupational Health Surveillance Program. Full report can be accessed at http://nj.gov/health/fhs/asthma/documents/asthma_update2006.pdf



Early Intervention System Part C Annual Performance Report 4/05-4/06

The Part C Steering Committee met on November 30, 2006 to advise and assist in the development of the NJEIS Annual Performance Report (APR), also in response to the Individuals with Disabilities Education Act of 2004. Stakeholder members reviewed improvement activities, timelines and resources for each indicator to determine which were completed, to examine the efficacy of each, and to make recommendations about any necessary revisions or additions to the activities, timelines and resources. Full report can be accessed at http://nj.gov/health/fhs/documents/partc_apr05-06.pdf



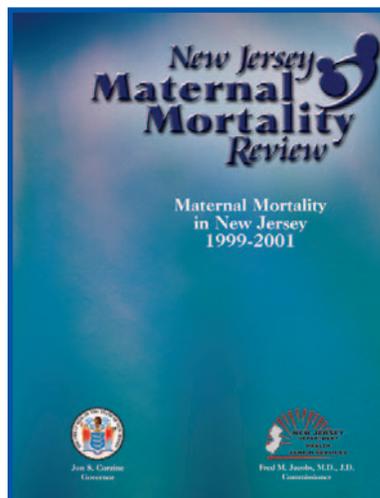
The Burden of Diabetes in New Jersey: A Surveillance Report: Diabetes Control Program-2005/2006 <http://nj.gov/health/fhs/documents/diabetesinnj.pdf>

Denk CE, Kruse LK, Jain N. *Surveillance of cesarean section deliveries*, New Jersey 1999-2004. Birth. 2006 Sept: 33(3): 203-209.

Kruse LK, Denk CE, Feldman-Winter L, Rotondo F. *Longitudinal patterns of breastfeeding initiation*. Maternal and Child Health Journal. 2006 Jan: 10(1):13-18.

Dandalu V, Jain NJ, Hernandez E, Kruse LK. *Shoulder Dystocia at noninstrumental vaginal delivery: relation to episiotomy*. Am J Perinatol 2006; 23:439-444.

Ferraro, E. *Maternal Mortality in New Jersey 1999-2001* www.state.nj.us/health/fhs/documents/maternal_mortality_review_report.pdf



New Jersey PRAMS: Smoking and Pregnancy in New Jersey
www.state.nj.us/health/fhs/documents/brief_smoking_prevalence.pdf

New Jersey PRAMS: Breastfeeding in New Jersey
www.state.nj.us/health/fhs/documents/brief_breastfeeding.pdf

New Jersey PRAMS: Intimate Partner Violence During Pregnancy in New Jersey
www.state.nj.us/health/fhs/documents/brief_ipv.pdf

New Jersey PRAMS: Pre-Pregnancy Weight Status and Pregnancy Weight Gain
www.state.nj.us/health/fhs/documents/brief_obesity.pdf



Programs and Services

Reproductive and Perinatal Health Services

Family Planning (FP) Program

In New Jersey there are 17 funded family planning agencies providing services at 53 clinic sites. Hospitals, local health departments, free-standing non-profit organizations, and Planned Parenthood affiliates are all part of the family planning network in the state. Agencies are supported by grants using a combination of State and Federal funding. Sources include: Social Service Block, Title X and Maternal and Child Health Block grants. Federal Title X funds are allocated specifically to support family planning services through two New Jersey grantees: the Department of Health and Senior Services and the New Jersey Family Planning League. By Federal statute, no Title X funds are used to provide abortion services.

In addition to delivering reproductive and preventive health care services to clients in the clinic setting, agencies train health care professionals and provide outreach and education in the community. Direct services also include sexually transmitted infection (STI) education, testing and treatment for men and women; and, HIV/AIDS counseling, education and testing. Adolescent enhanced services include education, counseling, and risk behavior assessment targeted toward the prevention of unplanned pregnancy, STI/HIV prevention, unintentional injury, substance abuse, violence, sexual abuse, unhealthy lifestyles and coercion/resistance strategies. Parental involvement and abstinence is encouraged. All services are available and accessible regardless of age, sex, race, income level or ability to pay.

The Eighth Annual Adolescent Health Institute, *What Were You Thinking? Exploring Adolescence*, sponsored by the Family Planning Program was held on November 15, 2006. This conference focused on providing information to providers about adolescent risky behaviors and the appropriate intervention skills needed to minimize these behaviors. Adolescents are vulnerable to high-risk behaviors because of issues related to development and limited life experiences. They are also remarkably resilient when given the proper interventions and support. This conference focused on providing information about adolescents and risky behaviors and the appropriate intervention skills needed to minimize these behaviors. At the conclusion of the conference, participants were able to describe the following:

- ❖ Depression;
- ❖ Suicide Prevention;
- ❖ An Overview of Family Planning Services;
- ❖ Adolescent Sexual Practices, Myths and Facts;
- ❖ Parent/Child Communications; and
- ❖ Adolescent Prostitution.

The Division of Family Health Services maintains a webpage with linkages that include “A Guide to Family Planning Services in New Jersey” at <http://nj.gov/health/fhs/chshome.htm>

The nutrition manual, “A Guide for Developing Nutrition Services in Family Planning Clinics,” was revised by NJDHSS staff with the assistance of a consultant from Cicatelli Associates, Inc. and distributed in April 2006 to all family planning clinics.

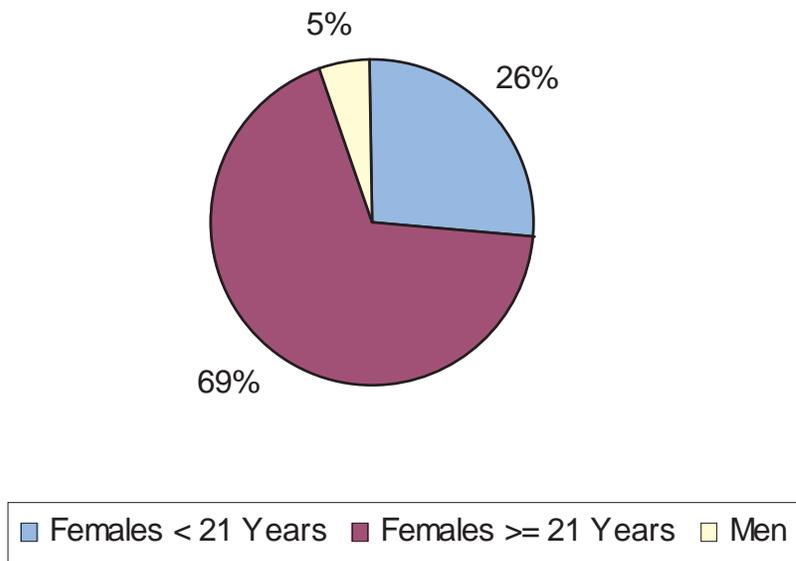
Clinic coordinators from family planning clinics met twice and received nursing continuing education credits for presentations by NJDHSS TB Prevention and Control staff in April 2006 on “Preventing TB Transmission and New CDC Guidelines” and executive directors from NJDHSS funded family planning agencies in December 2006 on “Strategies to Increase Compliance with Family Planning Appointments.” A joint meeting of clinic coordinators and health educations was held in September 2006 and nursing continuing education credits were provided for a presentation by Cicatelli Associates on “Contraceptive Update.”

In Calendar Year 2006:

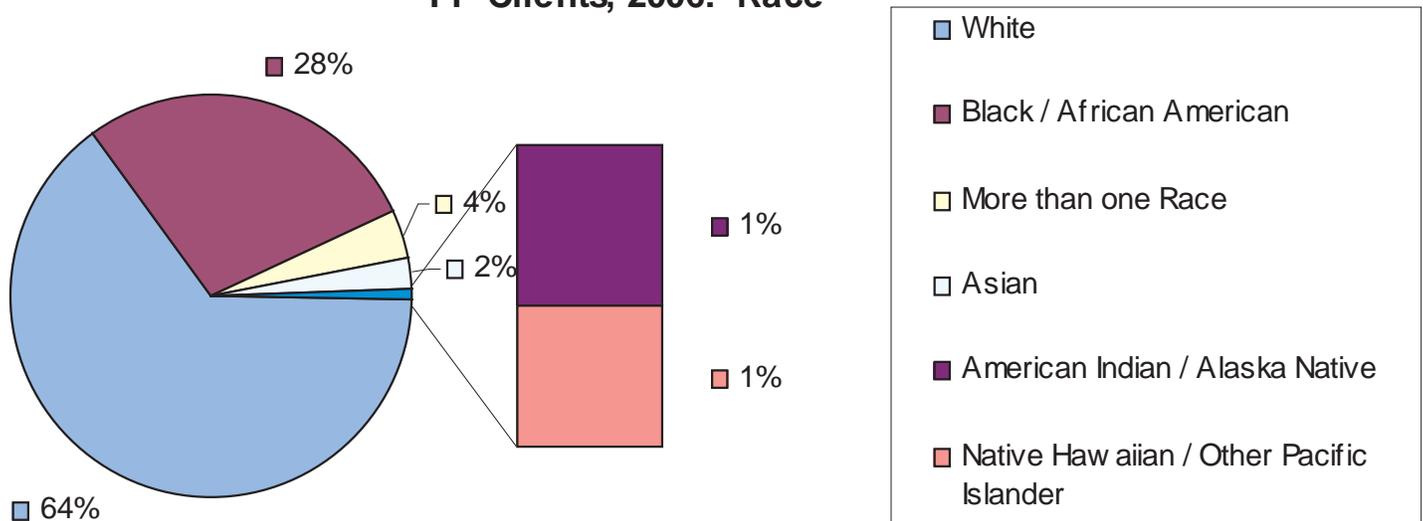
- ❖ 131,756 clients were served at clinics operated by 17 publicly funded family planning agencies in New Jersey, a 3.9% increase over CY 2005;
- ❖ 28% of the female clients served in CY 2006 (34,804) were below age 21;
- ❖ Ninety one percent of family planning clients lived in households that were below 150% of the federal poverty level;
- ❖ Family planning clients received over 100,000 tests for STIs and HIV;
- ❖ Only 16% of clients seen in publicly funded family planning clinics are Medicaid recipients;
- ❖ Outreach and education activities conducted by the family planning agencies reached more than 50,000 New Jersey residents in CY 2006.

Reproductive and Perinatal Health Services

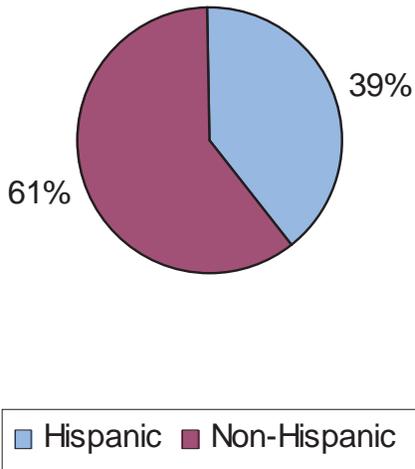
FP Clients, 2006: Sex & Age



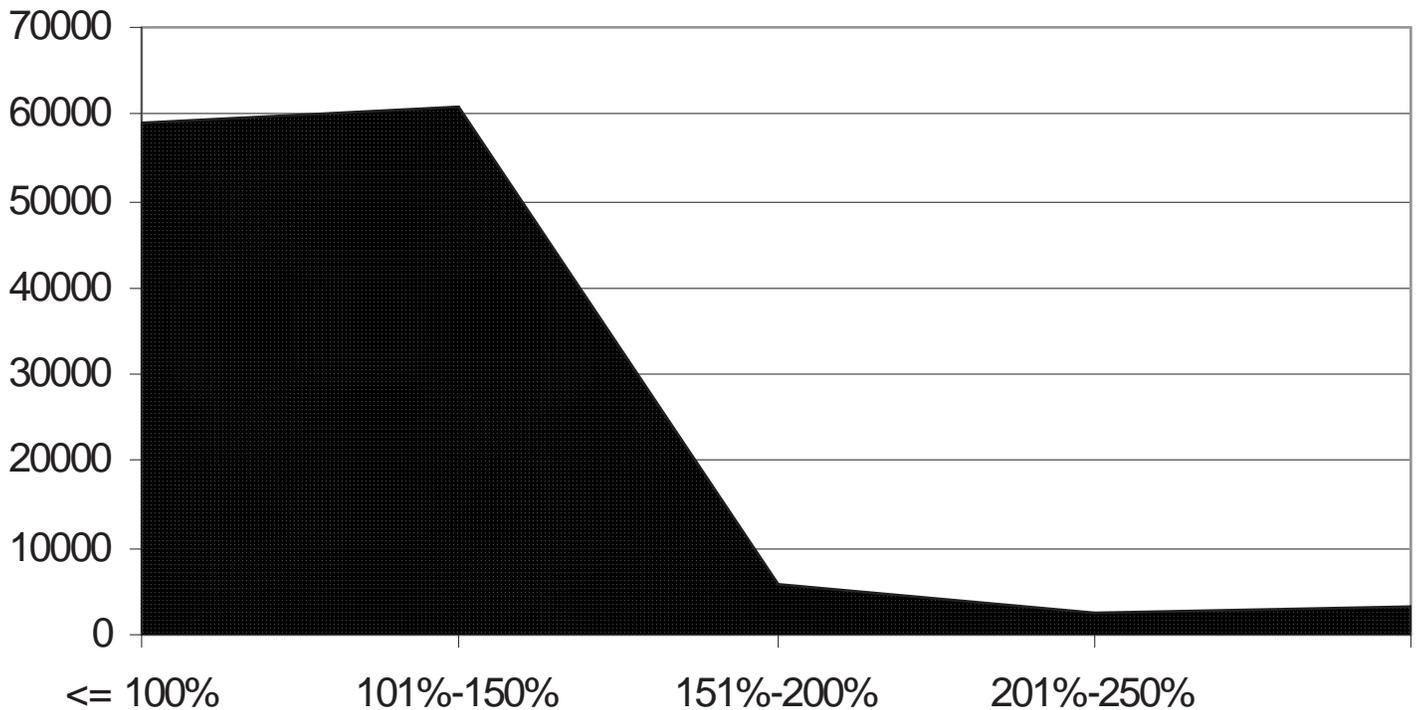
FP Clients, 2006: Race



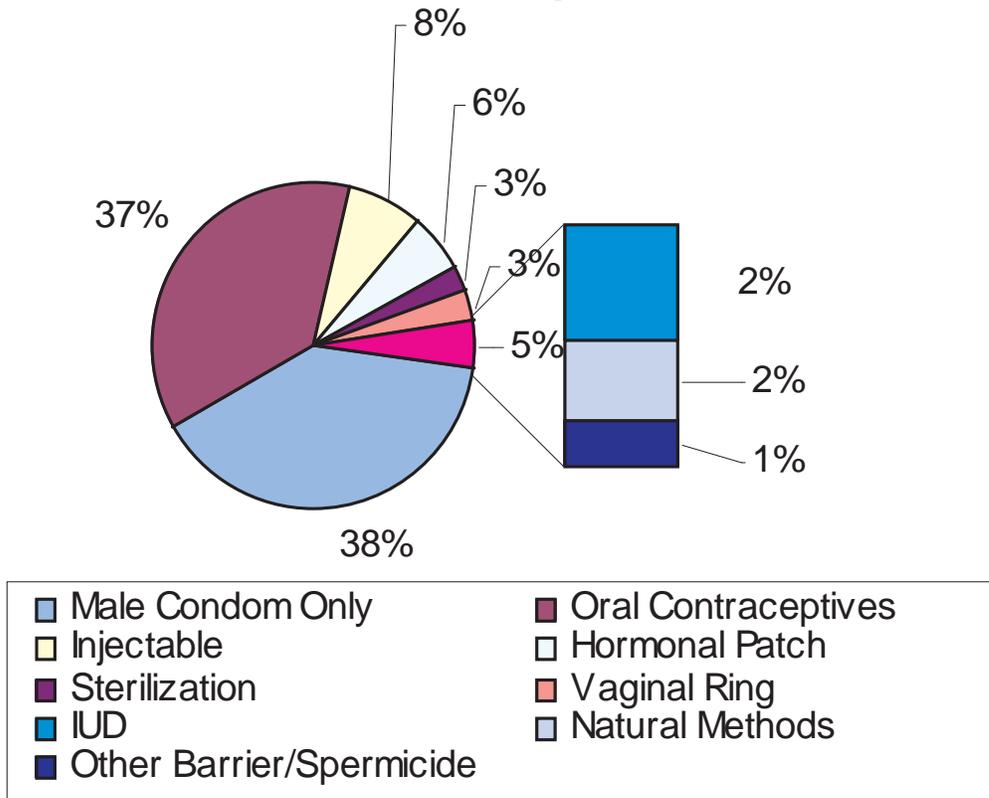
FP Clients, 2006: Hispanic Origin



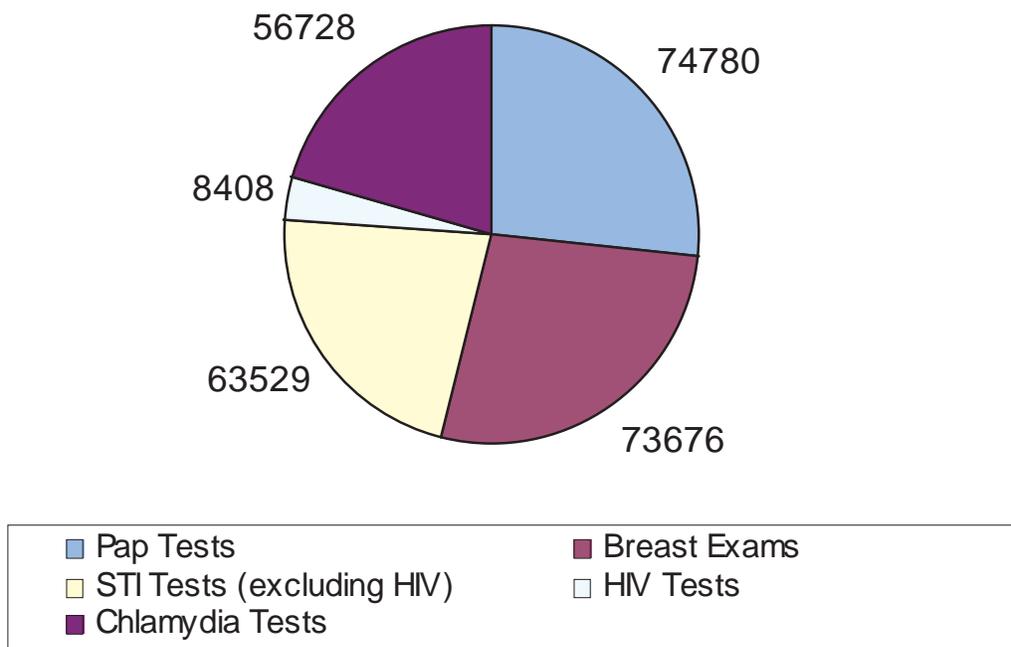
FP Clients, 2006: Poverty Level



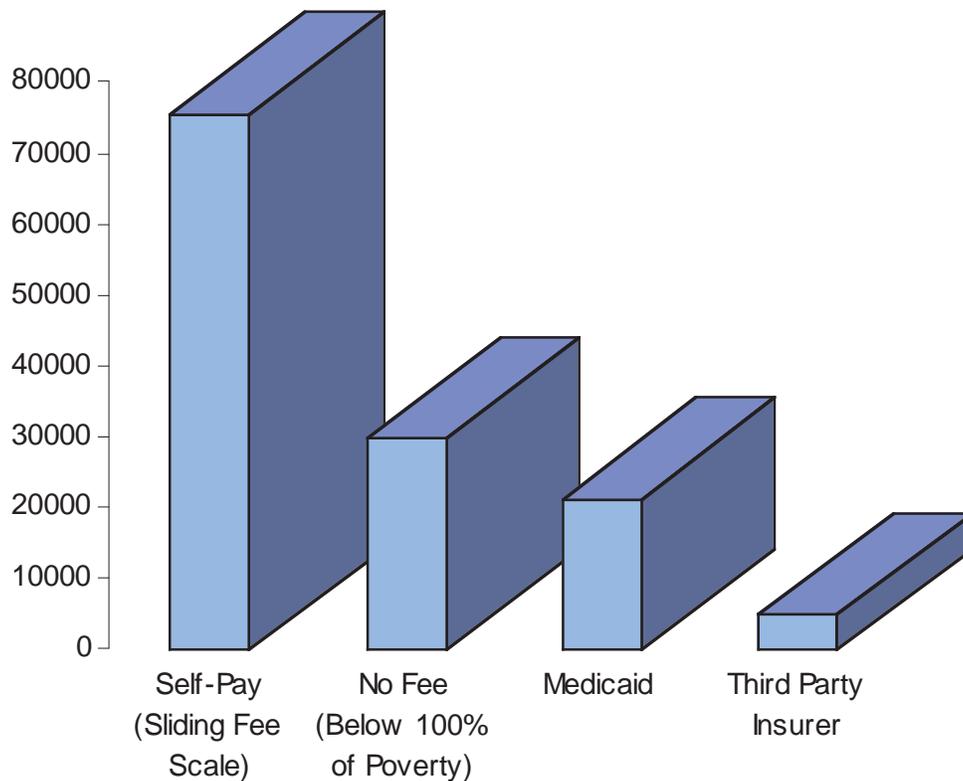
FP Clients, 2006: Contraceptive Methods Used



FP Clients, 2006: Services Delivered (Women)



FP Clients, 2006: Source of Payment for Services



Maternal and Child Health Epidemiology Program (MCH Epi)

MCH Epi efforts have focused on the following major areas:

- ❖ Expanding a surveillance system for Maternal and Child Health (MCH) Indicators;
- ❖ Examining race/ethnic disparities in MCH indicators;
- ❖ Linking MCH databases through the State Systems Development Initiative grant;
- ❖ Implementing the Pregnancy Risk Assessment and Monitoring System (PRAMS) Survey and disseminating its findings;
- ❖ Developing and submitting the annual Maternal and Child Health Block Grant;
- ❖ Examining pediatric injury surveillance trends for specific injury types;
- ❖ Enhancing maternal mortality surveillance through record linkage; and
- ❖ Completing applied MCH research projects.

MCH Epi research publications in 2006 included:

Denk CE, Kruse LK, Jain N. *Surveillance of cesarean section deliveries, New Jersey 1999-2004*. Birth. 2006 Sept; 33(3): 203-209.

Kruse LK, Denk CE, Feldman-Winter L, Rotondo F. *Longitudinal patterns of breastfeeding initiation*. Maternal and Child Health Journal. 2006 Jan; 10(1):13-18.

Dandalu V, Jain NJ, Hernandez E, Kruse LK. *Shoulder Dystocia at noninstrumental vaginal delivery: relation to episiotomy*. Am J Perinatol 2006; 23:439-444.

MCH research projects presented at national conferences in 2006 included:

Denk CE, Kruse LK. Health insurance and healthy pregnancy in New Jersey. Presented at the 12th Annual Maternal Infant and Child Health Epidemiology Conference, Atlanta GA, December 2006.

Reproductive and Perinatal Health Services

Jain N, Denk CE, Kruse LK. Trends in method of delivery and risk of maternal postpartum complications and readmission. Presented at the 12th Annual Maternal Infant and Child Health Epidemiology Conference, Atlanta GA, December 2006.

Kruse LK, Aamir T. Integrating health information to support routine newborn pulse oximetry screening for congenital cardiovascular malformations. Presented at the 12th Annual Maternal Infant and Child Health Epidemiology Conference, Atlanta GA, December 2006.

Asare LA, Jain NJ, Kruse LK. Promoting smoking cessation in New Jersey – challenges and opportunities. Presented at the National PRAMS Conference, Atlanta GA, December 2006.

Denk CE, Kruse LK. Interpreting insurance status in New Jersey PRAMS: operational and validation issues. Presented at the National PRAMS Conference, Atlanta GA, December 2006.

Deshpande S, Kruse LK. Pediatric asthma emergency department and hospital admissions surveillance by race/ethnicity and age. Presented at the American Public Health Association Conference, Boston MA, November 2006.

The Pregnancy Risk Assessment Monitoring System (PRAMS) is conducted in New Jersey by the MCH Epidemiology Program. PRAMS is a joint research project of the Department of Health and Senior Services, the Centers for Disease Control and Prevention (CDC), and Bloustein Center for Survey Research at Rutgers. Information from PRAMS is used to help plan better health programs for New Jersey mothers and infants - such as improving access to high quality prenatal care, reduction of smoking during pregnancy, and encouraging breastfeeding. More information about PRAMS and reports based on PRAMS data are available at the NJ PRAMS website - www.state.nj.us/health/fhs/pramsindex.shtml

One out of every 38 mothers with newborn infants is surveyed each month, or approximately 3,000 women interviewed each year. The questionnaire addresses their feelings and experiences before, during and after their pregnancy. Leading topics include:

- ❖ Pre-conception health, pregnancy intention, and assisted reproduction;

- ❖ Prenatal care and health insurance;
- ❖ Maternal and infant health care;
- ❖ Maternal smoking and alcohol use during pregnancy;
- ❖ Breastfeeding;
- ❖ Infant sleep position and other SIDS risk factors; and
- ❖ Partner abuse.

MCH Data Trends monitored by the MCH Epidemiology Program

- ❖ The birth rate in New Jersey has been gradually declining since 1990. There were 114,443 births to New Jersey resident women in 2004. Over the past decade, median maternal age has increased steadily among all race/ethnicity groups. Births to Hispanics and Asians are increasing.
- ❖ The infant mortality rate (IMR) in New Jersey has decreased by one-third from 8.4 deaths per 1,000 births in 1993 to 5.7 in 2003. The national IMR is slightly higher (6.8 in 2003) and has also been slowly decreasing.
- ❖ Very low and low birth weight rates have all slowly increased over the last 10 years due to the rise in multiple births.
- ❖ Singleton low birth weight rates have remained stable.
- ❖ First Trimester Prenatal Care (PNC) Initiation and Adequacy of PNC (# of PNC visits adjusted for gestation age) have improved over the last decade. Prenatal care utilization rates for New Jersey mothers remain slightly less than the national average.
- ❖ Breastfeeding rates at hospital discharge are slowly increasing.

N.J. Fetal-Infant Mortality Review

Fetal and Infant Mortality Review (FIMR) is a process overseen by Reproductive and Perinatal Health which investigates factors associated with fetal and infant mortality. Increasing the understanding of the circumstances and factors associated with fetal and infant deaths assists state and local agencies to assess needs, improve the social and health care delivery system, target resources, and develop policies for women, infants, and their families. In SFY 2006, nine FIMR projects reviewed approximately 270 fetal-infants deaths. A comprehensive database is being developed, which will include data elements and findings and recommendations from all cases. A report summarizing statewide findings will be prepared with an anticipated release date of summer 2007.

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N.J. Maternal Mortality Review

New Jersey's obstetricians, through the Medical Society of NJ, have been reviewing maternal deaths for over 70 years. In the 1970's, the New Jersey Department of Health joined with the obstetricians in the review efforts, improving surveillance and increasing the number of cases referred for review. In 1999, the New Jersey Department of Health and Senior Services (NJDHSS) Reproductive and Perinatal Health unit implemented a revision of the traditional physician-based maternal mortality review to one using the FIMR model to review and investigate maternal deaths.

The N.J. Maternal Mortality Review defines a maternal death as a "pregnancy-associated death, the death of a woman, from any cause, while she is pregnant or within 1 year of termination of pregnancy, regardless of duration and site of the pregnancy." A report of the review of pregnancy associated deaths for the years 1999-2001 was released in summer, 2006.

Outreach, Education and Enabling Services for Pregnant Women and their Families

Maternal and Child Health Consortia (MCHC)

There are six regional MCHCs in New Jersey. The consortia are private non-profit 501(c) (3) organizations and are licensed and regulated by the N.J. Department of Health and Senior Services as central service facilities. Members include perinatal and pediatric providers, hospitals, consumers, and community-based agencies, including any group or individual with an interest in health services for families.

The MCHCs primary functions are to provide prevention activities, consumer and professional education, total quality management, data analysis, infant and pediatric follow-up, coordination of perinatal/pediatric transport systems and the development of comprehensive perinatal/pediatric regional plans. The consortia receive financial support from all of the hospitals in New Jersey with maternity and/or pediatric services as well as their members.

The MCHCs also are recipients of federal and state grants including many from the Division of Family Health Services to support perinatal risk reduction,

fetal/infant mortality review, outreach and education, childhood lead poisoning prevention, and the post partum mood disorder initiative.

Postpartum Mood Disorders

Postpartum Depression (PPD) Screening Legislation was enacted by the Senate and General Assembly and approved on April 13, 2006. The Act, P.L.2006, c. 12 amends N.J.S.A. 26: 2-175 et seq. and took effect on October 10, 2006. This law states that physicians, nurse midwives and other licensed health care professionals who provide prenatal care to women shall provide education to women and their families about PPD. Both fathers and appropriate family members shall be included in both the education and treatment processes to help them better understand the nature and causes of PPD. The law also requires health care professionals to screen all new mothers for PPD prior to and after being released from the hospital after giving birth.



In July, Assistant Commissioner Celeste Andriot Wood convened a multi-agency, multi-disciplinary workgroup to develop a statewide roll out plan.

The New Jersey Board of Medical Examiners and the New Jersey Board of Nursing were part of that work group. A letter was developed and sent to the relevant practitioners that discussed the law and provided resources to aid in their compliance. A sub-committee was developed to review the screening tools that are available. This group agreed with the recommendations of the group from last year. The Edinburgh Postnatal Depression Scale continues to be the preferred tool to be used to screen postpartum women for PPD.

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The workgroup was divided into smaller groups to develop policies, guidelines, a patient handout and a resource guide that were distributed to maternity hospitals to assist them in the development of their own policies and procedures. These resources were given to all of the hospital representatives who attended the informational seminars at the New Jersey Hospital Association. One of these presentations was held on October 18, 2006 with 100 participants and the other presentation was held on October 30, 2006 with 80 people in attendance.

The MCHC are now in the process of going to hospitals and private physician's offices to provide additional education and distribute the resource materials. During the course of this grant year, all of the birthing hospitals are expected to have developed and implemented their PPD screening policies.

Healthy Mothers, Healthy Babies (HM/HB) Coalitions

Eight Healthy Mothers, Healthy Babies (HM/HB) Coalitions were established by the N.J. Department of Health and Senior Services (NJDHSS) in 1985, as part of a \$1.83 million infant mortality reduction initiative. This initiative targets the 11 cities at highest risk for poor pregnancy outcomes. The cities include Atlantic City, Camden, East Orange, Irvington, Jersey City, New Brunswick, Newark, Orange, Paterson, Plainfield and Trenton. These community-based coalitions include consumers, community agencies, providers and other organizations or individuals with an interest in improving the health status of families in the target cities.

Healthy Mothers, Healthy Babies consumer outreach and education activities include:

- ❖ Preconception and prenatal health education, parenting and grand parenting classes, mentoring programs, breastfeeding, empathy belly and "Baby Think It Over" doll programs, "Game of Life", "Pregnant Pause", "Comenzando Bien", Baby Health and Safety Showers, preconception or prenatal counseling, pregnancy prevention and STI workshops, car seat and seat belt usage and infant mortality reduction.

Professional training for health and social services workers include:

- ❖ Identifying domestic violence and depression, infant mortality reduction, resources for emergency food, shelter and clothing, newborn and infant developmental screening, parent education, breast feeding, lead poisoning prevention, cultural competency training, and substance abuse prevention.

In SFY 2006, the State funded Healthy Mothers, Healthy Babies Coalitions served over 7,200 women of childbearing age through outreach activities including education and counseling. Case management services were provided to over 2,500 families. Over 430 community education programs and 40 professional education programs were conducted with over 7,200 and 1,100 participants, respectively.

Perinatal Addictions Prevention Project

The major goals of the Perinatal Addictions Prevention Project include providing professional and public education, encouraging all prenatal providers to screen their patients for substance use/abuse and developing a network of available resources to aid pregnant substance abusing women.

There have been over 26,000 pregnant women screened over the past year for alcohol and/or drug use during pregnancy. The risk reduction coordinators continue to work toward the goal that all pregnant women will be screened for substance use and given information about the effects this behavior could have on their baby. The tool that has been universally used by this project is the 4P's Plus screening tool. During the past year over 100 private practitioners were approached and educated about this statewide initiative. Approximately half of those providers have agreed to participate in the universal screening project. The 15.9% of the women who consumed alcohol in the month before they knew they were pregnant received education and are encouraged to refrain from drinking during the remainder of their pregnancy. Referral information is given to those women who are smoking, using drugs and/or alcohol and indicate their usage is frequent and those who have domestic violence issues.

This screening tool is often used to start the discussion about alcohol and drug use since it naturally flows from the family history. The original 4 P's tool was designed

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to rapidly identify obstetric patients in need of intervention. The following are the results of the 4P's Plus screening of women in 2006:

Parents use a problem	13.4%
Partners use a problem	4.9%
Partners temper a problem	4.8%
Past use of alcohol	42.0%
Cigarettes month before pregnancy	20.0%
Alcohol month before knew about pregnancy	15.9%
Marijuana month before pregnancy	5.9%

During the year, programs designed to educate the general public about the risks of substance use during pregnancy have reached 4,500 men and women during 1,000 offerings. There have been 80 professional educational offerings with over 2,500 participants.

Eliminating Disparities in Perinatal Health (Healthy Start)

Isaiah House Healthy Start Mother and Child (MaC) Program, located in the city of East Orange, is supported with Federal Healthy Start grant funds from the Health Resources and Services Administration (HRSA), Maternal and Child Health Review (MCHB). The goal is to improve pregnancy outcomes for African American women of childbearing age and reduce the high infant mortality for residents in the city of East Orange. The program core services are provided to 350 plus clients and include case management, outreach and client recruitment, home visits, interconceptional care, depression screening and health educational workshops to staff and local providers. For FY 2006 the agency met its goals and objectives for the target population.



Black Infant Mortality Reduction

In August 2006, a competitive request for applications (RFA) was issued by the perinatal program to address black infant mortality reduction. Health service grants are awarded to seven agencies throughout the state for outreach and other direct services to black women of childbearing age. The goal of these grant projects is to reduce the health disparity between the black and white infant mortality rates in New Jersey through innovative community programs that include unique strategies to

decrease Black infant mortality and low birth weight.

The Black Infant Mortality Reduction (BIMR) Resource Center, established at the Northern Maternal Child Health Consortium in 1999, continues to serve as a resource to both the African American community and health professionals to reduce the high rates of black infant mortality.

Sudden Infant Death Syndrome (SIDS) Assistance Center of New Jersey

This service is a collaboration of UMDNJ-Robert Wood Johnson Medical School and Hackensack University Medical Center. Services provided include: bereavement counseling for families of children who die from SIDS, training for first responders and other health professionals and professional and public education. The Center also maintains surveillance data on SIDS cases in New Jersey.

SFY 2005 Preliminary Data:

44 SIDS Deaths (43 final; 1 pending final cause of death)

Black	27 (61%)
White	10 (23%)
Hispanic	4 (9%)
Asian	1 (2%)
Other	2 (5%)

Prevention education reached 126,506 persons.

Reproductive and Perinatal Health Services

Child Fatality and Near Fatality Review Board

The Reproductive and Perinatal Health Services provides representation on the Child Fatality and Near Fatality Review Board (CFNFPB), established through legislation (N.J.S.A. 9:6-8.88). The CFNFPB conducts an impartial review of circumstances involved in child fatalities and near fatalities and develops recommendations for broad based systemic, policy and legislative revisions to help prevent child fatalities and to provide for a more coordinated response in the tragic event of a child's death.

New Jersey Public Umbilical Cord and Placental Blood Bank Initiative

The objective of the above initiative is to encourage expectant mothers to donate their umbilical cord blood, as well as placenta stem cells, for storage to a public blood bank.

The Reproductive and Perinatal Health Services (RPHS) was charged with the responsibility of promoting and educating the public about this initiative. To this end, a Cord Blood Brochure for Consumers and a Cord Blood Fact Sheet for Providers were developed in consultation with the Coriell Institute for Medical Research in Camden, and the Elie Katz Umbilical Cord Blood Program in Paramus. Both of these resources were translated into Spanish, and posted on the Department of Health and Senior Services website for public and provider utilization. In addition, two Regional Cord Blood Trainings were sponsored by Northern New Jersey Maternal and Child Health Consortium in the north, and the Southern New Jersey Perinatal Cooperative, Inc. in the southern part of New Jersey.



New Jersey Special Supplemental Nutrition Program For Women, Infants and Children (WIC).

WIC was created by the U.S. Congress in 1972 in response to concerns that a significant number of women, infants, and children, from families with inadequate income, are at special risk with respect to physical and mental health. In 1974, New Jersey implemented one of ten programs nationwide. The Program provides eligible participants with supplemental foods, nutrition education, and referrals to healthcare and other support services. The program also serves as a gateway to preventive healthcare during critical times of growth and development in order to prevent health problems and improve the health status of vulnerable populations.

In 2006:

- ❖ 266,000 women, infants and children received program benefits, including supplemental foods, breastfeeding education, nutrition counseling, and access to healthcare and referrals to other appropriate service providers.
- ❖ Over 170 clinic locations are operational throughout the State.
- ❖ \$34 million in rebate earnings served approximately 89,000 program participants. (Since the inception of infant formula rebate cost containment initiative in 1989, New Jersey has received over a quarter of a billion dollars in rebate earnings at no cost to the taxpayers of the State.)
- ❖ Rebate dollars from the new Infant Formula Rebate Contract with Ross Products Division, Abbott Laboratories has increased by 10% over the previous contract.

The Intergenerational School Breakfast Program (ISBP)

New Jersey WIC Services, in collaboration with the New Jersey Department of Agriculture and the DHSS Division on Aging and Community Services, created the Intergenerational School Breakfast Program. The Program, in operation since 1999, supports nutrition education to young children preschool through third grade. In 2005, WIC Services developed and launched a website for the program, www.nj.gov/health/isbp. Marketing brochures announcing the new website were mailed to 800 child-care programs and elementary schools in New Jersey. The website allows New Jersey

schools to register and receive free program materials to support nutrition education. Schools may order five free kits of materials. Each kit includes a tote bag containing eight children's books with nutrition themes. Schools also receive a box of nutrition education materials to distribute to students. The website contains downloadable tips and fact sheets, nutrition education curriculum, links and other resources for schools. The registration database and automated evaluation surveys allow WIC to collect information on how schools are using the materials to support nutrition education to young children. Since August 2005, 45 schools have registered for the program and 225 free kits of children's books and materials have been distributed to schools.



New Jersey WIC Farmers' Market Nutrition Program:

The New Jersey WIC Farmers' Market Nutrition Program began in 1994 as part of the nationwide effort to provide fresh, unprepared, locally grown fruits, vegetables and herbs directly to WIC participants and to expand the awareness and use of local farmer's markets. WIC participants receive four \$5 vouchers to purchase fresh fruits, vegetables and herbs from local farmers.

The program is funded by the United States Department of Agriculture (USDA). The New Jersey Department of Health and Senior Services, in collaboration with the New Jersey Department of Agriculture, administers the program through 18 local WIC agencies.

In 2006, the program served over 54,000 WIC participants, including pregnant, breastfeeding, and postpartum women, and children ages two through five years. In 2006, thirteen new farmers were recruited and five new farmer's markets opened, bringing the total to 80 community farmers' markets and 192 certified farmers participating in this program. Several faith-based and community agencies participate as outreach partners in various communities.

WIC Services

Breastfeeding Peer Counseling

New Jersey WIC Services received funds to implement a breastfeeding peer counseling program, which were allocated to grantees to enhance breastfeeding services for WIC participants. The funds are being used to target specific objectives to increase breastfeeding initiation and duration among WIC participants and to serve underserved communities. WIC grantees are encouraged to develop community partnerships to overcome the barriers to breastfeeding and to hire breastfeeding peer counselors who come from the targeted communities and speak the same language as WIC participants. Breastfeeding peer counselors are available outside normal work hours to serve women.

Fruit and Vegetable Nutrition (5 A Day) Program

Development of a New Jersey State Plan to Increase Fruit and Vegetable Consumption was initiated and will be modeled after the National Action Plan published by the Produce for Better Health Foundation. The goal is to put into action at the State and local level a set of policy, marketing, business, public health and communication strategies that can increase fruit and vegetable consumption. A Friend Raiser was sponsored to increase the program's capacity for expansion.

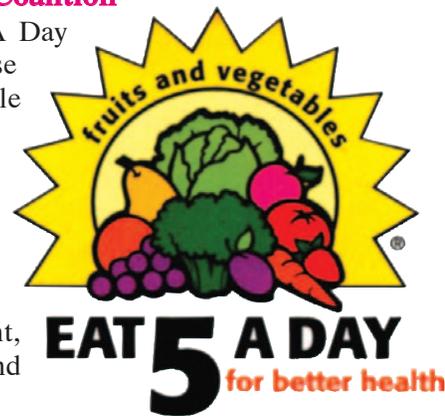
The 5 A Day Program worked to increase fruit and vegetable consumption as an important step to improve the health, weight, and nutritional status of WIC participants and all New Jersey residents. Partnerships with faith-based partners were expanded to increase opportunities and strategies available for Nutrition Education in the WIC and Senior Farmers' Market Programs.

The New Jersey 5 A Day Program made most significant strides in the school setting to increase fruit and vegetable consumption in schools. 5 A Day Program materials were used to support the educational component of the New Jersey team nutrition grant. As a result of this partnership, increased consumption of fruits and vegetables was achieved at 11 New Jersey schools. Statewide regional trainings for foodservice workers to increase the quality of the fruits and vegetables served in school cafeterias were another result of this partnership. Partnerships and new strategies included advocates to extend and expand the snack program during the 2006-07 school year.

Steps were taken to increase fruit and vegetable consumption messages in New Jersey worksites, in collaboration with New Jersey Department of Personnel's *Working Well New Jersey*. Community Interventions continued although in smaller strides within several community intervention settings.

New Jersey 5 A Day Coalition

The mission of the 5 A Day Program is to increase fruit and vegetable consumption to improve quality of health for all New Jerseyans. The Coalition currently has 64 members which represent government, industry, healthcare and non-profit agencies.



WIC Moms Reading for Love

"WIC Moms Reading for Love" is a literacy initiative that assists with the reading development of preschool age WIC participants. This initiative focuses its efforts on WIC clinics in Abbott school districts. The goals are to enlist parents, caregivers, and community members to read to children at the WIC sites and at home. The Garden State Discovery Museum's Center for Learning facilitates training workshops for WIC employees and volunteers within the Abbott school districts. A trained storyteller along with trained educators from the Center for Learning, show WIC staff and volunteers how to combine techniques for reading books to very young children with fun and engaging activities that encourage parental involvement. The WIC professionals read books that promote proper nutrition and physical activity to WIC preschool age participants. WIC participating children each receive nutrition themed books to take home and reread with their parent or caregiver. This initiative is being promoted through WIC mobile clinics, reading racks in health clinics in the Abbott school districts, and local WIC offices. A multi-cultural marketing campaign promoting reading literacy among the WIC population was launched. The multi-cultural marketing campaign targeted strategic locations throughout the Abbott districts. The campaign included advertising on public transportation. Overall, these sessions will help make reading a fun, easy and enriching pastime for WIC families.

Newborn, Infant and Toddler Services

Newborn Screening & Genetic Services

Newborn screening is an essential, preventive public health program for early identification of disorders that can lead to catastrophic health problems. The Newborn Screening and Genetic Services Follow-up Program is responsible for ensuring that:

- ❖ all infants testing outside normal limits for a newborn screening disorder receive prompt and appropriate confirmatory testing;
- ❖ all infants diagnosed with newborn screening disorders are maintained on appropriate medical therapy through communications with parents, physicians, and medical specialists; and
- ❖ parents, practitioners and consumers receive educational materials about each disorder.

The Program provides oversight and partial funding to specialty care centers for metabolic and genetic services, pediatric endocrine services, pediatric hematological services, pediatric pulmonary services and specialized confirmatory and diagnostic laboratory services.

Newborn Screening Annual Review Committee (NSARC)

NSARC was reconvened in accordance with Executive Order 199. The purpose of the NSARC is to assist in the ongoing review of newborn biochemical screening policy and activities. NSARC assists in ensuring that New Jersey's Newborn Screening Program remains current in accordance with advances in medical technology.

In SFY 2006:

Newborn Screening Annual Review Committee had its third meeting in May 2006. NSARC reviewed the current practices of NBS lab and discussed the multiplex nature of testing. The NBS lab currently screens for twenty mandated disorders using biochemical markers. However, these markers may be indicative of more than one disorder and are called

“secondary targets”. A final determination of the specific disorder can only be made after confirmatory diagnostic testing.

As a result of the NSARC recommendations last year new disorders are being added to the New Jersey Newborn Screening Panel. While these new disorders are detected as primary targets, several secondary targets are also detected. These disorders are currently grouped in the Non-Mandated category. The NSARC recommended that in order to provide optimal follow-up services, these secondary disorders should also be mandated. The NSARC further recommended that New Jersey Newborn Screening Panel should follow the same nomenclature that was followed by American College of Medical Genetics in its 2005 report. As a result of these recommendations New Jersey will be officially screening for 45 disorders.

In addition to these 45 disorders, there is a subset of nine disorders which may be detected in extremely rare cases due to the current algorithms and cutoffs used for screening. The following chart shows a list of disorders for which New Jersey will be screening after expansion.



Newborn, Infant and Toddler Services

EXPECTED NEW JERSEY NBS PANEL AFTER EXPANSION

Category	Abbreviation	Name of the Disorders
13 Organic Acidemias (OA)	IVA	Isovaleric Acidemia
	GAI	Glutaric Acidemia Type I
	HMG	3-hydroxy 3-methyl glutaric aciduria
	MCD	Multiple Carboxylase Deficiency
	MUT	Methylmalonic Acidemia (mutase deficiency)
	Cbl A,B	Methylmalonic Acidemia (Cbl A, B)
	3 MCC	3-Methylcrotonyl-CoA carboxylase deficiency
	PROP	Propionic acidemia
	BKT	Beta Ketothiolase deficiency
	3MGA*	3-Methylglutaconic Aciduria
	2MBG*	2-Methylbutryl-CoA dehydrogenase deficiency
	IBG*	Isobutryl-CoA dehydrogenase Deficiency
	Cbl C,D*	Methylmalonic Acidemia (Cbl C, D)
10 Fatty Acid Oxidation Disorders (FAOD)	MCAD	Medium-chain acyl-CoA dehydrogenase deficiency
	VLCAD	Very-long-chain acyl-CoA dehydrogenase deficiency
	LCAD	Long-chain acyl-CoA dehydrogenase deficiency
	SCAD	Short-chain acyl-CoA dehydrogenase deficiency
	LCHAD	Long-chain L-3-OH acyl-CoA dehydrogenase deficiency
	TFP	Trifunctional protein deficiency
	CUD	Carnitine uptake deficiency
	GA-II*	Glutaric Acidemia Type II
	CPT-II*	Carnitine Palmitoyltransferase II deficiency
	CACT*	Carnitine/Acylcarnitine translocase deficiency
13 Amino Acid Disorders (AA)	PKU	Phenylketonuria
	H-PHE*	Benign Hyperphenylalaninemia
	BIOPT-BS*	Defects of biopterin cofactor biosynthesis
	BIOPT-REG*	Defects of biopterin cofactor regeneration
	MSUD	Maple syrup urine disease
	HCY	Homocystinuria
	TYR I	Tyrosinemia type I
	TYR II*	Tyrosinemia type II
	TYR III*	Tyrosinemia type III
	CIT	Citrullinemia
	ASA	Argininosuccinic acidemia
	CIT-II*	Citrullinemia type II
	MET*	Hypermethioninemia
4 Hemoglobinopathies	HbSS	Sickle cell anemia (Hb SS disease)
	Hb S/àTh	Hb S/à-thalassemia
	Hb S/C	Hb S/C disease
	VARIANT Hb	Variant Hb
5 Other	CH	Congenital Hypothyroidism
	BIOT	Biotinidase deficiency
	CAH	Congenital Adrenal Hyperplasia
	GALT	Galactosemia
	CF	Cystic Fibrosis

TOTAL: 45

Footnote: * Secondary targets which are recommended to be mandated.

NON-MANDATED DISORDERS WHICH MAY VERY RARELY BE DETECTED

Abbreviations

MS/MS Detectable disorders

ARG
MAL
CPT 1-A
M/SCHAD
MCKAT
2M3HBA
DE RED

Non MS/MS Disorders

GALE
GALK

Name of the Disorder

Argininemia
Malonic Aciduria
Carnitine Palmitoyl transferase I-A deficiency
Medium/Short Chain 3-OH acyl-CoA DH deficiency
Medium Chain Ketoacyl-CoA thiolase deficiency
2-Methyl 3-hydroxy butyric aciduria
Dienoyl-CoA reductase deficiency

Galactose Epimerase deficiency
Galactokinase deficiency

Expansion planning for NBS panel:

The Commissioner approved the recommendations of the NSARC in October 2006. The final implementation date of expansion will be determined by the computer system upgrade at the NBS lab. In the meantime, the NBS follow up program is working towards completion of preparations for implementation of this expansion. These efforts include:

- ❖ NBS software vendor is providing an upgrade to the current software and hardware environment. This upgrade will provide more storage space, improved reporting times and an expanded laboratory results report.
- ❖ The Follow-up staff reviewed and prepared the following material regarding new disorders:
 - ❖ Follow-up Protocol Action Sheets for expanded disorders
 - ❖ Disorder Information for Parents
 - ❖ Disorder Information for Health Professionals
 - ❖ Physician and Parent Notification Letters
 These materials were reviewed and approved by the Metabolic Consultant Task Force.

Physician Education Initiative

The Newborn Screening and Genetic Services provided grant funding to UMDNJ-New Jersey Medical School for a new Physician Education Initiative. In view of the pending expansion as well as reports in recent literature and from the specialists in the field, a need was identified to address the lack of knowledge among primary care

physicians about the disorders in the expanded newborn screening panel. A recent report found that preferred ways of education regarding NBS, as identified on a survey, is through grand rounds, web-based information and postal mailings. Accordingly, this project aims to achieve the goals and objectives through three different methods:

- ❖ a series of grand rounds;
- ❖ web-based CME program; and
- ❖ mailings in the form of laminated fact sheets.

A grand round lecture series was developed consisting of a series of three closely scheduled talks:

- ❖ The NBS system in NJ, Metabolic disorders screened in NJ, the initial, emergency and long term management of screened positive cases with these disorders;
- ❖ Brief overview of NBS system in NJ, Endocrine Disorders screened in NJ and the initial, emergency and long term management of screened positive cases; and
- ❖ Brief overview of NBS system in NJ, Cystic Fibrosis screening and initial, emergency and long term management of screened positive cases.

These lectures were developed by a team of two pediatric sub-specialists for the respective disorders, the Director of Clinical Genetics at UMDNJ-NJ Medical School, Medical Director of SCHEIS, one genetic counselor and Public Health Consultant- Nursing. This grand round lecture series is currently being conducted or is scheduled in various hospitals statewide. These lecture presentations will also be used for the web-based

Newborn, Infant and Toddler Services

continuing medical education (CME) course for pediatricians in collaboration with UMDNJ Center for Continuing and Outreach Education. The laminated fact sheets were developed in 2005 by UMDNJ-Robert Wood Johnson Medical School through a grant for revision and distribution of laminated sheets for providers. These laminated fact sheets consist of three easy to use laminated chi-sheets providing guidelines to the primary care providers. These three sheets are:

1. Initial Management guidelines for disorders screened in the NBS program;
2. Emergency guidelines for sickle cell disease; and
3. Pregnancy complications arising from these disorders.

Due to the expected expansion, the laminated fact sheets are currently being revised to include the new disorders. When complete the fact sheets will be available for distribution at grand round lectures, as well as through the FHS website.

New Parent Information Material “These Tests Could Save Your Baby’s Life - Newborn Screening Tests”.

In order to improve parent informational material regarding newborn screening, the NBS program adopted new brochures which were designed after extensive federal Health Resources and Services Administration and American Academy of Pediatrics funded studies (PEDIATRICS Vol. 117 No. 5 May 2006, pp. S326-S340). These brochures were developed using input from providers and parents in the study, review of current brochures from different states, patient education and communication literature as well as previous studies. New Jersey adopted both English and Spanish versions with minor changes. These brochures titled “These Tests Could Save Your Baby’s Life - Newborn Screening Tests” were distributed to 68 New Jersey birthing facilities.

Amendments to the rules

The proposed amendment at N.J.A.C. 8:18-1.2 which adds the definitions of “health care provider” and “qualified laboratory” and the new rule at N.J.A.C. 8:18-1.14 which require a health care provider to advise the parent or guardian of newborn children in New Jersey about the availability of testing for disorders in their infants other than those disorders for which testing is required under State law were approved by the Governor’s Office on April 11, 2006. The proposed amendment and proposed new rule were adopted and published in the February 5, 2007 New Jersey Register.

Pulse oximetry as potential newborn screening tool:

Study completed in SFY2006, Aamir T, Kruse LK, Ezeakudoo O, “Delayed Diagnosis of Selected Congenital Cardiovascular Malformations and Need for Pulse Oximetry Screening of Newborns”. The abstract of this study was submitted in poster session at MCHPEP Annual conference, National Birth Defects Prevention Network Annual Meeting 2007. It is also accepted for oral presentations at Pediatric Academic Society Annual Meeting in May ’07, and at Association of Public Health Laboratories’ 2007 Newborn Screening and Genetic Symposium in May ’07. Currently the final manuscript of the study is being submitted to professional journals for publication.

Early Hearing Detection and Intervention (EHDI):

Mandated by P.L. 2001 c.373, N.J.S.A. 26:2-103, the EHDI Program is responsible for overseeing universal newborn hearing screening, maintaining the EHDI tracking system for children with hearing loss, and linking families with services. The EHDI Program ensures all children born in New Jersey are screened for possible hearing loss. Children with any level of hearing loss are offered services through the Special Child Health Case Management System and the New Jersey Early Intervention System (NJEIS).

EHDI program activities during 2006 included:

- ❖ Distribution of new program brochures (“Can Your Baby Hear” and “Your Baby Needs Another Test”) in English and Spanish versions;
- ❖ Complete redesign of EHDI web site (www.state.nj.us/health/fhs/ehdi);
- ❖ Distribution of a New Jersey Pediatric Hearing Health Care Directory, which was developed after surveying all licensed audiologists and hearing aid dispensers;
- ❖ Site visits to all 60 hospitals in New Jersey with maternity services to review each hospital’s EHDI procedures, performance, and compliance with new regulations;
- ❖ Site visits by the EHDI Audiologist to audiologists throughout New Jersey to review reporting obligations and standards of pediatric care; and
- ❖ Development of an interface with the New Jersey Immunization Information System (NJIIS) to allow audiologists to report outpatient hearing evaluations electronically and to allow pediatricians access to view inpatient and outpatient screening results.

Newborn, Infant and Toddler Services

NEWBORN SCREENING PROGRAM STATISTICS STATE FISCAL YEAR 2006

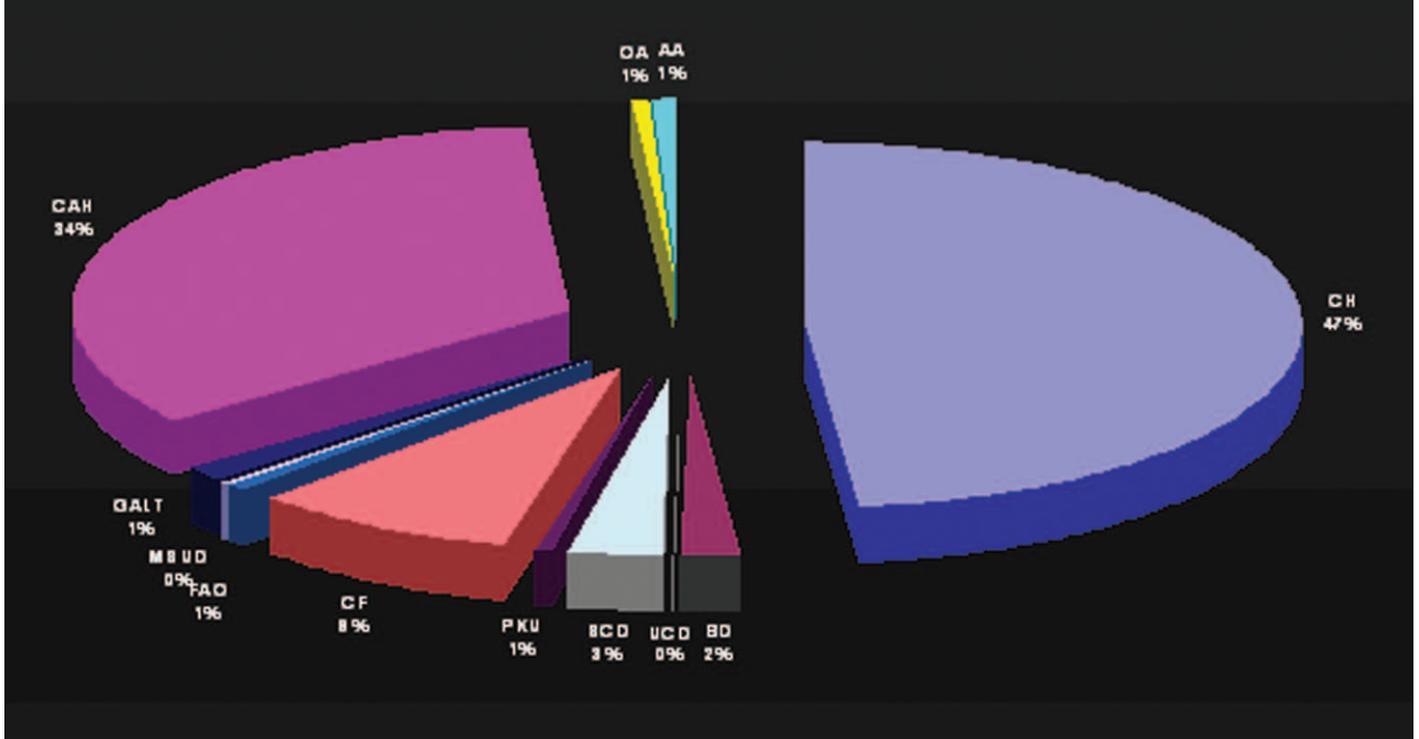
DISORDERS	Number of Babies Screened	Babies with Abnormal Results Reported to Follow-up (#)	Babies Confirmed with Classical Disease (#)	Babies with Variant Form of Disease (#)
Phenylketonuria (PKU)	110,851	19	9	3
Congenital Hypothyroidism	110,851	1,673	82	42
galactosemia	110,851	48	5	19
Sickle Cell Disease	110,851	98	54	44
Cystic Fibrosis	110,851	298	10	2
Congenital Adrenal Hyperplasia	110,851	1,169	5	4
Maple Syrup Urine Disease	110,851	5	3	0
Biotinidase Deficiency	110,851	63	1	4
Fatty Acid Oxidation Disorders	110,851	25		
Medium Chain Acyl-CoA Dehydrogenase (MCAD) Deficiency			8	0
Short Chain Acyl-CoA Dehydrogenase (SCAD) Deficiency			2	0
Long Chain Acyl-CoA Dehydrogenase (LCAD) Deficiency			0	0
Very Long Chain Acyl-CoA Dehydrogenase (VLCAD) Deficiency			1	0
Urea Cycle Disorders	110,851	4		
Citrullinemia			0	0
Arginosuccinic academia			0	0
Organic Acidemias	110,851	24		
Methylmalonic Acidemia			0	0
Propionic Acidemia			1	1
Glutaric Acidemia, Type I			0	0
Isovaleric Acidemia			3	0
3-Hydroxy-3-Methylglutaryl CoA Lyase Deficiency			0	0
3-Methylcrotonyl-CoA Carboxylase Deficiency			3	0
Amino Acid Disorders	110,851	28	0	3
TOTAL for SFY 2006	110,851	3,454	187	122

There were 2,888 additional babies reported to follow-up with sickle cell trait.

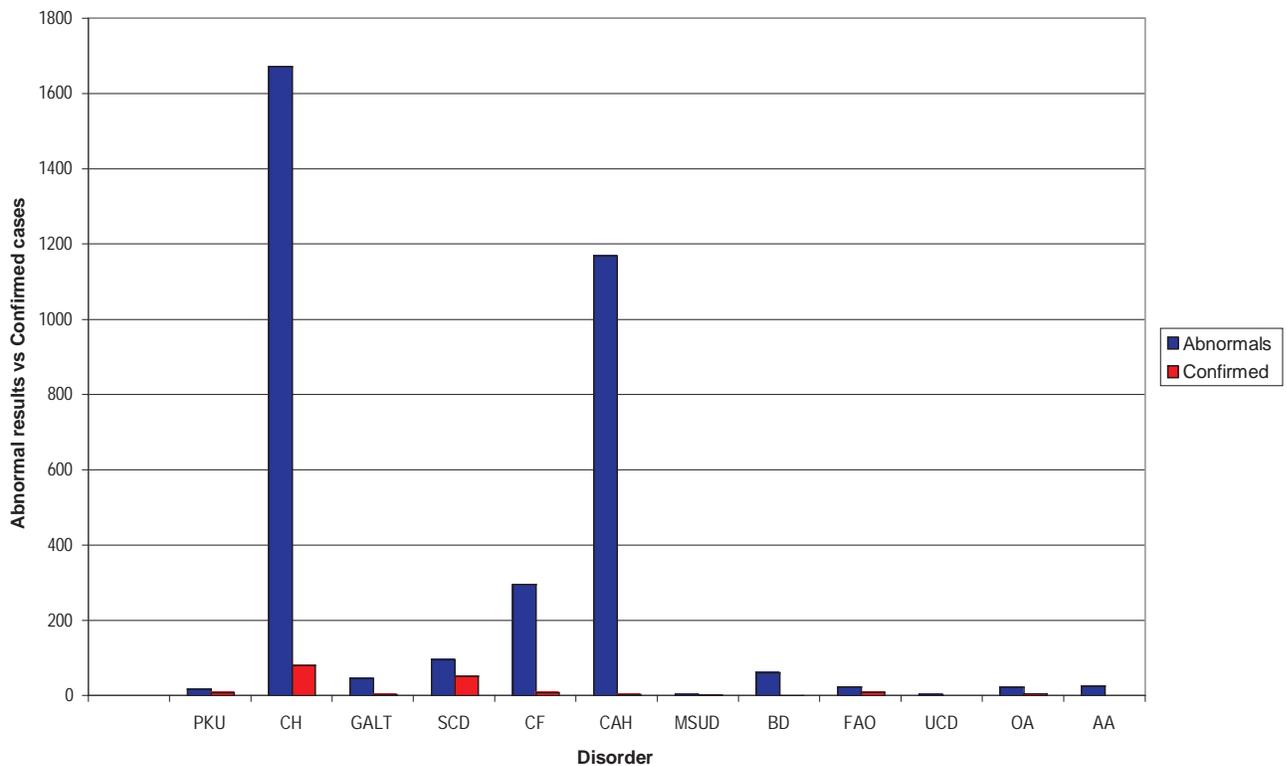
There were 28 abnormal results reported to follow-up as “possible amino acid disorder”. Currently, these disorders are not mandated, but may be detected using current technology. If these disorders are suspected, affected babies are followed by NBS until the babies are cleared of the disorder or diagnosed with the disorder.

Newborn, Infant and Toddler Services

Breakdown of Abnormal Test Results reported to NBS Follow-up Services



NJ NBS FY06 Abnormal; Results vs confirmed cases



In Calendar Year 2006:

- ❖ 99.2% of babies discharged home from New Jersey hospitals had their hearing tested, with 109,181 babies receiving screening. This is an improvement over the 2004 and 2005 rates of 98.8%. The following chart illustrates this point.
- ❖ For babies born during the first half of 2006 that did not pass their inpatient test, rates of reported follow-up testing were comparable to 2005, with 63.5% having follow-up reported to the EHDI Program.
- ❖ Data for registration of babies with hearing loss is still incomplete for 2006 births. Of babies born in 2005, there were 106 babies reported to the EHDI Program with a diagnosis of hearing loss as of December 2006. Seventy-four of these babies were diagnosed before six months of age, an increase over 2004 births with 66 babies identified by six months.

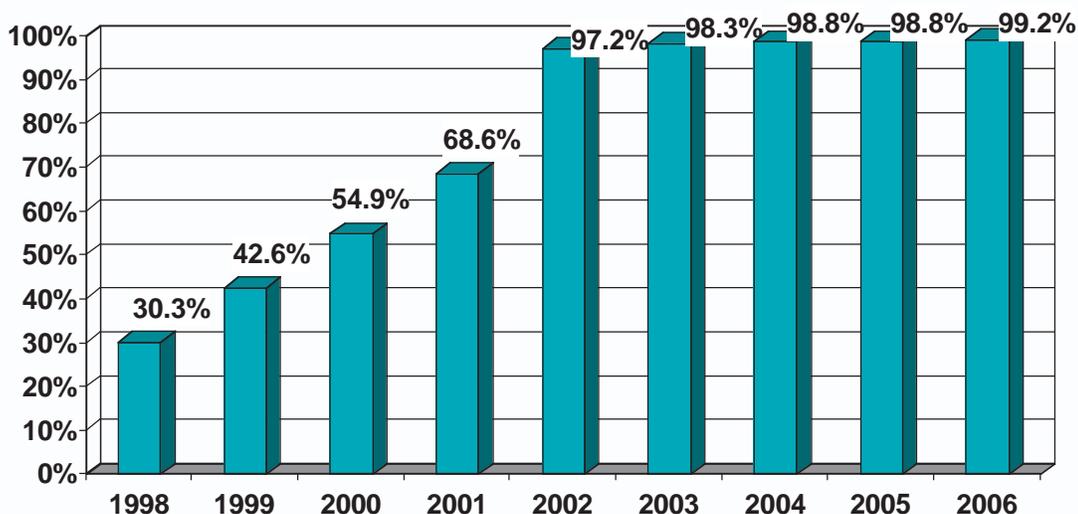
Birth Defects Registry and Monitoring Program

New Jersey has had a birth defects reporting system since 1928. The original system, which required the reporting of 'crippled children', was the first enacted in the United

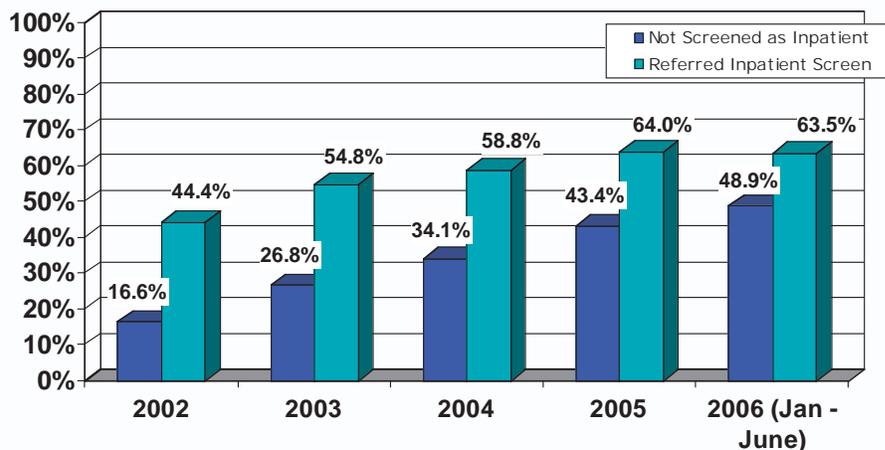
States. The reporting served as an entry point into a system of services for indigent children with certain disabling conditions. A birth defects reporting system continues, mandated by P.L. 1983 Chapter 291 (Birth Defects Registry Law) and N.J.S.A. 26-8-40.20 et seq.

The Birth Defects Registry and Monitoring Program identifies children born with specific birth defects, which may be diagnosed at birth or later, and refers them to the County-based Case Management Units, who link the identified children and their families with specialized services. See Table 1 for the number of children registered by the type of diagnosis for the calendar years 2002 through 2006. Tables 2 and 3 contain information about selected birth defects in children born from 2000 through 2004. More detailed information about the types of birth defects present in New Jersey's children may be found in the annual Congenital Malformations Surveillance Report published by the National Birth Defects Prevention Network (NBDPN). The 2006 Report was published in the December 2006 issue of Birth Defects Research Part A Clinical and Molecular Teratology.

Screened before nursery discharge



Percent with outpatient follow-up documented



*Includes both children receiving either outpatient rescreening or diagnostic testing

In 2006, the Centers for Disease Control and Prevention continued to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance System. Rutgers, the State University – Bloustein School of Planning and Public Policy - continued the development of a new Birth Defects Registry System (BDRS) through a multi-year Memorandum of Agreement (MOA). They continued to work with staff from the Early Identification and Monitoring (EIM) Program, hospitals, county-based case management units, and the Family Centered Care Services Program to identify critical needs. A preliminary electronic registration form was developed during 2006. The emphasis in 2007 will be on the development of a case management component for the electronic reporting system. The BDRS will improve reporting from hospitals and medical providers as well as improve the information transfer between the Department and the County-based Case Management Units through a secure and HIPAA-compliant virtual private network.

In 2006, the Special Child Health Services (SCHS) Registry:

- ❖ Processed nearly 11,000 registration forms;
- ❖ Identified over 8,000 new children with special health needs;
- ❖ Updated about 1,000 records of previously registered children; and

- ❖ Referred over 8,000 families of living children to the Special Child Health Services County-based Case Management Units

In addition to identifying children through the formal registration process, the EIM Program attempts to identify additional children by cooperatively working with the birthing hospitals, Early Hearing Detection and Intervention (EHDI) Program, and New Jersey Early Intervention System (NJEIS). The Program conducts annual audits of all New Jersey birthing hospitals to identify children who have not been registered. A quarterly report, which lists all children registered by the hospital, is sent to each birthing hospital to assist them in their quality assurance efforts to ensure that all children with mandated birth defects are reported to the SCHS Registry. The Program also works with the EHDI Program and NJEIS to identify children who are known to these programs but have not been registered.

In 2006, the yearly birth defects registry quality assurance audit was conducted at the 61 maternity hospitals in New Jersey and the two Children's Specialized Hospitals. The audit has been conducted for the past ten years as one method to ensure that all hospitals are in compliance with the mandate to report birth defects. For the year 2005, the audit found that the

Newborn, Infant and Toddler Services

Table 1. Children Registered by Type of Diagnosis

Calendar Year	Special Needs	Birth Defects	Total
2002	3022	5370	8372
2003	2267	5104	7371
2004	2172	6049	8221
2005	2258	5716	7974
2006	2738	6190	8928

Table 2. Children Registered with Congenital Defects

NEW JERSEY REGISTRATIONS OF CONGENITAL DEFECTS

BIRTH YEARS 2000 - 2004

	Non-Hispanic White	Non-Hispanic Black or African	Hispanic	Other/Unknown	TOTAL
Metabolic Disorders	552	166	208	79	1005
Central Nervous System	471	251	280	86	1088
Cardiovascular	6293	2781	2175	829	12078
Respiratory System	345	108	128	48	629
Digestive System	1136	343	493	115	2087
Genitourinary	3262	678	843	471	5254
Musculoskeletal	2042	605	779	273	3699
Chromosomal Anomalies	774	229	283	116	1402
Miscellaneous Anomalies	81	22	35	12	150
Teratogens	79	113	59	7	258
Orofacial Anomalies	863	237	416	145	1661
Integument Anomalies	427	189	186	104	906
Total	13886	4741	4801	1876	25304
00-'04 NJ LIVE BIRTHS	299,542	88,401	122,456	66,820	577,219

Table 2. Children Registered with Congenital Defects by Race

BIRTH DEFECTS RATES PER 1000 LIVE BIRTHS

BIRTH YEARS 2000 - 2004

	Non-Hispanic White	Non-Hispanic Black or African	Hispanic	Other/Unknown	TOTAL
Metabolic Disorders	1.84	1.88	1.70	1.18	1.74
Central Nervous System	1.57	2.84	2.29	1.29	1.88
Cardiovascular	21.01	31.46	17.76	12.41	20.92
Respiratory System	1.15	1.22	1.05	0.72	1.09
Digestive System	3.79	3.88	4.03	1.72	3.62
Genitourinary	10.89	7.67	6.88	7.05	9.10
Musculoskeletal	6.82	6.84	6.36	4.09	6.41
Chromosomal Anomalies	2.58	2.59	2.31	1.74	2.43
Miscellaneous Anomalies	0.27	0.25	0.29	0.18	0.26
Teratogens	0.26	1.28	0.48	0.10	0.45
Orofacial Anomalies	2.88	2.68	3.40	2.17	2.88
Integument Anomalies	1.43	2.14	1.52	1.56	1.57
Total	46.36	53.63	39.21	28.08	43.84

Information on the occurrence in New Jersey of 45 selected birth defects may be found in the annual reports published by the National Birth Defects Prevention Network on their website, www.nbdn.org. Current and previous reports are available. All reports were published in peer reviewed journals (Teratology or Birth Defects Research Part A: Clinical and Molecular Teratology) and are comprised of two parts: 1.) a series of articles relating to various issues in surveillance, epidemiology and application of surveillance data to birth defects prevention and public health programs, and 2.) statistical data from population-based registries and surveillance programs across the United States.

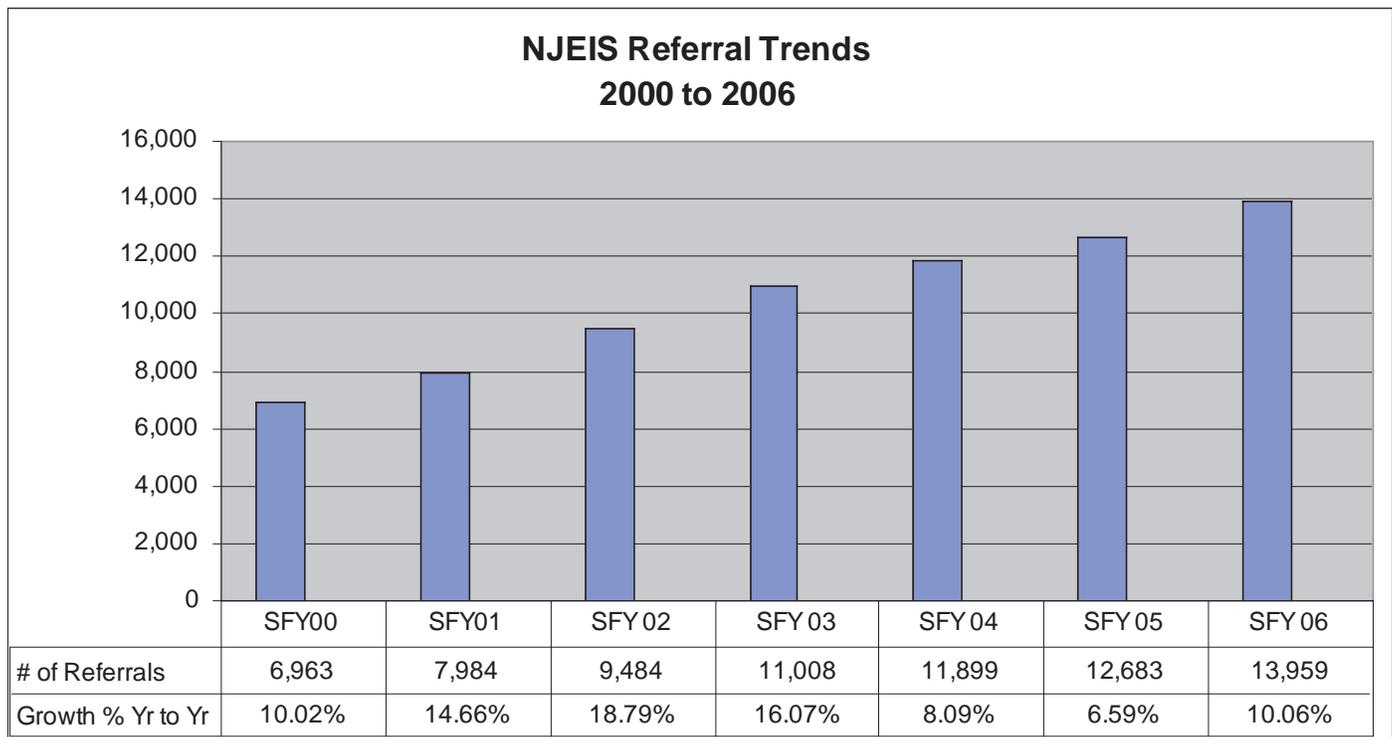
percentage of children not registered was 11.3% compared to 1998 when the percentage of non-registered children was 17.2%. Conducting audits each year has proven to be beneficial in reducing the number of children not registered, thus ensuring that children with mandated conditions are reported to the Registry. Through registration, children with birth defects and other special health care needs and their families gain access to comprehensive, community-based culturally-competent, family centered care through our Family Centered Care Program. In addition, identification of these non-registered children provides a more accurate statistical analysis of the incidence of birth defects in the State.

An Act passed on August 5, 2005, mandated the Department to amend the Birth Defects Registry rules

to expand reporting to birth through age five years; current rules mandate birth through age one year. Additionally, the law mandated adding severe hyperbilirubinemia as a reportable condition. These amendments will increase the identification of children to the Birth Defects Registry. During 2006, an expert panel was convened to assist Registry staff in developing protocols and procedures for the expanded reporting. New rules implementing the recommendations of the panel will be proposed in 2007.

The Program continues to work with staff from NJDHSS Consumer and Environmental Health Services and New Jersey Department of Environmental Protection (NJDEP) on an Environmental Public Health Tracking (EPHT) project to study selected birth defects and environmental factors in New Jersey. An abstract

Newborn, Infant and Toddler Services



NJEIS Referral Trends 2000 to 2006:

This table documents that NJEIS has experienced significant growth in the number of cumulative referrals received each year from 6,963 in 2000 to 13,959 in SFY 2006.

related to this work was submitted and accepted for presentation at the 10th Annual National Birth Defects Prevention Network Meeting held in February, 2007 in San Antonio, Texas.

The Program actively participates in the National Birth Defects Prevention Network, which is a group of individuals involved in birth defects surveillance, research, and prevention. The mission of the National Birth Defects Prevention Network is to establish and maintain a national network of state and population-based programs for birth defects surveillance and research to assess the impact of birth defects upon children, families, and health care; to identify factors that can be used to develop primary prevention strategies; and to assist families and their providers in secondary disabilities prevention. A poster describing the use of pulse oximetry to identify children with congenital cardiac malformations was presented at the most recent national meeting.

New Jersey's Early Intervention System (NJEIS)

The New Jersey Department of Health and Senior Services (DHSS) is designated by the State of New

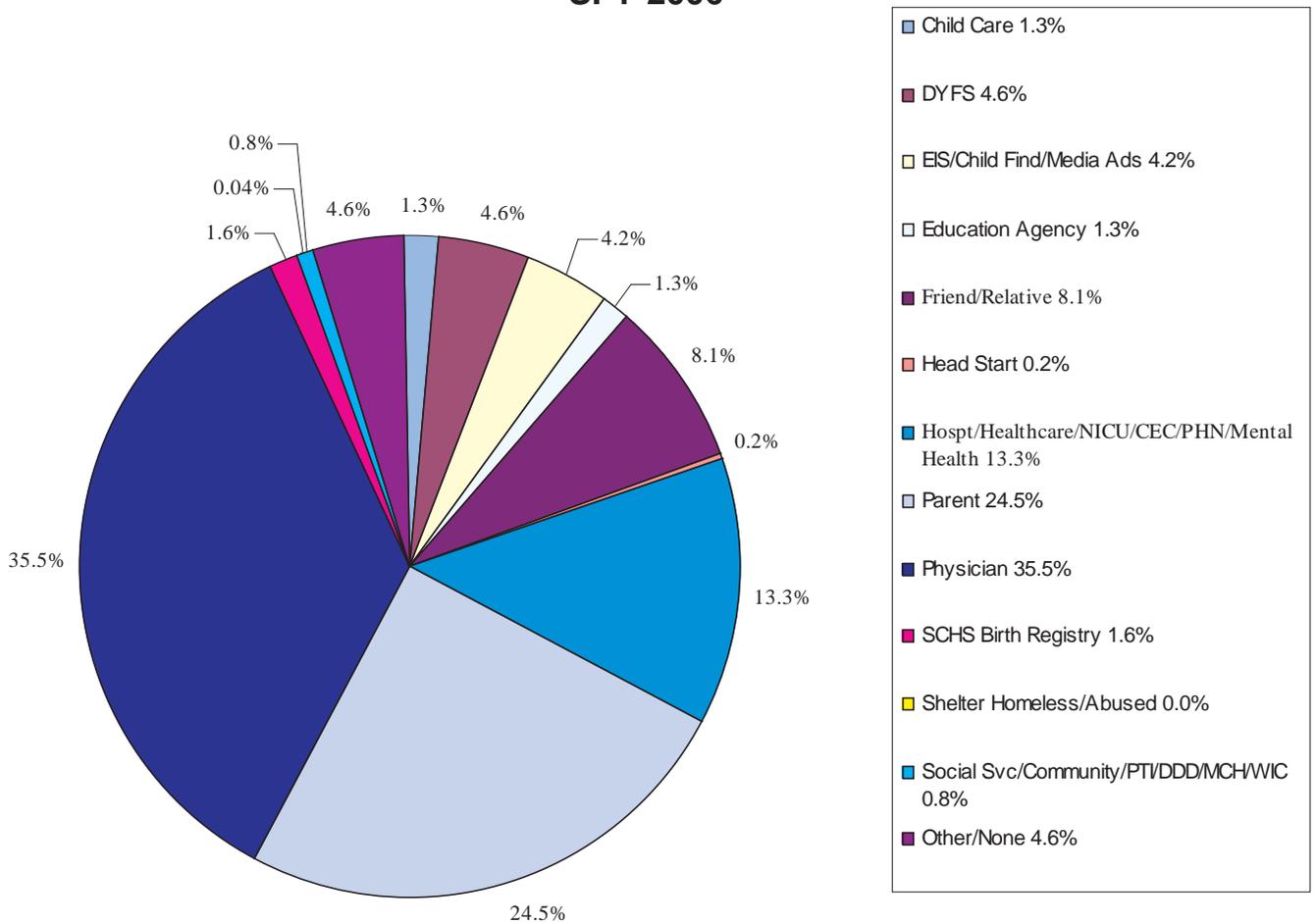
Jersey as the lead agency for early intervention for children, birth to age three, with developmental delays/disabilities, and their families. As such, DHSS is ultimately responsible for implementing its general supervisory authority to ensure the availability of appropriate early intervention services for eligible infants, toddlers and their families in accordance with the Part C requirements under the Individuals with Disabilities Education Act (IDEA). Additional information on the Early Intervention System is available at www.nj.gov/health/fhs/eis/index.shtml.

As required under the reauthorization of the Individuals with Disabilities Education Act, NJEIS submitted a six year State Performance Plan (SPP) to the U.S. Department of Education, Office of Special Education Programs on December 2, 2005. A revised SPP and Annual Performance Report (APR) were submitted on February 1, 2007.

Improving fiscal and programmatic management of the system continued as a priority in SFY 2006 through the implementation of a Central Management Office

Newborn, Infant and Toddler Services

**NJEIS Referral Pattern by Source of Total Referrals
SFY 2006**



NJEIS Referral Pattern by Source of Total Referrals in 2006: This table documents referral sources on all children referred in State Fiscal Year 2006 (July 1, 2005 to June 30, 2006). This documents that the highest percentage of referrals come from health and medical referral sources.

(CMO). Priority activities included:

- ❖ Data entry and data clean-up for the comprehensive system point of entry database to ensure data is accurate and complete in meeting general supervision requirements;
- ❖ Analyzing the system point of entry data to project short and long term cost of early intervention services, actual utilization of services versus planned or anticipated use, and data audits to monitor statewide performance and compliance;
- ❖ Conducting data audits to monitor performance and, as necessary, correct non compliance using system point of entry data; and

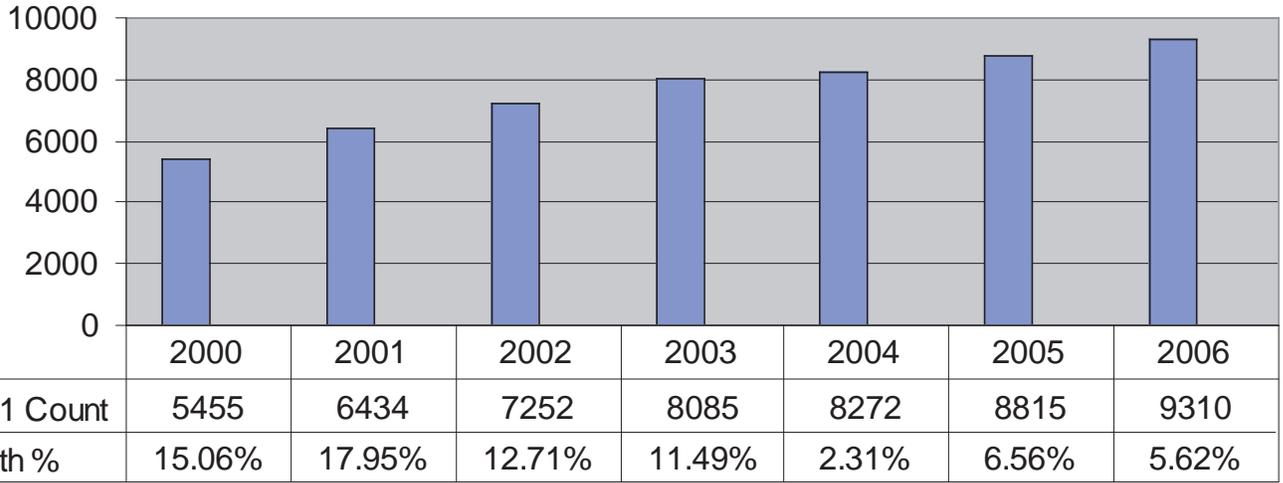
- ❖ Increasing fund recovery through family cost participation billing and Medicaid claims.

In SFY 2006:

- ❖ Referrals - 13,959;
- ❖ Cumulative Child Enrollment Count – 17,472;
- ❖ December 1, 2006 Count (Point in Time Enrollment) - 9,310; and
- ❖ December 1, 2005 - 2006 growth rate - 5.62%

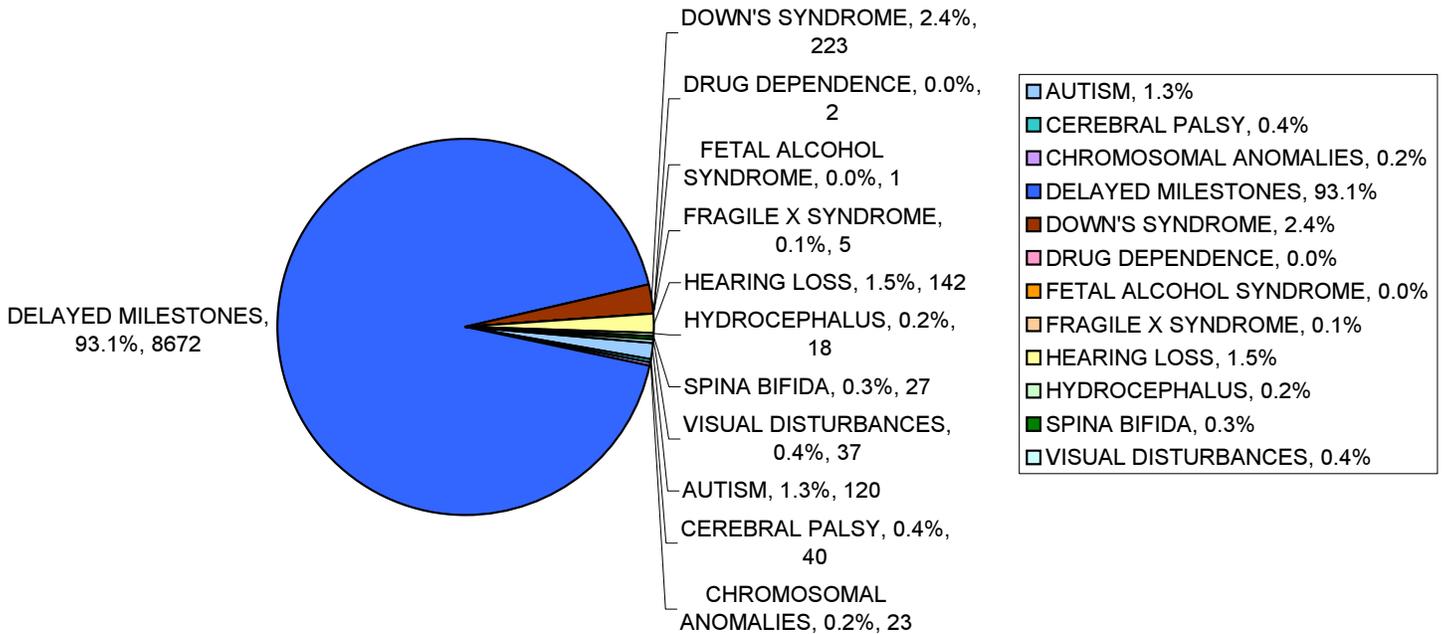
Newborn, Infant and Toddler Services

NJEIS Receiving Early Intervention Services on December 1



Number of Children Receiving Early Intervention Services on December 1:
NJEIS has experienced significant growth each year with a 70.67% growth increase since 2000.

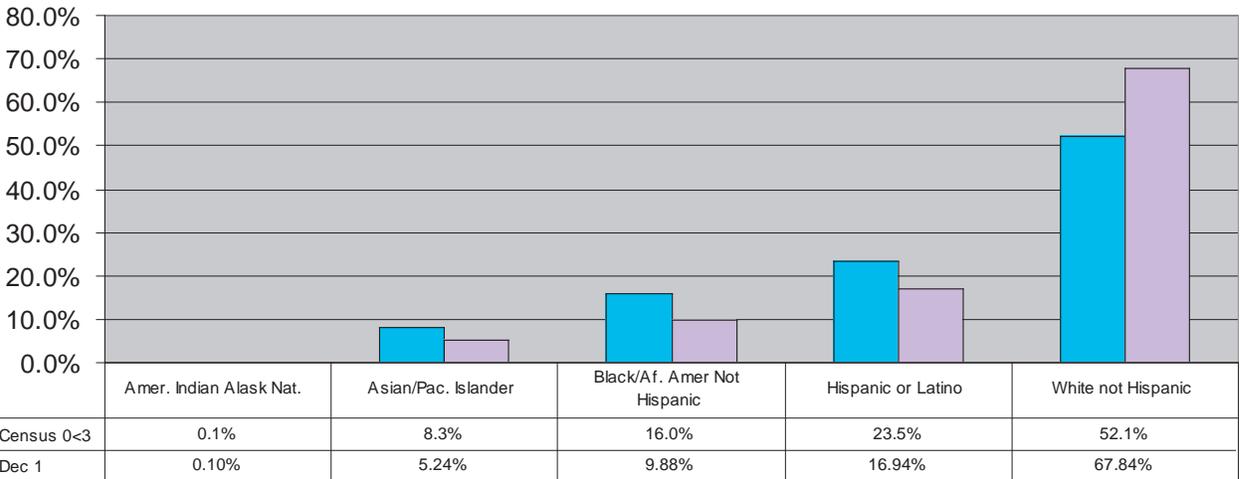
**NJEIS Most Commonly Served Diagnoses
 December 1, 2006**



NJEIS Most Commonly Served Diagnosis:
 This table documents eligibility/diagnosis data on children in the December 1, 2006 Federal Child Count as represented in the System Point of Entry database.

Newborn, Infant and Toddler Services

**NJEIS Dec 1 2006 Child Count
Race & Ethnicity Percentage Compared to
2005 Projected Census < 3 yrs**



Race & Ethnicity

NJEIS December 1, 2006 Child Count Race and Ethnicity Percentage Compared to 2005 Projected Census age 0 to 3 years: This table reports on the race/ethnicity of children in the NJEIS on December 1, 2006 as compared to the race and ethnicity on the 2005 Census. This data will be used to inform child find efforts.

Child and Adolescent Health Services

Child Health

Child Health Services works to improve the health, safety, and well being of children and families in New Jersey. Supported programs are designed to promote, and protect the health of parents, and children, with an emphasis on at-risk populations, through assessment, policy development and assurance of access to quality services, in collaboration with other State agencies, local health departments, and community based agencies.



Programs emphasize the adoption and maintenance of healthy behaviors, preventive services, and primary care, with a strong commitment to excellence at all levels. State level responsibility includes coordinating initiatives and grant activities in the areas of Prevention Oriented Services for Child Health, Childhood Lead Poisoning Prevention, Child Care Health Consultation, Early Childhood Comprehensive Systems Planning, Nutrition and Fitness and Oral Health.

Childhood Lead Poisoning Prevention

Because their neurological system and organs are still developing, lead exposure is most damaging to children under six years of age, particularly those between six months and three years. Lead's effects can include learning disabilities, developmental delays, hyperactivity, decreased hearing, mental retardation and possible death.

State law [N.J.S.A. 26:2-137.2](#) requires health care providers to screen all children six years of age and younger for lead poisoning. [N.J.A.C. 8:51](#) requires all children to be screened at approximately 12 and 24

months of age, as well as children three to six years of age who have not previously been screened. This schedule conforms to current CDC guidelines. The lead screening law also requires laboratories to report the results of all blood lead tests of children to the DHSS. This requirement became effective in July 1999. The Childhood Lead Poisoning Surveillance System (CLPSS) receives and records these reports. The system identifies elevated test results and notifies the local health department in whose jurisdiction the child resides. These notices are tracked to monitor local health department compliance.

[N.J.S.A. 24:14A](#) bans the use of lead-based paint. This same law also requires local boards of health to investigate reported cases of lead poisoning.

In SFY 2006, 200,581 children were tested. This is a 2.1% increase over FY 2005. In SFY 2006, 3653 children were identified with elevated (> 10 ug/dL) blood lead. This is 1.8% of all children tested. 615 children (0.3% of all children tested) were identified with elevated blood lead levels > 20 ug/dL. These children were reported to their local health departments for follow-up. Between 1994 and 2006, the number of children reported annually with blood lead levels > 20 ug/dL decreased from 4,757 to 615 - a decrease of 87.1%.

CHILDREN WITH BLOOD LEAD >20 ug/dL

BY STATE FISCAL YEAR (SFY):

The bar chart, on page 37, demonstrates the change in number of children reported with elevated blood lead levels by the fiscal year

The “*Si No Sabes, Pregunta Que Es El Plomo*” (If You Don't Know, Ask About Lead) DVD was developed based on the success of the 2004 award winning video “Prevent Lead Poisoning”. This DVD gives lead poisoning prevention messages in Spanish through the use of Latino music. The DVD was developed by program staff and produced through New Jersey Network.

A Case Management Evaluation Plan was developed in January 2006 with assistance from Centers for Disease Control and Prevention (CDC) staff and Harvard School

Child and Adolescent Health Services

Table 1 (New Jersey State data)

Number of Children between 6 and 29 months of age, by blood lead levels as reported during each State Fiscal Year

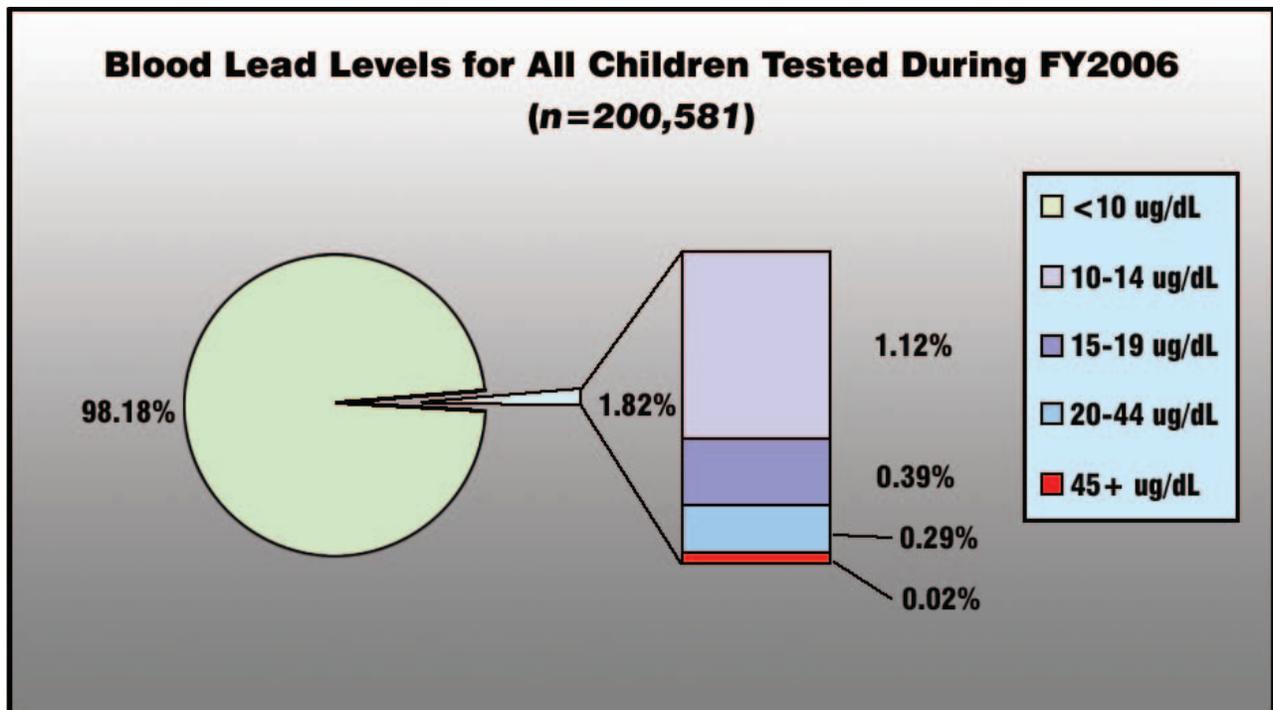
SFY	10-14	15-19	20-44	>45	Total >10 ug/dL	Total > 20 ug/dL	Number of Children Screened
2003	1283	514	330	23	2150	353	90112
2004	1301	442	354	23	2120	377	92645
2005	1188	420	334	24	1966	358	98076
2006	1017	334	281	14	1646	295	102505

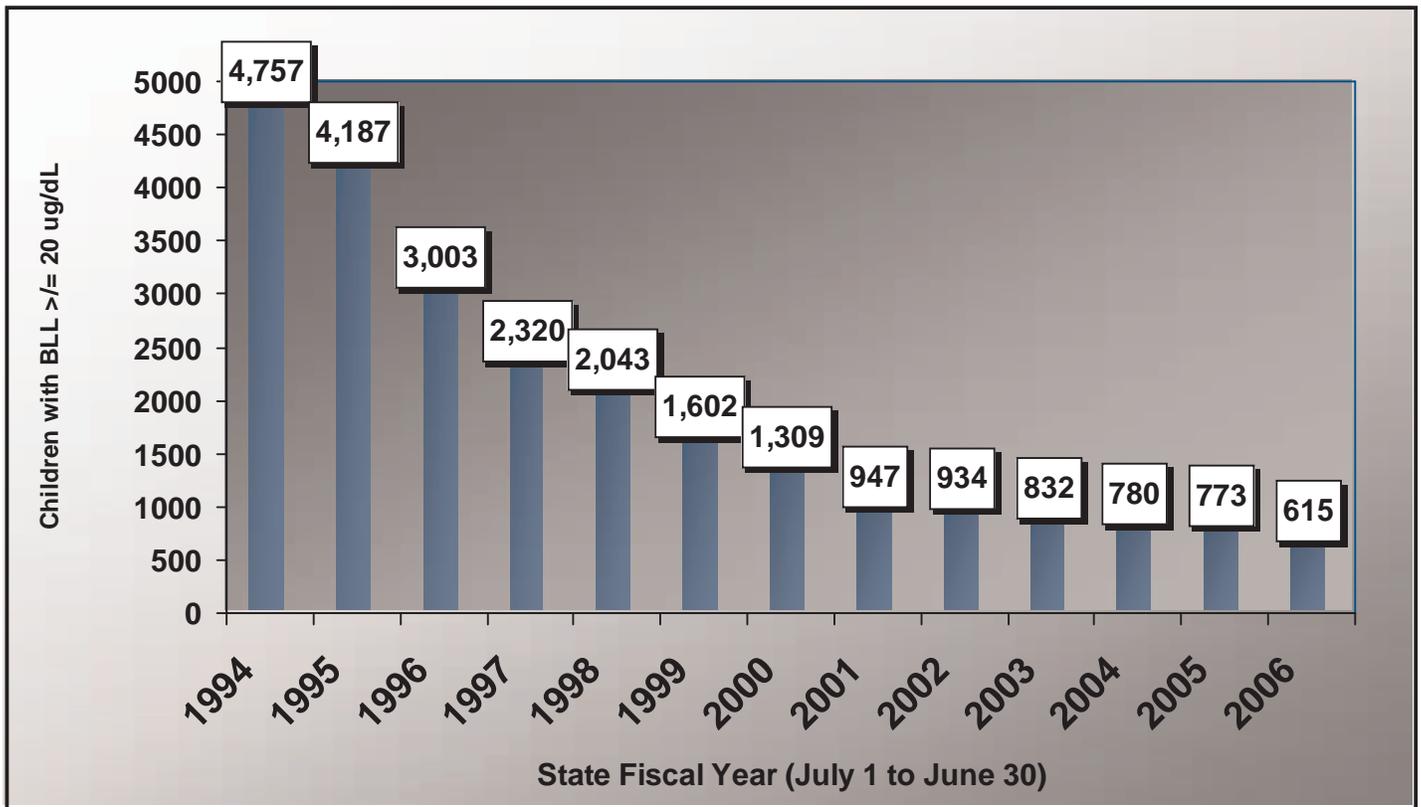
Table 2 (New Jersey State data)

Number of all Children by blood lead levels as reported during each State Fiscal Year

SFY	10-14	15-19	20-44	>45	Total >10 ug/dL	Total > 20 ug/dL	Number of Children Screened
2003	3263	1135	776	56	5230	832	172932
2004	3059	1036	725	55	4877	780	181265
2005	2784	990	731	42	4547	773	196335
2006	2249	789	583	32	3653	615	200581

*Children under the age of 17 Years





of Public Health graduate students. Program staff was involved in the development of the evaluation plan, which will be implemented over the next 3 years. The outcome will determine best practices for local health departments to effectively and efficiently manage elevated blood lead cases to levels lower than 10 ug/dL.

Early Childhood Comprehensive System (ECCS) for Healthy Growth and Early Learning

The Early Childhood Comprehensive Systems grant is in the first year of implementation. Systems partnerships have expanded to include the Head Start-State Collaboration Project, the newly established Department of Children and Families, Division of Prevention and Community Partnerships, and the Governor's Office.

A task force was assembled in January 2005 to develop best practice standards for infants and preschool children served by public health nurses from local health departments. The task force will be forwarding their recommendations to the Office of Public Health Infrastructure in October 2006. The four recommended strategies involve the provision of: 1) Child Health Conferences services to a select population, 2) Child

Care Health Consultation services to the child care population, 3) Home visiting services, in collaboration with community partners, and to be defined by the needs of the population, and 4) Professional development opportunities to address the first three strategies. During the past year the task force has also begun work on developing the tools necessary to implement, document, and track the services and educational opportunities of the four recommended strategies.

The Child Health Regional Network (CHRN), established in 1986, continues to: facilitate communication between personnel from the State Health Department and local health departments; promote networking among public health nurses, other local health department staff, and other governmental and non-governmental community agencies and stakeholders involved in children's issue; and provide educational opportunities to support the provision of preventive health services to children, families, caregivers and providers. Topics for 2006 include: Early Childhood Nutrition and Physical Activity, Child Abuse Prevention: Issues, Reporting, and Interventions; Eliminating Childhood Lead Poisoning by 2010: Surveillance, Case Management and Prevention; Public

Child and Adolescent Health Services

Health Issues for New Jersey Immigrants and Vulnerable Populations. Approximately 200 public health nurses, school nurses, nurses working in child care, case managers, health officers, nutritionists, social workers, and other allied health and social service providers attended each of the quarterly CHRN meetings held in four locations statewide.

Following the home visiting forum held in April 2005, members of the Prevention Subcommittee of the New Jersey Task Force on Child Abuse and Neglect (NJTFCAN), Home Visiting workgroup, established a Comprehensive Home Visiting System model that was presented to and accepted by the NTFCAN. This collaboration model will be used to promote home visiting as a strategy for parent education and family support in the effort to reduce the risk for child abuse and neglect in New Jersey.

The CHRN will be used as a vehicle to enlist the engagement of public health nurses in providing home visiting services to targeted populations in their communities as well as providing ongoing education on topics relevant to home visiting service delivery, child care health consultation, and enhancement to services provided in Child Health Conferences (CHCs).

Among the activities accomplished as a result of sustaining the efforts of Health in Child Care New Jersey and implementation of the New Jersey's ECCS grant project are the following:

- ❖ There has been continued involvement with the Pediatric and Adult Asthma Coalition of New Jersey's Child Care Subcommittee that included the writing of a train-the-trainer curriculum in response to a grant award from the Environmental Protection Agency "Steps to Controlling Asthma Triggers in the Child Care Setting for Directors". The curriculum was piloted in 2006 in three cities—Newark, New Brunswick, and Plainfield. This project complements the asthma tool kit for child care that was developed and piloted in 2004 and is currently being presented to child care providers statewide.
- ❖ The PLAY Task Force, that developed curricula for infant/toddler and preschool physical activity, joined with the Interagency Council on Osteoporosis to develop an early childhood nutrition curricula. The nutrition curriculum was introduced to participants at the Annual Health in Child Care Conference held in May 2006. Individuals had an opportunity to express their interest in participating in a training of

such a curriculum and/or to participate in a train-the-trainer session that would be piloted in the coming year.

- ❖ The *Early Childhood Health Link Newsletter* continues to be produced and distributed quarterly to regulated child care providers through the 21 county Child Care Resource and Referral Agencies. The newsletter is also available on the Department/Division's website at www.state.nj.us/health/fhs.

The **Prevention Oriented System for Child Health (POrSCHe)** was a home visiting program that provided children/families with a comprehensive prevention oriented outreach and case management system that focused on low income families with children six years of age and younger. Special emphasis was placed on identifying direct home-based, parent-focused, intervention strategies utilized to achieve healthy outcomes for the infant and child as measured by immunization rates, blood lead levels, nutritional status, growth and development milestone, parent-child interaction patterns and general health indicators.

Eleven Health Departments were awarded grants in 1997 and admitted both lead burdened families and non lead burdened families to the program. In early 2006 the POrSCHe programs were notified that funding for the program would be redirected to only those families that had children that were lead-burdened. This change was necessary in order to provide support for case management services for children affected by lead poisoning and their families living in high risk areas of the State. It is also hoped that this effort will help New Jersey reach the goal of eliminating lead as a public health problem by 2010. During 2006 all POrSCHe families who were lead burdened were transitioned to Childhood Lead Poisoning Prevention Programs (CLPPP) and the non- lead burdened families were either referred to other programs or discharged from case management.

The Childhood Lead Prevention Programs adhere to the same mission and model of case management as defined for the POrSCHe programs but solely focuses on the management of children/ families with elevated lead levels. The State now funds twelve CLPPPs at health departments with the largest at-risk lead burdened populations including: Camden County, Newark, Irvington, Jersey City, Trenton, Middlesex County, Monmouth County, Paterson, Plainfield, East Orange, Cumberland /Salem Counties and the City of Passaic.

Oral Health Education

A statewide Children's Preventive Oral Health Education Program is coordinated through a system of regional Preventive Oral Health Coordinators (dental hygienists). The coordinators provide preventive age-appropriate oral health and hygiene education for preschool and schoolage children, school staff, and parents, and support the schoolbased Fluoride



Mouth-rinse programs. The coordinators promote good oral hygiene, fluoride, dental sealants, nutrition, prevention of periodontal disease, and the prevention of oral trauma through the use of mouth guards. School staff and parents also receive education on the importance of dental care and dental sealants.

In FY 2006:

- ❖ Approximately 32,000 school age children participated in the weekly fluoride mouth-rinse program "Save Our Smiles";
- ❖ Over 55,000 children received preventive oral health education in school and community settings through a variety of age appropriate teaching methods such as formal classroom presentations and oral health teaching kits;
- ❖ Approximately 3,900 children and parents received oral health education by participating in community health fairs; and
- ❖ Approximately 1,200 pre-school children participated in the "Cavity Free Kids Programs".

Childhood Obesity Prevention

Obesity in childhood is a growing global concern and New Jersey is not exempt. Results of a 2004 statewide, retrospective survey of height and weight status indicated that 38% of sixth-grade students in our State are obese (20%) or overweight (18%).

The publication of the New Jersey Obesity Prevention Task Force Report and Action Plan was released and presented to the Governor and Legislature.

A one-day Leaders' Academy for Healthy Community Development was held in May 2006, to assist communities with designing local projects to promote health and physical activity. In tandem with the Leaders' Academy, the New Jersey Council on Physical Fitness and Sports and DHSS launched Healthy Community Development Grants. The competitive mini-grants of \$2,500 (twenty five hundred dollars) were awarded to communities to create a more healthy and active community by addressing physical inactivity. 20 individual New Jersey communities have been able to launch a variety of efforts to promote health and wellness at the local level. It is hoped that this 'seed' money will launch community

efforts that will be self-sustaining. Grants completed in December 2006 will be followed up to determine continuation efforts/success.

A sampling of accomplishments include projects such as Smart Steps - a pedometer walking project; marketing of a 'Safe and Healthy Community' with accompanying activity based community activities; first time provision of swimming lessons to seniors and young children; creation and distribution of walking maps and web site; an adult physical activity program created at a middle school to address both adult health of the teachers and simultaneously aimed at 'modeling' healthy behaviors for the students; creation of city-wide walking campaign; creation of a historic walking tour to increase physical activity in the community; collaboration with local health department and local businesses to stimulate walking in the town proper; designed map of recreational walking, biking and canoeing trails.

In May 2006 the New Jersey Council on Physical Fitness and Sports released a publication available in book and CD form titled *Get Fit New Jersey!*.

Child and Adolescent Health Services

Additional obesity prevention projects include:

- ❖ Fitness for Life staff at Pinelands Regional provided the motivation, encouragement and time availability to speak with each student to determine individual goals and objectives. 68 of 82 (83%) students completed the program; 73% of the students completing the program felt they improved their body image; and everyone participating gained knowledge regarding their health and fitness.
- ❖ A pedometer program with 200 children in four Sussex County schools was implemented. Math and Geography skills were incorporated into the program with students converting steps into miles and plotting their school's walking route using a U.S. wall map. Over the 8-12 week period of the program, the students were determined and surprised to reach the 10,000 step goal! Students had improved their sense of self-esteem and confidence, wanted to join sports teams and programs they had not previously considered, and increased their social skills. Many participants said that they felt better. The participants also shared the health information with family members and encouraged their family members to walk and exercise with them – once they got the “bug” themselves! The majority of children did not know there was so much sugar in soda!

Adolescent Health

Adolescence is the transitional period from childhood to adulthood characterized by challenges involving a changing and developing body, significant peer pressure, and changes in the relationship with the adults in their lives. There are more than one million adolescents in New Jersey ages 10-19 who are making decisions regarding a whole host of behaviors that can improve their health or, conversely, increase their risk for health problems.

Making a positive impact on adolescent behavior requires more than just focusing on traditional health education activities. Strategies for improving adolescent health now incorporate positive “youth development” activities to build skills and competencies that strengthen resiliency, an important asset not just for adolescence, but for life. Additionally, the needs of adolescents are evolving, multidimensional and complex. This requires a multi-faceted strategy, implemented and coordinated by a diverse network of key community



stakeholders, in order to increase the likelihood of successful outcomes.

The Adolescent Health initiative supports community-based health promotion and risk behavior reduction initiatives targeted to adolescents. Priorities in Adolescent Health include: reducing violence and injuries, including bullying and gang prevention; substance abuse; teen pregnancy, sexually transmitted infections, and teen parenting; promoting healthy food choices and increasing physical activity; and coordinating school health activities. These priorities are addressed at the community level through several initiatives:

Community Partnerships for Healthy Adolescents

This initiative funds adolescent-focused partnerships in eight New Jersey communities to develop a community-wide plan for jointly addressing the priority health needs of their adolescents; identify health education activities and programs to increase the knowledge and skills and ultimately the behavior of adolescents; and, to coordinate health resources and services. All the Partnership grantees have established and involved Youth Advisory Boards which function as liaisons between other youth in the schools and community and the adult members of the Partnerships. These youth

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identify current and emerging adolescent issues, recommend strategies to the Partnership and participate in the activities and events of the Partnership. This year, almost 56,000 youth were encountered through the activities of these 8 Partnerships. Highlights of their 2006 accomplishments include:

- ❖ The 5-day, out-of-school Suspension Alternative Program (SAP) in Bergen County for middle- and high- school students offers: one-on-one and group counseling; an on-site gym and PAL mentoring; conflict resolution/anger management; academic tutoring, goal setting; follow-up to assess goal(s) achieved at 3-6 month post SAP; and, referrals to intervention services. SAP currently serves 297 students from 22 school districts. Of the current enrollment, 56 students were referred for other intervention services. According to post-program school follow-ups, 51% of SAP students succeeded in achieving their behavioral goals and 39% had partial success. Two schools have established male and female group counseling sessions to assist students with making positive changes in their behavior. SAP is being independently evaluated, by Columbia University, for use as an evidence-based model program.

- ❖ The peer-to-peer Conflict Mediation Program at Perth Amboy High School completed 148 mediations, the majority referred by school administration; some were referred by teachers, indicating the program's recognition by staff. Students involved in conflicts as disputants in the previous year, were trained as mediators. With one exception, students involved in multiple disputes and mediations, required no further mediation.

- ❖ The "Photovoice" project in Burlington County got off on "shaky" ground with students that were referred to participate, lacking interest, being unsure of their role and disliking public speaking. With time, four students stepped into leadership roles and worked passionately taking pictures, writing captions and discussing how this project could impact the community. Photovoice received news coverage by several local newspapers, including the Philadelphia Inquirer. The opening night reception was held at the County College. The students "gleamed" with pride and confidence and were able to express their

feelings clearly and effectively. They were given recognition for their hard work and dedication.

- ❖ The Photovoice project at Dwight Morrow High School in Englewood, using twelve high school journalism students, documented the assets and significant issues. Many of the students had no prior photography or documentary experience. An exhibit was held at the Englewood Public Library where a slideshow/ lecture, reception and awards ceremony took place. The exhibit was subsequently moved to the Englewood City Hall.



- ❖ The Sussex County Gang Task Force is a community-based program with representatives from law enforcement, local businesses, schools, colleges, and other community-based, non-profit organizations. It has been recognized by the Juvenile Justice Commission as a unique prevention effort to be used as best practices/model-program for other N.J. counties. Presentations are audience specific (educators, parents, etc.) and coordinated through the Task Force to send a consistent message on gang prevention and awareness. This Task Force model is being replicated in Mercer County.

- ❖ 490 students experienced health information presented in a positive, fun environment at the Mt. Hebron Middle School Health Fair by 12 Statewide

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Parent Advocacy Network (SPAN) Partnership members. Evaluations are being used to plan the next fair.

- ❖ SPAN hosted Girlspeak/Girls, Inc., a grassroots effort, focusing on assertiveness training and harassment prevention in a six hour workshop. Twenty-three (23) middle and high school girls were bonded with 10 adult mentors, some being parents. Girlspeak will form the basis for an eight week fall 2006 program with 40 high school girls.

Since last year's report, the number of Partnerships advocating for, developing or changing policy has doubled from three to six, of the eight Partnerships. Examples of the policy topics were:

- ❖ Out-of-school suspension; requiring collaboration; changing case management requirements;
- ❖ School Wellness;
- ❖ Approval to "miss" class to participate in a health program;
- ❖ Dress code prohibiting gang attire or colors;
- ❖ Funding of services for children and families, parent education and involvement;
- ❖ Smoke Free New Jersey; and
- ❖ Alcohol tax increase if the funds would be used for treatment, prevention and enforcement.

In the youth arena, the Community Partnership for Healthy Adolescents initiative actively engages youth as partners. Youth provide input through youth focus groups and youth advisory boards. For a second year, youth have also had the opportunity to develop skills in planning, implementing and evaluating a "For Youth, By Youth" project. Youth conceive the idea; see it through implementation to the final outcome and "lessons learned." Here are some project highlights:

- ❖ "Bridging the Gap" brought together 30 students from two public high schools, committed to weekly meetings, to raise and discuss issues between the schools and work on

activities to bring about a more unified school environment. Their perseverance and efforts caught the attention of the school's administration and there was extensive media coverage throughout the school year. Their efforts provoked action from the school's administration that will promote greater unity between the schools for the following school year. Students want "Bridging the Gap" to continue and new students will be engaged to expand activities.

- ❖ "Art Where You Least Expect It!" changed the environment of the entire high school and affected the lives of a broad number of people. It was innovative, surprising and expanded both students and staffs' concept of health. The project was evaluated and in the future, an art project with a different group of students or different medium "Music (or Performance) Where You Least Expect It!" may be tried.
- ❖ Youth answered the question: "If you could change one thing in your community what would it be?" Changes in the youth, community leaders and the general community were triggered by letters written by the youth and mailed to the City Council and the Board of Education expressing their concerns in the community. In response to their letters, a Councilman arranged to meet with the Youth Advisory Board at the High School. Youth spoke honestly and offered suggestions on improving their community. An article



was printed in the local paper and an email from the Councilman documented the issues addressed by the youth and the action steps to follow. In addition, the Middle School is now interested in creating focus groups to have youth input.

- ❖ Cherokee HEAL (Healthy Eating Active Living) project raised awareness and educated youth on body image and self-esteem during National Eating Disorder week. The entire student body of 2,600 was exposed to a daily PSA that included facts about eating disorders and community resources. Two educational workshops were facilitated on eating disorders and resource cards were disseminated as well as placed in the nurse's offices and counseling centers. The youth learned responsibility, time management, decision-making, and leadership skills.
- ❖ The Students Against Destructive Decisions (SADD) gave pre-and post- knowledge tests and presented original skits on conflict resolution and violence prevention to 140 incoming sixth graders, at two schools. The result, 77% and 92% of students, respectively increased or maintained their knowledge. A vice principal requested SADD to return the following school year. The choice of topic would be up to the youth. The youth had difficulty getting administrative approval to present a skit on adolescent sexual abstinence to 8th graders but expect to have approval to present it in September 2007.
- ❖ A REBEL (Reaching everyone by exposing lies) group conducted a survey at a "Healthy Kids Day" to ask youth how they managed day-to-day stress and if they used tobacco, drugs and/or alcohol, to cope. The survey was followed up with stress management examples and demonstrations using creative, spiritual and healthy ways to manage stress. It was affirming for youth to see the topic of stress being acknowledged and addressed as an issue for them. The project was also interesting and helpful for adults to learn how to help kids when they feel overwhelmed.

These examples of involvement and partnership with youth are a win-win situation for all: youth have meaningful experiences and the Partnership has meaningful input from their youth audience!

Coordinated School Health

In 2006, the "Resource Guide to School Health Programs" identifying all the various school health programs sponsored by the Department, was updated. In August 2006, federal partners, including the Association of Maternal and Child Health Programs (AMCHP), sponsored a 2nd collaborative training in Albuquerque, New Mexico for DHSS and the Department of Education staff on "Breakthroughs in HIV/AIDS Prevention." New Jersey's vision is "To create and maintain a collaborative infrastructure that maximizes resources and outcomes through more accessible and effective sexual health education programs and services for youth". The Division's of Family Health Services and AIDS will be collaborating on the implementation of the Annie E. Casey model program "Plain Talk" in Vineland, Cumberland County. "Plain Talk" is a pro-active, community-based intervention that outreaches to adults-parents, family or other supportive adults – and educates them on adult/teen communication related to responsible sex, access to contraception and comprehensive sexual education. It is proven to be effective in reducing teen pregnancy, sexually transmitted infections (STI's) and HIV/AIDS in Latino, African



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American, white and Asian teens. The cost of implementing this model in New Jersey is approximately \$85,000 for a community size of 5000-7,000. Implementation is anticipated for January 2007.

On a local level, SPAN's Community Partnership for Healthy Adolescents approaches its work through the framework of a Centers for Disease Control Coordinated School Health (CSH) model. Through this model, the Partnership targets each of the eight CSH components (bolded below) and, in so doing, assures that its work is comprehensive. The School Health Index is used to assess each school's needs. This effort is led and sustained by a Health and Wellness Committee in each school and through the support of parents/caregivers who volunteer. A sampling of activities includes:

❖ **Comprehensive Health**

- ❖ *Week of Self Empowerment* to combat bullying and gang violence at Glenfield Middle School with 700 students.
- ❖ *Keepin' It Healthy*. Student-planned health fair for 650 youth in Mt. Hebron Middle School on topics addressing nutrition and fitness, depression, and rape prevention. Students also presented on chosen health topics and completed an evaluation of fair.

❖ **Environment**

- ❖ *Promotion of a Safe Environment*. Collaboration with the Upper Montclair Business Association and Union Congregational Church to create a safe haven for 140 middle school students on Friday afternoons as an alternative to "hanging out on the street".

❖ **Nutrition**

- ❖ *Promotion and Implementation of Federal and State Mandates on the School Wellness Policy*. Mountainside Hospital provided funding for an array of activities targeted at youth, parents and teachers for 2006-2007 school year including how to fundraise without sweets, distribution of free fruit in schools and celebrity chefs in the lunchroom.

❖ **Physical Education**

- ❖ *Y Nights*. Approximately 600 parents/students/teachers from four (4) schools enjoyed and explored an evening of physical activity at the Montclair YMCA.

❖ **Counseling**

- ❖ *Enhanced Services*. Local mental health agencies enhanced pro bono counseling services available within the middle schools.

❖ **Parent/Community Involvement**

- ❖ *First Annual Parent Conference* – 150 parents and caregivers participated in a day of workshops on issues ranging from substance abuse prevention and bullying prevention to communicating with your teen. Dr. Pat Cooper, nationally recognized expert on Coordinated School Health, was the keynote speaker.

❖ **Health Services**

- ❖ *Tracking the Connection between Physical and Mental Symptoms in HS*. Initiated computer tracking of students' physical symptoms and use of in-or out-of counseling services.
- ❖ *FEM Group*. High school nurses received funding for healthy snacks and reflection journals for FEM Group (For Exceptional Mothers) a group for pregnant students and new mothers.

❖ **Staff Wellness**

- ❖ *Annual Community Walk/Run in June* - district-wide staff participation, including School Board members, and sponsored by Community Partnership stakeholders.

Teen PEP

The New Jersey Teen Prevention Education Program (Teen PEP) was developed in 1995, and continues to be implemented through a collaboration of the Princeton Center for Leadership Training (PCLT), HiTOPS Teen Health and Education Center, Inc., and the New Jersey Department of Health and Senior Services.

Teen PEP is a school-based peer education and sexual health promotion program for 11th and 12th grade high school students. Teen PEP is taught by a team of trained faculty advisors who use group facilitation to provoke thoughtful discussion and self-discovery about sexuality issues. The students develop their communication, problem-solving, decision-making and, self-management skills making them not only knowledgeable peer educators but also effective sexual health advocates and role models. They conduct innovative prevention education workshops on a range of sexual health topics with peers, parents and educators in schools and in the community.

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In 2006, Teen PEP's accomplishments include:

- ❖ A total of 44 schools and organizations have implemented the Teen PEP model with an enrollment of 880 junior and senior high school peer educators;
- ❖ Four additional high schools began their planning year for program implementation;
- ❖ Thirty-four (34) advisors were trained at the Residential Training held January 17th to the 19th, 2006. Retreats are conducted throughout the spring, summer and fall by each individual school. Over 40 schools conducted retreats with their peer educators;
- ❖ A Stakeholders Institute was held on September 28, 2006 with thirty-five participants representing four schools;
- ❖ Twenty-seven (27) advisors were trained at the August Residential Training held on August 22-23, 2006;
- ❖ Six schools in their first implementation year were able to start Teen PEP by October 2006. One (1) school will hold their Teen PEP class starting February 2007;
- ❖ Twenty-three advisors were trained on hosting their Family Night event in August 2006. Additionally the decision was made for an additional training for advisors on conducting Family Night for December 5, 2006; and
- ❖ Approximately 300 workshops were conducted with a participation of about 25,000 students.

Teen Pregnancy Prevention / Teen Parenting

New Jersey

ADOLESCENT BIRTHS PROFILE

Total Female Population	1997	1998	1999	2000	2001	2002	2003
10-14	259,762	264,690	272,615	287,615	297,208	301,679	305,041
15-19	247,049	251,468	252,339	254,196	266,190	274,142	279,779
Number of Births to Teens under 20							
10-14	197	160	167	125	143	144	90
15-17	3,211	3,082	2,756	2,642	2,539	2,478	2,364
18-19	5,413	5,579	5,469	5,385	5,113	4,850	4,760
Total	8,821	8,821	8,392	8,152	7,795	7,472	7,209
Percent of Total Births to Teens	7.8%	7.7%	7.4%	7.1%	6.7%	6.5%	6.2%
Birth Rate							
15-17	21.0	20.1	18.0	16.6	15.5	14.7	13.8
18-19	56.3	56.5	55.2	56.9	49.9	45.9	43.9
15-19	34.7	34.1	32.6	31.6	28.8	26.7	25.5
Repeat Births to Teens < 20 (1)	20.6%	20.3%	20.1%	19.0%	18.3%	18.3%	N/A
Births to Unmarried Teens < 20	90.0%	89.5%	89.4%	89.3%	88.3%	88.9%	88.4%
Percent of Teens Who Received <20 First Trimester Prenatal Care	54.2%	53.8%	52.7%	50.4%	50.6%	51.6%	52.3%
Percent of Teens Who Received <20 No Prenatal Care	2.5%	2.0%	2.2%	1.8%	3.3%	2.6%	2.9%

Data is from the Center for Health Statistics unless otherwise noted.

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Adolescent Births by year, and percent of change

Age	1991	1993	1995	1997	1999	2001	2002	2003	% change 1991-2002	% change 1991-2003
10-14	243	279	226	197	167	143	144	90	-40.74%	-62.96%
15-17	3660	3586	3585	3211	2756	2,539	2,478	2,364	-32.30%	-35.41%
18-19	6192	5470	5512	5413	5469	5,113	4,850	4,755	-21.67%	-23.21%
Total Teens	10,095	9,335	9,323	8,821	8,392	7,795	7,472	7,209	-25.98%	-28.59%
% of Total	8.3%	7.9%	8.1%	7.8%	7.4%	6.7%	6.5%	6.2%		
State Births Totals	121,545	117,841	114,935	113,332	113,810	115,769	114,642	116,996	-5.68%	-3.74%

Adolescent Parenting

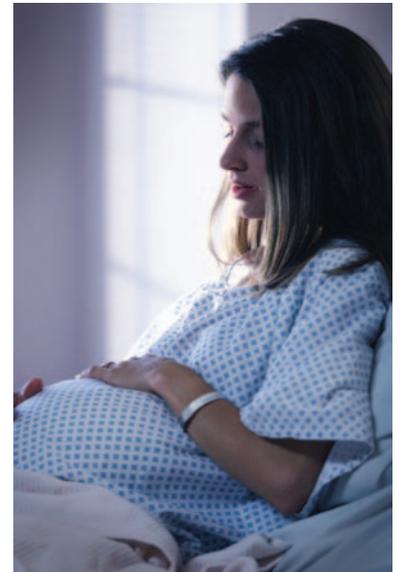
During 2006, the FamCare Adolescent Parenting Program served 83 clients with case management referral services that included home visits, preventive health promotion and education, reproductive health counseling, and follow-up monitoring to referrals made for economic and medical services for moms and their children. The program enrolled 69 infants/children <2 years and 99% were linked to a pediatrician or primary care provider, and 96% were age appropriately immunized. There were no referrals to DYFS for suspected child abuse or any confirmed cases. 97% of the clients did not have a repeat pregnancy within 24 months after delivery. In addition, a total of 46 group education sessions focusing on healthy relationships, developmental parenting skills, child support, goal setting, nutrition, and pregnancy prevention, were conducted with pregnant and parenting teens at Bridgeton and Cumberland Regional high schools in a collaborative agreement with School-Based Youth Services Program (SBYSP).

Abstinence Education

The Abstinence Education program was created by federal welfare reform law through the addition of Section 510 to Title V of the Social Security Act, and provided New Jersey with funding support starting in 1998 and continuing to the present.

New Jersey's abstinence education program supports nine community based programs that focus on youth ages 10 – 14 and stresses three elements of the federal definition of abstinence education:

- ❖ Teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health related problems;
- ❖ Teach young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances; and
- ❖ Teach the importance of attaining self-sufficiency before engaging in sexual activity.



In SFY 2006, 26,891 youth ages 10-14 received abstinence education through the program. Results of the 2004-2005 Abstinence Education Statewide Survey showed the following increased changes in three designated questions of importance. These are:

- ❖ I plan to be abstinent when I date. 44% of 2789 youth responded “yes” on the pre-test survey and 60% of 2,694 youth responded positive on the post-test survey. This was a 9% increase over last year's 27% increase.

- ❖ I can say “no” to someone who wants to have sex. 77.3% of 2,791 youth responded “yes” on the pre-test survey and 83.4% of 2,709 youth responded positive on the post-test survey. This was a 4% increase over last year’s 4% increase.
- ❖ Have you talked about abstinence with your parents? 41% of 2792 youth responded “yes” on the pre-test survey and 48% of 2708 youth responded positive on the post-test survey. This was a 9% increase over last year’s 7% increase.

The State of New Jersey has not applied for Title V abstinence education funding for federal fiscal year 2007 due to the strict guidance in regards to compliance with all eight (8) elements of the federal definition of abstinence education. New Jersey is one of seven states rejecting the federal money for abstinence-only sex education (California, Connecticut, Maine, Montana, New Jersey, Rhode Island and Wisconsin). After serious consideration, New Jersey rejected the funds because of significant changes to the federal requirements which would directly conflict with New Jersey’s Core Curriculum Content Standards and other state laws and regulations.

When the New Jersey Core Curriculum Content Standards for Comprehensive Health and Physical Education were revised and readopted in 2004 by the State Board of Education, (http://www.nj.gov/njded/cccs/s2_chpe.htm) the department made a concerted effort to emphasize abstinence while still requiring schools to address other forms of risk reduction and prevention. The standards also support instruction in goal setting, communication skills, and character development and address healthy relationships as well as peer and media influences. A fully implemented, high-quality PreK-12 health education program will prepare students for the rigorous challenges in adolescence and beyond.

Injury Prevention

Since 1995, the Mercer County Division of Mental Health has supported the suicide prevention and intervention initiatives undertaken through the Mercer County Traumatic Loss Coalition. This Coalition provides a coordinated response to traumatic loss incidents which can include suicides, homicides, motor vehicle crashes, natural or man made disasters, including terrorist attacks that may occur in the county. This Coalition is a State model and has been replicated on a part-time basis in all New Jersey counties.



The coalition has been available for on-going training for school personnel on managing traumatic loss in the community.

In collaboration with the Department of Human Services’ Traumatic Loss Coalitions, Family Health Services co-sponsored the 4th Annual Suicide Prevention Conference on May 11, 2006.

Cooperation with University of Medicine and Dentistry of New Jersey (UMDNJ) facilitated statewide trainings:

- ❖ January 12, 2006 Protocols For Response to Suicide;
- ❖ February 15, 2006 Protocols for Response to Homicide and gang violence;
- ❖ March 3, 2006 Ethno Cultural Variables – 1st Amendment Violations; and
- ❖ April 4, 2006 Resiliency Building

Staff from Department of Health and Senior Services provided technical assistance to all 21 Traumatic Loss Coalition at trainings held on June 14, 2006 and December 13, 2006.

An inter-agency, interdisciplinary team was convened by Department of Health and Senior Services Deputy Commissioner Eddy Bresnitz, MD, MS, to develop a New Jersey State Plan for Suicide Prevention. The team met on May 23 and 24, 2006 to review progress to date in New Jersey in the field and to adapt the National Strategy for Suicide Prevention: Goals and Objectives for Action to suit the needs of New Jersey. The meeting was facilitated by Ramya Sundararaman, Coordinator from the Suicide Prevention Resource Center, in Newton, Massachusetts. The New Jersey Suicide Prevention Plan was developed and is pending publication.

Services for Children with Special Health Care Needs

Services for Children with Special Health Care Needs

Case Management

A coordinated statewide county based Special Child Health Services case management for children age birth to 21 years with special health needs has been operational since the early 1980's. Case Management also operated the Fee-for-Service program, assisting eligible children without insurance to purchase hearing aids, orthotics and pharmaceuticals to treat asthma and/or cystic fibrosis.

The county based system of case management assists families of special needs children age birth to 21 years access comprehensive family centered culturally competent care, and serves as a single point of entry for the Early Intervention System.

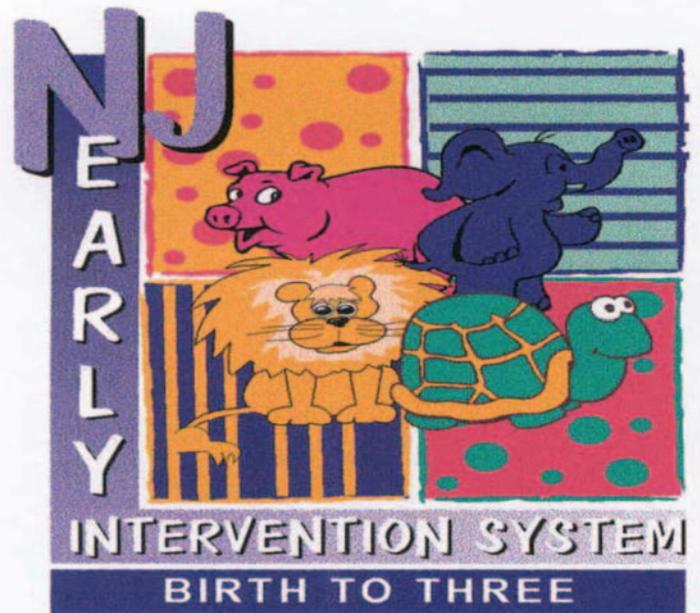
The case management units follow-up on 100% of children referred (Birth Defects Registry, Supplemental Security Income (SSI), Catastrophic Illness in Children Relief Fund Program, community based, and self referrals) to determine need for information and referral and/or active case management services. The Units screen all children for status of health care coverage and refer accordingly.

The case management system:

- ❖ Empowers families with children with special health care needs (CSHCN) to partner in decision making at all levels;
- ❖ Facilitates access to coordinated, comprehensive medical home for CSHCN;
- ❖ Assists CSHCN and families to access early and continuous health screening;
- ❖ Assists CSHCN and their families to access community based health services; and
- ❖ Assists children/youth with special needs to access appropriate supports to make transitions to all aspects of adult life, including adult health care, work and independence.

In 2006:

- ❖ Clients/beneficiaries served annually: 12,400 through case management and 125 through Fee-for-Service;
- ❖ Insurance status for children served through case management statewide; 30% SSI Disabled; 38% Medicaid, 4% Uninsured and non-Medicaid eligible, balance reported private insurance; and



- ❖ Age distribution of children served through SCHS Case Management indicated majority (88%) under age 13 years. However, slight increase in children served between ages 14-21 years, 12% of statewide caseload (3% increase from SFY 05).

In 2006 the program:

- ❖ Conducted a statewide family satisfaction survey on SCHS case management units. Overall, families were satisfied with Case Management services.
- ❖ Collaborated with the Statewide Parent Advocacy Network (SPAN) on Health Resources Services Administration (HRSA) funded Champions for Progress Center grant. The focus of the grant was Transition to Adulthood, and the intended work product is the development of New Jersey specific resource materials for use by families and professionals.
- ❖ Collaborated with the Early Hearing Detection and Intervention (EHDI) program, community partners assisting families with children that are hearing impaired, and families in planning and conducting a conference targeting services and supports for parents of deaf and hard of hearing children.
- ❖ The Fee-for-Service program realized a 7% increase in the number of hearing aids reimbursed in SFY 2006 (155 hearing aids) versus SFY 2005 (145 hearing aids). Likewise, children are being assisted to purchase hearing aids through the Fee-for-Service

Services for Children with Special Health Care Needs

program at a younger age. In SFY 2006, 43% of the children receiving assistance with the purchase of hearing aids were age 3 years or younger, versus 28% in SFY 2005. Mandatory electrophysiological newborn hearing screening, earlier reporting to the Birth Defects Registry and referral to the Case Management Units (CMUs), outreach by the CMUs, and linkage between the CMUs and Early Intervention Services appears to be resulting in earlier access to hearing aids through the Fee-for-Service program.

Child Evaluation Centers

Eleven statewide hospital-based Centers of Excellence provide comprehensive multidisciplinary evaluation of children age birth to 21 years, with congenital or acquired neurodevelopmental and behavioral disorders, follow-up newborn hearing screening and regional centers for fetal alcohol services.

In 2006:

- ❖ Jersey Shore University Medical Center Child Evaluation Center (CEC) held a spring conference for parents and providers, “Timely Topics in Pediatric Neurology and Developmental Disabilities;
- ❖ Morristown Memorial Hospital CEC held an evening educational program for parents and providers on the development of an Individual Education Plan (IEP);
- ❖ The six Fetal Alcohol Syndrome (FAS) Centers continued to make community based presentations; 57 presentations, reaching 2122 participants. The FAS Centers, as part of the FAS Task Force, conducted a statewide multi-media campaign to promote awareness of FAS, the importance of screening and diagnosis, and access to care. The web site maintained by the Centers has been updated as needed and can be accessed at www.beintheknownj.org;
- ❖ Statewide, the FAS Diagnostic Centers are continuing to use a one page FAS screening tool developed through a collaborative effort by the Centers; and

- ❖ UMDNJ/NJ Medical School, FAS Diagnostic Center continues in its efforts to develop a core curriculum for training health and allied health professionals on FAS, through a multi-year grant from the Centers for Disease Control.

In 2006, the CECs reported:

- ❖ Approximately 10,000 clients/beneficiaries were served, accounting for almost 37,000 visits;
- ❖ 47% of children presented with one of the Medicaid programs, representing a 10% increase from the previous year. 32% had private insurance non-HMO; a decrease of 7% from the previous reporting period. 11% reported having a commercial HMO, consistent with last year’s report; and
- ❖ 20% of the children evaluated were in the age range 3-5, while 54% of the children were in the age range 5-13.

Ryan White Title IV – Family Centered Care Network

New Jersey’s Statewide Family Centered HIV Care Network provides a full range of high quality, culturally sensitive and coordinated HIV/AIDS medical and social support services to women, infants, children, and adolescents infected with or affected by HIV disease.



Services for Children with Special Health Care Needs

The program continues to emphasize the identification of and outreach to HIV positive pregnant women, and minority adolescents.

The Network's vision of family health builds on an innovative integration of clinical services, research, and educational services to provide the best family care possible. For over 18 years, Network physicians and staff have been at the forefront of HIV care and are committed to improving the quality of life for people living with HIV disease.

In 2006 the program:

- ❖ The Ryan White Network developed and implemented two Statewide Case Study Days designed as educational forums for nurses, social workers, and physicians. The topics focused on TB and HIV Co-morbidity, and the HPV vaccine for HIV positive female adolescents and young women.
- ❖ The Ryan White Network offered two Statewide Learning Day Workshops for consumers. One was an adult retreat which focused on coping with grief and loss, and caregiving for chronic illness patients, and the second was designed for adolescent consumers and focused on the development of transitioning skills.
- ❖ The annual Care Act Data Report, including demographic, medical, and social service data, were collected from all seven agencies, aggregated and submitted to the federal office.
- ❖ Analysis of the interview data collected for the Ryan White biennial patient satisfaction survey was completed this reporting period. Three hundred sixty HIV positive patients responded to questions on 18 issues. The Network's Executive Advisory Committee reviews the aggregated data and recommends corrective action when needed.
- ❖ The annual Quality Improvement study was completed for 2006. In total, 244 charts were reviewed across three age groups, for receipt of medical and social services. Since the inception of a statewide total quality improvement effort in 2001, the pap rate for HIV positive women receiving care at a Network site has increased from 40% to 78%. Another significant change has been the number of children with an undetectable viral load. This number had steadily increased from 26% to 66% in 2006.



Enhancing service delivery to the target population:

- ❖ Continue to target youth, adolescents, and pregnant women for counseling, testing and treatment;
- ❖ Facilitating access to research;
- ❖ Maintaining consumer involvement;
- ❖ Furthering the reduction of perinatal HIV transmission;
- ❖ Identifying new adolescent infections and linking these patients to care;
- ❖ Enhancing visibility of the Network; and
- ❖ Evaluating the effectiveness and impact of the New Jersey Title IV Network.

Services for Children with Special Health Care Needs

2006 Demographics:

- ❖ African Americans account for 66% of clients receiving services from the Network and Hispanic clients account for 22% of enrolled clients.
- ❖ 3,654 clients were served
- ❖ A trend analysis as shown below demonstrates fewer babies born with HIV infection, and a growing adolescent population.

	2002	2003	2004	2005	2006
0-23 months	11	16	15	9	6
2-12 years	375	338	284	242	229
13-24 years	297	338	379	404	428
Women 24+	1368	1462	1451	1468	1425

Tertiary and Cleft Lip/Palate Services

A total of eight hospital based Centers of Excellence (three Tertiary and five Cleft Lip/Palate) provide regional, multidisciplinary pediatric specialty and subspecialty services to children age birth to 21 years with birth defects, chronic diseases, handicapping conditions or at risk for handicapping conditions.

For over twenty years the Centers have provided comprehensive, multi-disciplinary services for children with complex medical conditions and supports for their families.

The network continues to maintain the safety net of regional and sub-regional agencies providing pediatric subspecialty care for chronic illness and disabilities including but not limited to services for children with cancer, cystic fibrosis, cleft lip/palate, cardiac defects, and genetic diseases. These Centers enable children to stay in New Jersey to receive requisite comprehensive multi-disciplinary evaluations, surgical interventions and follow-up as needed for complex conditions.

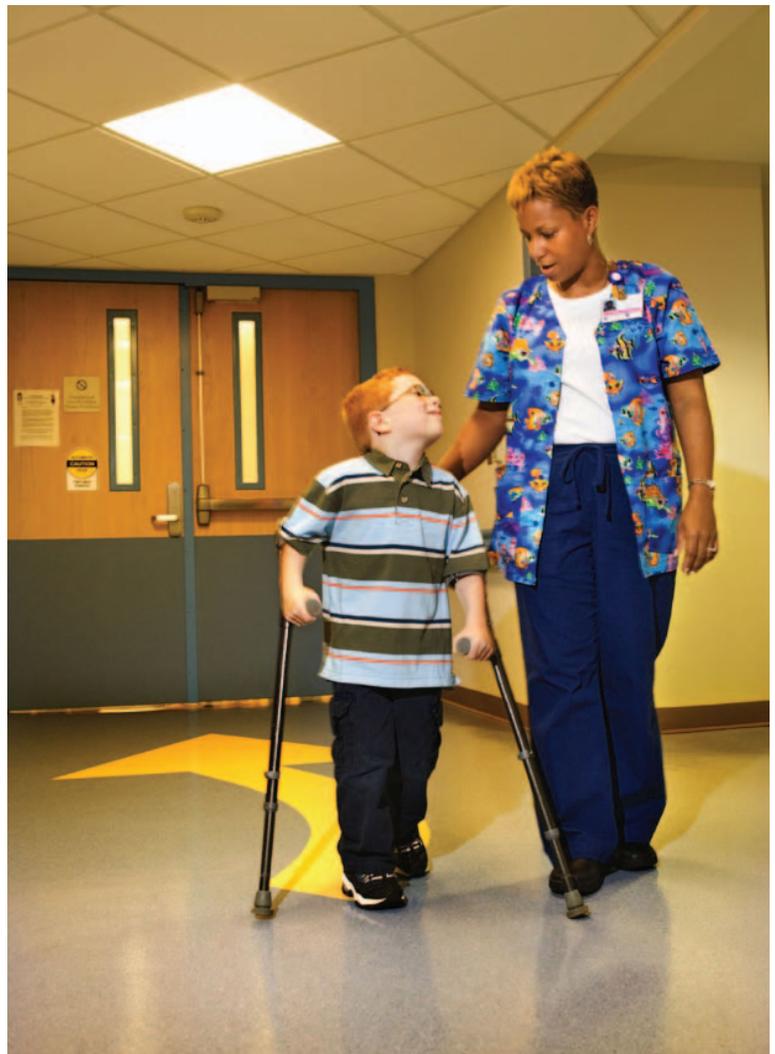
In April, Cooper University Hospital's Cleft Center conducted a provider conference, "Cleft and Craniofacial Care-Tots to Teens."

St. Peter's University Hospital's Cleft Center continues to provide support programs for both boys and girls.

To address the increased need for specialty services, all three Tertiary Centers are adding specialty staff such as pulmonology, gastroenterology, endocrinology and hematology. Robert Wood Johnson University Hospital's Tertiary Center has moved to the new Children's Building with enlarged clinic and office space to meet the increased demand for services.

Data for Reporting Period:

- ❖ Over 13,500 clients/beneficiaries are served annually; and
- ❖ 38% of children served in the five Cleft Centers presented with one of the Medicaid programs; almost 50 % of the children had some form of private insurance. In the three Tertiary Centers,



Services for Children with Special Health Care Needs

42% of the children had a Medicaid program and approximately 50% had some form of private insurance.

In the Cleft Centers 43% of the children were in the age range of birth to two years of age, another 30% were in the range of five -13 years old. In the Tertiary Centers 44% of the children seen were in the five -13 year age range with another 21% in the 14-19 year age range and 32% in the birth - four year age range.

Hemophilia Services

State funding is utilized to support, in part, four regional hemophilia treatment centers. The centers provide the necessary support personnel to assure appropriate outpatient and inpatient medical care and coagulation laboratory services for approximately 2,000 New Jersey residents with hemophilia A and B. The centers also

provide services to an additional 1,125 patients with other coagulation or bleeding disorders. Services are provided across the lifespan emphasizing the special requirements of those facing transition from pediatric-specific services to adult-specific services.

State funds also support the Hemophilia Association of New Jersey (HANJ) for the purchase of 46 health insurance policies and seven family policies for residents of New Jersey with hemophilia who require home care/self infusion treatment. These individuals are ensured immediate availability of necessary blood products as needed.

Women's Health

The New Jersey Office on Women's Health (OWH), created by legislation signed in January, 2002 (P.L. 2001, Chapter 376), acts as the lead agency in New Jersey government for women's health, in coordination with other public and private non-profit agencies that serve women's health needs.

The statute specifically noted cardiovascular disease, cancer, prenatal care, AIDS, and violence against women as major public health concerns to be addressed through prevention, early detection of disease, and equality of care. Additionally, the legislation mandated the establishment of a Women's Health Advisory Commission. This nine member commission will advise the OWH on program and service development, organize women's health priorities in the state, and provide assistance to the Office in carrying out its duties. Appointments and confirmation of members remain pending at the present time.

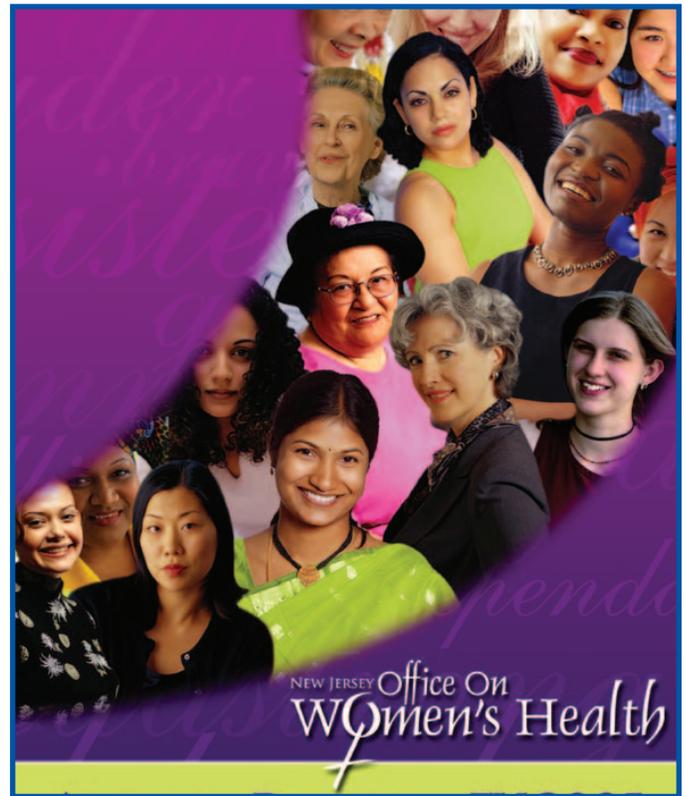
Mission Statement

The New Jersey Office on Women's Health (OWH) works to raise awareness of women's health issues across the lifespan and serves as a resource for information and referrals, advocates for gender specific research and the development of effective programs to improve women's health and coordinates with existing programs and organizations that provide health services to the women of New Jersey.

Cardiovascular Disease

Cardiovascular disease (CVD) is the number one killer of all women in both the United States and in New Jersey. CVD refers to a variety of different conditions, including coronary heart disease, which affects the heart and blood vessel system. Women often experience different symptoms and risk factors than men, such as nausea, stomach pain, exhaustion and flu-like symptoms, or a burning sensation in the chest. They also have an increased risk with age as estrogen levels decrease, and an increased risk for a second heart attack. African American and Mexican American women have more risk factors than white women, and African American women have a higher death rate from CVD than white women.

To raise awareness and educate the general public about heart disease in women, the OWH partners with organizations such as the American Heart Association



and the Women's Heart Foundation. In February, 2006 the OWH participated in a joint effort to deliver a women's heart program, Go Red For Women, Love Your Heart at the War Memorial. In May, 2006 the OWH participated in the 3rd Annual Women's Heart Walk/Run, celebrating National Women's Health Week. In September, the OWH, having served on the Executive Committee for this event, participated in the American Heart Association's Mercer County Walk/Run, and represented Governor Corzine, reading a letter about this critical issue.

The OWH serves on the Stakeholders Committee for the *Teen Esteem Program*, an alternative fitness program for 10th grade girls at Trenton Central High School, as well as a research study measuring the long-term effect of risk reduction interventions for CVD while tracking early onset of Type 2 Diabetes and self-esteem and its possible role in weight management in adolescent girls. As an alternative to traditional physical education and health classes, the young women learn about nutrition, food preparation, health, fitness and self-esteem, using hands-on activities, personal trainers and a dietician.

Throughout the year, the fitness program and research study receives repeated media coverage by area newspapers and local television stations.

Disabilities

Violence and Women with Disabilities Healthcare Initiative Professional Advisory Committee: Women with disabilities are at higher risk than other women for abuse and violence. To address this issue, the OWH provided representation on an advisory board created to develop and review training curricula for women with disabilities as well as health care professionals.

Sexual Assault

Nearly one in every six women in the United States experiences rape during her life and the majority (70 percent) of women know the perpetrator. In New Jersey, rape occurs nearly once every seven hours and according to the Uniform Crime Report, in 2005 there were a total of 1,204 reported rapes. However, these statistics are estimates and may be substantially higher because it is believed that almost 60 percent of rapes are not reported to the authorities. Statewide rape crisis centers receive about 30,000 phone inquiries each year.

To address the prevalence of rape and sexual assault in the state, the OWH provides representation as the designee for Fred M. Jacobs, M.D., J.D., Commissioner of the New Jersey Department of Health and Senior Services (DHSS) on the Governor's Advisory Council Against Sexual Violence. The Council, established by Executive Order No. 40 (2002), seeks to prevent sexual violence by evaluating the effectiveness and implementation of existing state policies and protocols, examining the needs and programs related to sexual violence in the state, and increasing provider awareness of services for people who experience sexual violence. It is charged with the task of providing a comprehensive report to the Governor, issuing policy and legislative recommendations on how to proceed in addressing this very serious public health issue.

The Council has four subcommittees, representing protocols and standards, prevention and education, needs research, and legislative review. The prevention and education subcommittee has evolved into the New Jersey Sexual Violence Prevention Team, and through the support of the Center for Disease Control's EMPOWER Program (Enhancing and Making Programs and Outcomes Work to End Rape), the OWH and its partners have begun a three year program

designed to build capacity in New Jersey to address the issue of sexual violence through primary prevention. To date, the team has traveled to Atlanta for three trainings, and hired an evaluator to assist in this project.

Domestic Violence

The OWH provides representation on the Domestic Violence Fatality and Near Fatality Review Board, established through legislation (P.L. 2003, Chapter 225). The Board's mission is to review facts and circumstances surrounding domestic violence-related fatalities and near fatalities in New Jersey in order to identify their causes and their relationship to government and non-government service delivery systems, and to examine and enhance or develop methods of prevention. This 21-member board meets every other month to review cases, evaluate responses, collect statistical data and improve collaboration between State and local agencies.

Additionally, the OWH provides representation on the STOP Violence Against Women (VAWA) Advisory Board. This group is charged with developing a spending plan for the Violence Against Women Act funding, through the Department of Law and Public Safety, Division of Criminal Justice.

Bleeding Disorders

A bleeding disorder, such as hemophilia or von Willebrand Disease (VWD) exists when there are not enough blood platelets or clotting factors in the blood. This causes a person to bleed more, and for longer periods of time than normal. Bleeding disorders affect up to 2.5 million American women and can cause problems in reproduction. One of the more common symptoms of bleeding disorders in women is heavy menstrual bleeding, or menorrhagia. Research indicates that bleeding disorders may be responsible for half of the cases of menorrhagia where a cause cannot be determined and may be treated with hysterectomies. Of the 500,000-600,000 hysterectomies performed annually in the U.S., many of which may be unnecessary, 20 percent are done to treat excessive bleeding. However, most women are not screened for a bleeding disorder and thus go undiagnosed because of a lack of awareness among health professionals and community members about bleeding disorders.

Created by Executive Order No. 51 (2003), the Governor's Task Force on Women and Bleeding Disorders, facilitated by the OWH, serves to assess the issue, including the number of bleeding disorders in New

Jersey women, diagnostic issues among health care professionals as well as treatment options. Through comprehensive research of the issue, the fourteen member Task Force developed a report, including recommendations addressing screening, diagnostic, and treatment measures in addition to community education and outreach efforts. This report was presented to the Governor for consideration in November, 2006.

In September, the director was interviewed by Nursing Spectrum Magazine for an article on the work of the Task Force around the issue of women and bleeding disorders.

Caregiving

As the American population ages, a growing number of adults require assistance in performing daily life activities. Over 44 million of U.S. adults care for another adult over the age of 18 without remuneration. Women of all races provide the majority (61 percent) of caregiving, and women typically spend four more hours each week providing care than caregiving men. In addition, 40 percent of women report emotional stress from caregiving versus 26 percent of men. As caregivers spend more time providing care, levels of emotional stress, physical health, unmet needs, and other risk factors increase.

For the second year, in partnership with the Family Resource Network's Family Support Center of New Jersey and the DHSS Division of Aging and Community Services, the OWH developed and sponsored an event recognizing women caregivers. Held at the Hyatt Regency in New Brunswick during National Women's Health Week, the full-day program focused on caregiving as both a public health and a women's issue. Vivian Greenberg, MSW, LCSW delivered the keynote speech, *"The Fairer Sex Needs to be Fairer to Herself"* on how to maintain care of the self while caring for others. Educational information and resource materials were distributed to over 150 women caregivers who attended the event.

Lung Cancer

Lung Cancer is the leading cause of cancer death in New Jersey and nationally. Lung cancer claims the lives of more women than breast, ovarian, uterine and cervical combined. And, while lung cancer incidence and mortality have been declining among men, there has been an alarming increase in lung cancer in women over the past 30 years. Lung cancer affects women differently

than men, and female smokers seem to be two to three times more susceptible to lung cancer than male smokers.

The OWH took the lead in convening a group to develop brochures and posters for a public awareness campaign on women and lung cancer. Dissemination of the materials began in September, and continued during November for lung cancer month.

Conferences, Councils, Workgroups and Networking

In January, 2006 the director traveled to Phoenix, AZ to present at the Women in Government's 12th Annual State Directors Meeting on the work of the New Jersey Women and Bleeding Disorders Task Force. The audience was women legislators from throughout the U.S.

The second annual "It's Your Health – Take Control of It" Conference, sponsored by Garden State Woman Magazine took place on October 14th. The OWH provided representation on the steering committee for this conference, and moderated a panel on domestic violence.

The OWH provided representation on the planning committee for the Department's HPV Summit, as well as the steering committee for the Governor's Conference for Women.



Women's Health

The OWH is represented on the Office of Cancer Control's Cervical Cancer workgroup, as well as the New Jersey Diabetes Council.

The New Jersey OWH is a member of a network of women's health offices throughout the country. As part of Region II of the U.S. Department of Health and Human Services, Office on Women's Health, the New Jersey office participates in regional monthly calls with New York, Puerto Rico, and the U.S. Virgin Islands, facilitated by the regional women's health coordinator. These calls provide up-to-date information regarding women's health issues on the federal level. There are also monthly national calls with other state offices that provide women's health services. Experts present current research and trends addressing different women's health topics during these calls. In addition, there is a national women's health conference every other summer that brings together all of the state offices. The 2006 State and Territorial Women's Health Conference was held in Denver, CO, and topics included a gender-centered approach to health, funding opportunities for women's health programs, emergency preparedness, coalition building, obesity, nutrition & physical activity, sexual health across the lifespan, post partum depression and violence.

Web Page

A new, comprehensive website for the OWH was rolled out in 2006, as part of the revised website for the Division. The OWH webpage can be found on the web at: <http://nj.gov/health/fhs/owh/index.shtml>.

Public Relations and Outreach

In October, 2006 the director was interviewed by Garden State Women Magazine for an article about the OWH and priority women's health issues. Ms. Nearon also

participated in a cable television show, "Lasting Lifestyles" on women's health issues, and serves on an "ask the expert" panel on the Viebridge Connections website, a program available to caregivers. In addition, the director represented Governor Corzine at a ceremony at the Kimball Medical Center for Cesarean Awareness Month in NJ, delivering the proclamation and celebrating Kimball's status as New Jersey's hospital with the lowest rate of cesarean sections.



Chronic Disease Prevention and Control – Adult Health

Diabetes Prevention and Control Program

Approximately 7.2% of New Jersey adults (473,000) have diabetes. An additional 189,000 people are believed to have diabetes but have not yet been diagnosed, making the total estimated number of people in New Jersey with diabetes 662,000. About 12.2 percent of black non-Hispanic adults (85,000 people) have been diagnosed with diabetes. An additional 34,000 adults are believed to have the disease but are unaware of it. Diabetes is a medical risk factor of pregnancy in nearly 5 percent of live births in New Jersey. Nationally, pre-diabetes affects about 21 percent of the population between the ages 40 to 74. Diabetes is a leading cause of retinopathy, nephropathy, and lower-extremity amputation. The New Jersey Diabetes Prevention and Control Program (DPCP) seek to reduce the burden associated with diabetes in New Jersey and to eliminate the disproportionate burden among population subgroups. These goals are to be reached through the combined efforts of statewide partners in affecting change in systems to promote access to and quality of comprehensive diabetes care. Specific program objectives focus on increasing rates of foot exams, eye exams, HbA1C testing, and immunizations among people with diabetes and elimination of disparities. The program is also laying groundwork for diabetes prevention efforts.

The DPCP is funded to conduct a Systems-Based Diabetes Prevention and Control Program through a cooperative agreement with the Centers for Disease Control and Prevention (CDC). For the 2006-2007 funding year, the DPCP received level funding from the CDC for a Basic Implementation Program (\$515,321).

The New Jersey Diabetes Council (NJDC) was fully restructured in 2005, but during 2006 the council worked towards combining task forces. Membership of the Council is now at 130 members. The restructured Council for 2007 will consist of a Coordinating Committee and 5 Task Forces. The Task Forces have identified areas of need and have proposed projects to address those needs. These proposed projects will provide a basis for a strategic plan for diabetes in New Jersey. In 2006, the New Jersey Diabetes Council

published its first newsletter and disseminated it to over 12,000 health care providers.

The DPCP continues to fund the Diabetes Outreach and Education System (DOES) Program in five counties (Atlantic, Cumberland, Salem, Ocean and Cape May) in the southern region of the state. The DOES project seeks to increase awareness among consumers and professionals of the seriousness of diabetes, current diabetes care recommendations, and the preventability of diabetes and its complications. In SFY2006, the DOES program's diabetes awareness raising efforts targeted to people with diabetes or people at risk for diabetes in a five county area of southern New Jersey included:

- ❖ Print Media efforts potentially reached 2,500,000;
- ❖ Face to Face Encounters (health fairs etc,) potentially reached 3,520;



- ❖ Provider education programs reached 250;
- ❖ Immunization campaign potentially reached 160,000; and
- ❖ Radio and TV media potentially reached 1,860,000.

Since people with diabetes or other chronic diseases are considered at high risk for serious complications of the flu, each year the DPCP conducts a flu and pneumococcal immunization campaign. In the 2006 campaign, information about flu and pneumonia immunizations for people with diabetes was distributed

Chronic Disease Prevention and Control—Adult Health

through a “November - Diabetes Month” email and website campaign. The information was also provided through the Department of Health and Senior Services LINCS network to about 30,000 providers and provider agencies throughout the state. Additionally, the DPCP developed an article on flu immunizations for the Department’s electronic bulletin board potentially reaching 2,000 Department employees; an article was placed in the electronic newsletter of the New Jersey Society of Health Educators potentially reaching 135 members; and the Office of Minority and Multicultural Health’s September 2006 calendar carried an immunization announcement. This calendar is distributed to approximately 10,000 community agencies statewide. The DOES project placed 38 newspaper printed advertisements highlighting the importance of influenza and pneumococcal immunization for individuals with diabetes. These printed media advertisements potentially reached 231,000 readers. Radio PSAs potentially reached 246,680 listeners and a television announcement on DH/Perfil Latino TV potentially reached 150,000 viewers.

The DPCP provides funds to the Commission for the Blind and Visually Impaired (CVBI) to conduct a Diabetic Eye Disease Detection (DEDD) Program. In 2006, the DEDD provided 1,539 uninsured individuals with dilated retinal exams during the grant period. The DEDD also screened 1,268 low-income individuals for hypertension. Of those screened 215 had abnormal blood pressure, 195 were under regular medical care, and 20 were referred for care.

The DPCP staff continues to support various county diabetes coalitions. The Southern New Jersey Regional Advisory Council was established to bring together partners from the five-county DOES target area. In one activity of the Regional Advisory Council, the DOES program, CBVI, and pharmacies and retail outlets promoted the importance of the annual dilated retinal examination among residents with diabetes in Cumberland County. As part of the Cumberland eye disease prevention project, CVBI conducted eye screenings in that county to serve the uninsured population.

The DPCP was a partner in a “Diabetes Prevention Campaign” which featured radio PSAs on NJ 101.5. Newspaper advertisements were placed in the Newark Star Ledger, Trenton Times, Asbury Park Press, Daily Journal, Nuestra Cummidad, Atlantic City Press, El



Especialito, Especial and Inquirer Neighbors. New Jersey Transit platform posters were placed in the following urban locations where diabetes prevalence is highest: Trenton, Metro Park, New Brunswick, Elizabeth, Lindenwald and Newark. Also, Spanish platform posters were placed in Trenton, Newark, Lindenwald and New Brunswick.

The DPCP worked in partnership with the Office of Minority and Multicultural Health (OMMH), DOES, the PRONJ and others to target messages to minority populations about the importance of controlling their diabetes and changing diet and exercise habits to prevent or delay the onset of Type 2 diabetes.

Comprehensive Care for Huntington’s Disease

A grant to the University of Medicine and Dentistry supports, in part, comprehensive care services, education, counseling, social services, outreach and in-service programming for patients and over 210 families affected by Huntington’s disease. It also provides professional education about Huntington’s disease and outreach services to professionals and care facilities. Support group meetings, genetic testing and counseling

Chronic Disease Prevention and Control—Adult Health

services and clinical management are just some of the services provided to affected families.

Pharmaceutical Services for Adults with Cystic Fibrosis

State appropriations support a grant to the New Jersey State Organization of Cystic Fibrosis to administer a program of financial assistance to adults with cystic fibrosis for the purchase of prescription drugs, medical equipment and supplies, nutritional supplements and nutritious foods that are necessary for the treatment of the disease. The program also provides up to \$500 per year to help meet the cost of the deductible on health insurance for adults with cystic fibrosis. During the past year, 106 low income adults with cystic fibrosis were provided financial assistance in purchasing medications, nutritional supplements and supplies and equipment essential for maintaining health.

End Stage Renal Disease (ESRD) Patient Assistance

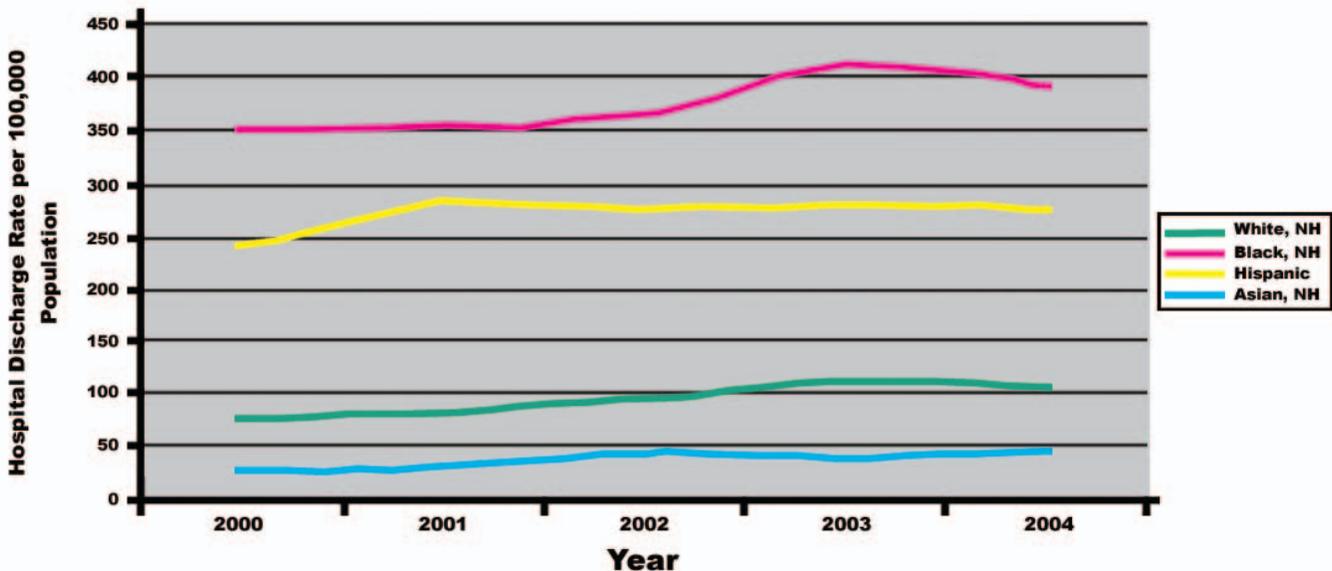
The Trans Atlantic Renal Council administers funds to dialysis facilities to provide financial assistance to dialysis patients with no other financial resources for medication and nutritional supplements. During the past year, 1,246 low income persons with ESRD were served. Sixty-seven dialysis facilities participated in the program. Products covered by the program in the last year

included nutritional supplements, cardiovascular agents, gastrointestinal agents, and anti-diabetic medications.

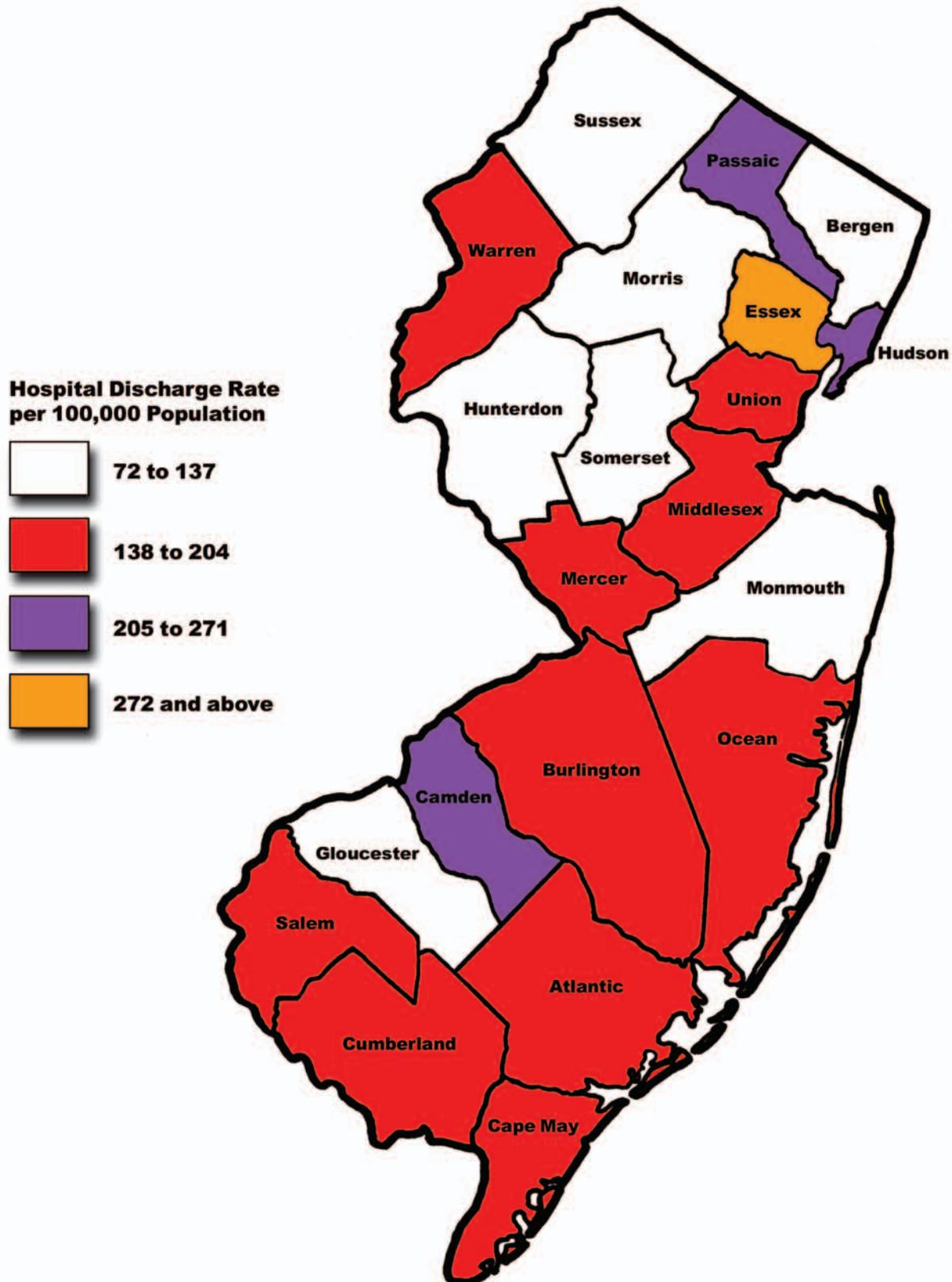
Asthma Awareness and Education Program

The Asthma Awareness and Education Program (AAEP) is funded by the Centers for Disease Control and Prevention (CDC) to conduct asthma awareness and education activities through a cooperative agreement “Addressing Asthma from a Public Health Perspective.” For the 2006-2007 funding year, the AAEP received \$335,000 a decrease of \$40,000 from funding year 2005-2006. The CDC reported an across the board reduction in funds to all states which impact the AAEP asthma initiatives. The goal of the AAEP is to coordinate efforts so that the capacity of the State to address asthma, its causes, and complications is enhanced and the burdens of asthma reduced. During this time, NJDHSS has successfully established a state asthma program, developed an asthma surveillance system, convened an Interdepartmental Asthma Committee (IAC), funded and participated on the Pediatric Adult Asthma Coalition (PACNJ), developed and implemented a Strategic Plan for Asthma, and supported statewide asthma awareness-raising and quality of life interventions. The implementation of these programs has resulted in increased knowledge and awareness of factors for improving asthma management.

Age Adjusted Hospital Discharge rates for Asthma, by Race/Ethnicity, New Jersey, 2000-2004



Average Age Adjusted Hospital Discharge Rates for Asthma, by County, New Jersey, 2001-2004



Chronic Disease Prevention and Control—Adult Health

Approximately 8% of New Jersey adults (509,641) have asthma, while 9% of New Jersey children (180,159) currently have asthma. There are significant disparities in the burden of asthma among specific populations in New Jersey. Although asthma affects people of all ages, races, and ethnic groups, low-income and minority populations experience substantially higher rates of fatalities, hospital admissions and emergency room visits due to asthma.

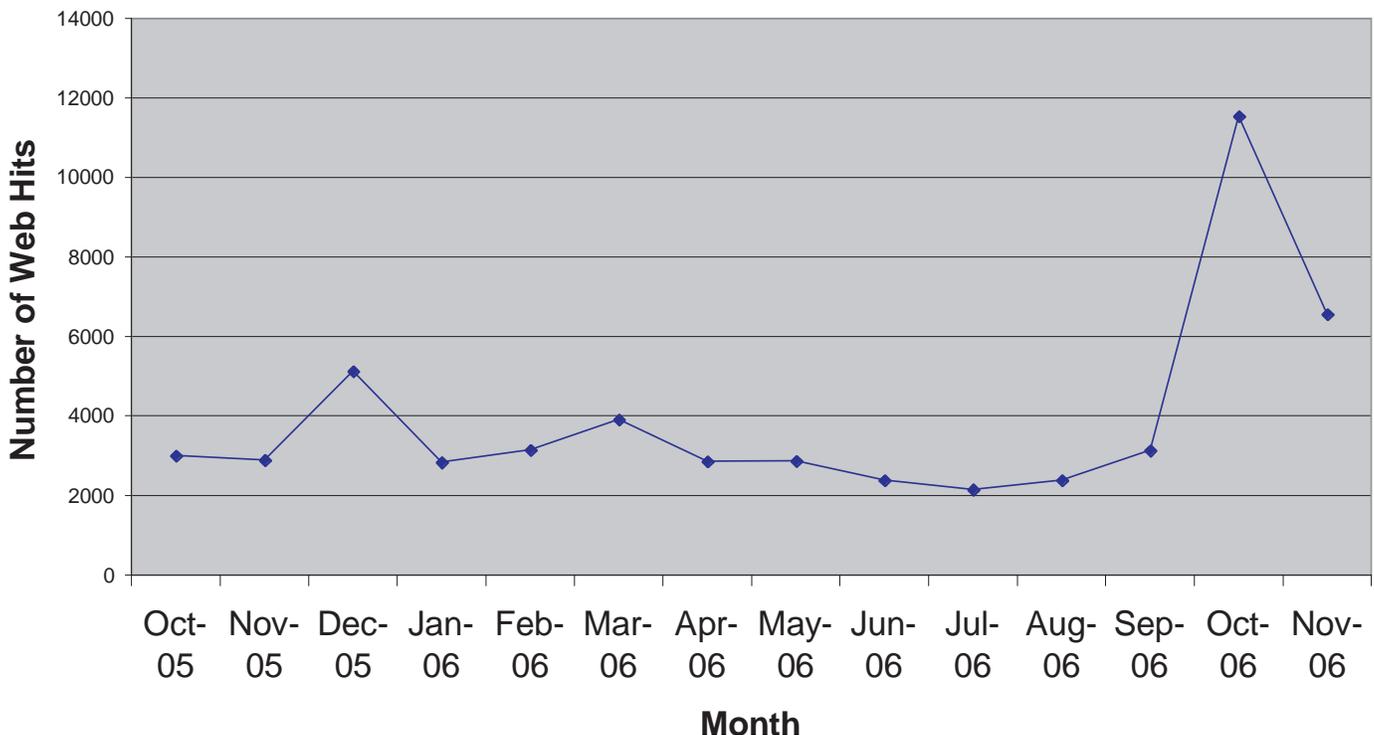
The AAEP and PACNJ held strategic retreats which redefined and expanded their scope in addressing asthma statewide. The major goal will be to: improve health outcomes for New Jersey residents with asthma. This goal will be accomplished through: 1) a delivery of care systems change in the New Jersey FQHCs; 2) increasing the use of Asthma Action Plans (AAPs); 3) improving provider and consumer knowledge of asthma management; 4) creating a systems change in schools and day care centers to accommodate a healthy environment for children with asthma; 5) reporting work related asthma (WRA) triggers and providing

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

Commissioner's Second Annual Asthma Summit

On October 6, 2006, the "Commissioner's Second Annual Asthma Summit," was held at the Forsgate Country Club in Monroe Twp., NJ. The Summit was co-sponsored by the Central New Jersey Maternal and Child Health Consortium (MCHC) and the Pediatric/Adult Asthma Coalition of New Jersey (PACNJ). The Summit focused on "Promising Practices to Reduce Asthma Disparities". Some of the promising practices included: 1) Increasing knowledge and ability to implement the New Jersey Asthma Collaborative Model; 2) Providing a framework to redesign healthcare

Asthma Awareness and Education Program Asthma Program Web Hits by Month, October 2005-November 2006



systems using the Care Model; 3) Enhancing awareness of community focused interventions in asthma management; and, 4) Increasing knowledge of “Asthma Friendly” environments in the control of asthma from a local perspective. Over 260 healthcare professionals attended the half-day event.

Asthma Webpage

The asthma webpage can be found on the web at : (<http://www.state.nj.us/health/fhs/asthma/index.shtml>). The website provides consumers and professionals with information about the asthma state program/partners; an overview of asthma; asthma surveillance data for New Jersey; work-related asthma and the Asthma Action Plan. In addition, the website provides access to several state and local asthma resources. In October 2005, the Asthma Program started collecting web-based statistics for the webpage. As illustrated in the chart below, the number of hits to the asthma program webpage has been increasing.

Agency for Healthcare Research and Quality (AHRQ)

In July 2005, New Jersey was selected as one of six states, to participate in the Learning Partnership to Decrease Disparities in Pediatric Asthma project. New Jersey joined Arizona, Michigan, Oregon, Maryland and Rhode Island in this groundbreaking initiative to develop and implement interventions to reduce disparities among minority children. A ten (10) member team comprised of representatives from AAEP, the Pediatric and Adult Asthma Coalition of New Jersey and various state partners are participating in this initiative. The Asthma Program envisions that participation in the Learning Partnership to Decrease Disparities in Pediatric Asthma will facilitate an environment to implement the Commissioner’s vision to address disparity in asthma management and the pediatric population. In addition, the opportunity should assist New Jersey in achieving Healthy New Jersey 2010 objectives. In 2006, the New Jersey team attended the Learning Institute in Texas to learn the tools necessary to develop and implement a Disparities Action Plan and Milestone Meeting to discuss lessons learned and progress to date. The New Jersey team has developed a Disparity Action Plan that targets three cities (Newark, Camden, and Trenton) with high asthma hospitalization rates. The Plan focuses on: 1) Partnering with schools, 2) Partnering with communities, 3) enhancing the capability of the emergency department to address asthma and create a follow-up system, and 4) develop a

white paper on New Jersey accomplishments. The implementation of the Action Plan will be a collaborative approach with AAEP’s stakeholders. To date, AHRQ has provided technical assistance and interventions have been outlined.

AAEP Outreach and Education

- ❖ The Asthma Program purchased several age-appropriate and culturally competent asthma education materials for dissemination at health fairs, educational trainings, and other venues. These educational materials will foster increase awareness of asthma throughout the lifespan. In addition, culturally appropriate materials (e.g. “Asthma-A Story about Miguel and His Family” and “Asthma Facts-For Parents”) are specific to high-risk populations with significant asthma disparities. The program promotes and reinforces asthma self-management among disparate populations.
- ❖ The “Asthma Action Plan and Back-to-School” posters were distributed to healthcare providers for posting in their respective facilities. The poster reminds parents and practitioners that a completed AAP is required for children returning to school.
- ❖ The Asthma Program has participated in numerous conferences and health fairs that promote asthma awareness and proper asthma management.
- ❖ New Jersey Asthma Disparities Collaborative – In response to the Commissioner’s vision for “Best Practices of Asthma Care,” the New Jersey Primary Care, with support from the Northeast Cluster and the AAEP has implemented the New Jersey Asthma Collaborative in sixteen of the state’s twenty-one FQHCs. The Collaborative is a state-funded initiative to decrease health disparities, improve the quality of asthma care, and ensure uniformity of asthma care for (FQHC) patients with asthma. Participating health centers have been granted equivalency status in the federal program. The Asthma Collaborative will be expanded to include all New Jersey FQHCs.
- ❖ AAEP staff collaborated on the “Educating Physicians in their Communities (EPIC)” project sponsored by the New Jersey Chapter of American Academy of Pediatrics. The project will focus on educating 10 pediatrician practices in Trenton on asthma management.
- ❖ The AAEP provides technical assistance on program evaluation and data analysis to partners and grantees.

- ❖ The AAEP staff participates on the Trenton Asthma Coalition (TCA). The TCA was convened as a result of the Trenton Childhood Asthma Project (TCAP). TCAP funded by the Robert Wood Johnson Foundation provided asthma education, environmental assessment and asthma management to children/families in Trenton. The TCA is developing a strategic plan to 1.) Secure funding for the TCAP 2.) Build capacity and infrastructure, 3.) Develop strategies and improve policies and practices on asthma care and 4.) Build on existing research.

AAEP Asthma Grants

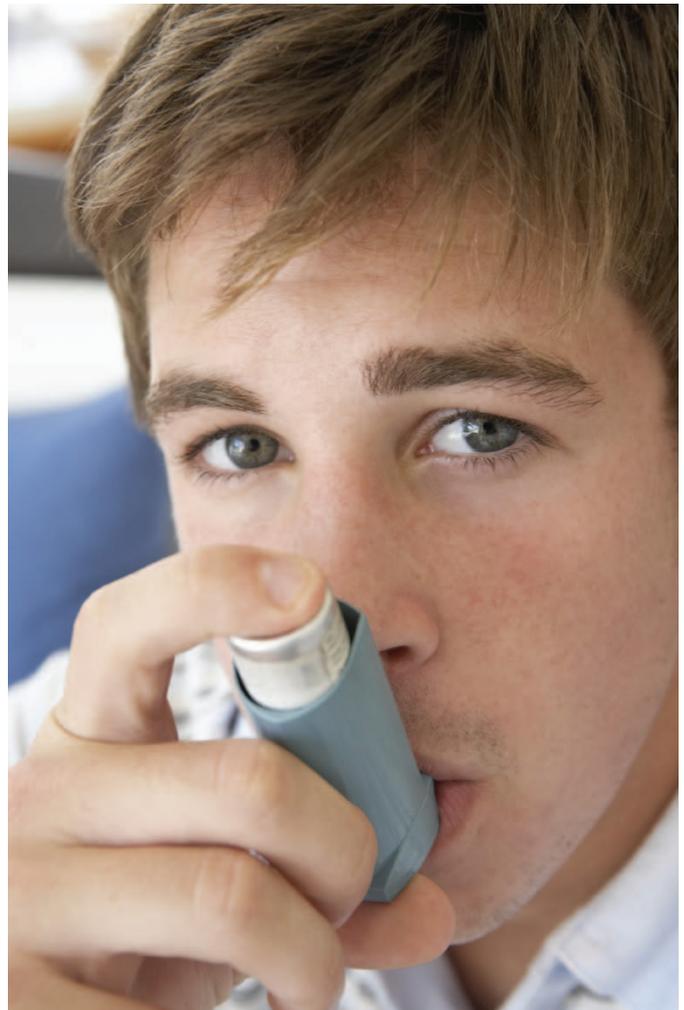
Hispanic Family Center (HFC) of Southern New Jersey

The AAEP provides grant support to the HFC to conduct the Pediatric Asthma Prevention Project. This project provides outreach, health education, risk reduction workshops, pediatric asthma screenings, referrals and case management for adults and children aimed at increasing access to health services for Latinos. The HFC is partnering with CamCare and Cooper Hospital which will refer asthmatic patients to HFC for intense case management to include home visits, health education, and more. The coordination of care between medical providers and bilingual case managers is expected to increase the compliance and self-efficacy of patients and parents with asthma treatment protocols.

Pediatric Adult Asthma Coalition of New Jersey (PACNJ)

The Asthma Program provides grant support for the PACNJ. The Coalition has over 150 participating member organizations and six active task forces working with schools, quality care, programmatic/data evaluation community groups, childcare and environmental agencies to reach all individuals in New Jersey with the most effective methods for managing their asthma. “Pathways to Asthma Control Implementation Plan” was established to accomplish the Coalition’s goals. Efforts of PACNJ:

- ❖ PACNJ “Asthma Friendly School Award” recognizes schools for their commitment to enhance the quality of education for students and staff with asthma. The award has six components: a) School has a nebulizer; b) Training in airway management and use of nebulizers and inhalers for school nurses – PACNJ “Asthma Management in the School Setting”



satellite training kit; c) Annual asthma education for faculty – PACNJ “ABCs of Asthma are All “Bout Control” video/training; d) School Nurse has taken the PACNJ/New Jersey State School Nurse Association “Asthma Action Plan-School Nurses Leading the Way” PowerPoint training; e) A school representative has taken the EPA “Indoor Air Quality Tools for Schools” or Trenton Healthy School trainings; and f) School or school district has taken the NJDEP “No Idling Pledge.” To date, approximately 158 schools have received the award.

- ❖ Developed training on the “Policies and Practices for Asthma Friendly Child Care” for directors of child care centers and home providers. The training was piloted in three target cities.
- ❖ “May Mondays Make Breathing Easier” email campaign to raise asthma awareness. Factsheets on Air Quality Awareness, Asthma Friendly Child Care Experience, Asthma Friendly School Experience, and Resources for Managing Asthma at Your Finger Tips, were disseminated.

Chronic Disease Prevention and Control—Adult Health

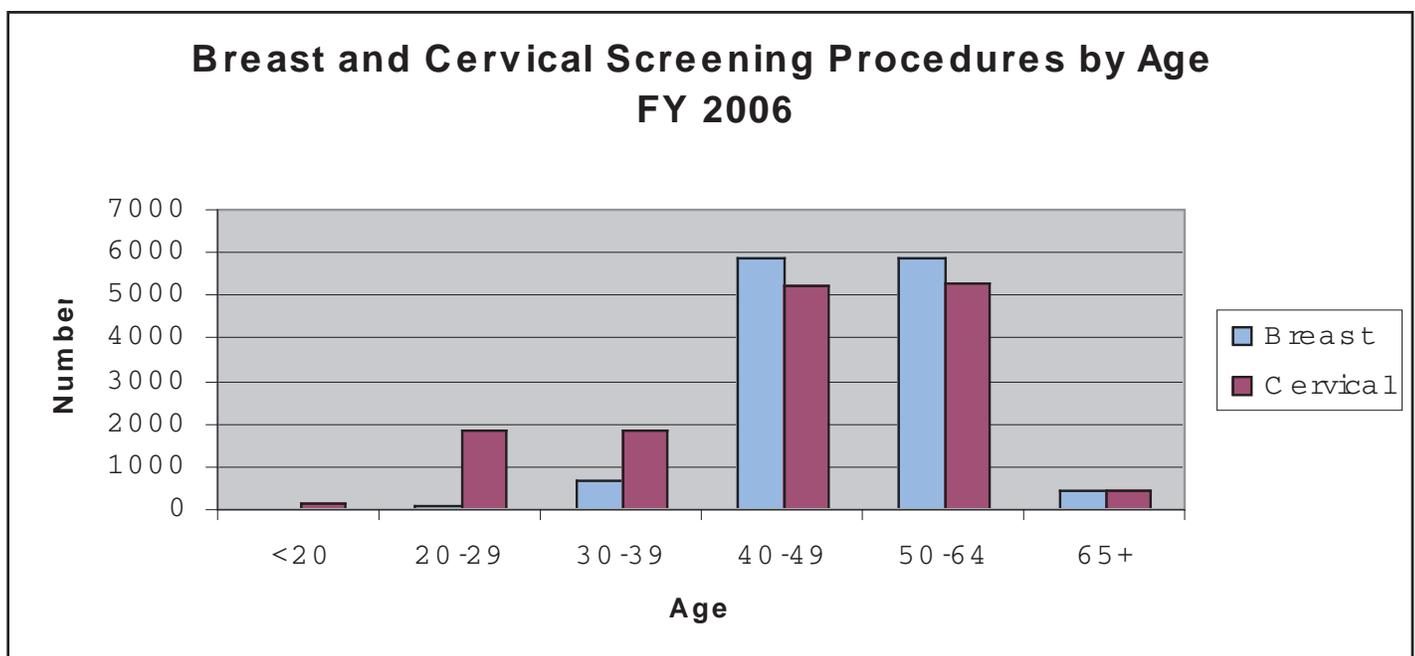
- ❖ Participation in the “Educating Physicians in their Communities (EPIC)” project sponsored by the New Jersey Chapter of American Academy of Pediatrics. The project will focus on educating 10 pediatrician practices in Trenton on asthma management.
- ❖ Developed and distributed the “Steps to Managing Asthma in the Child Care Setting” video.
- ❖ “Asthma Action Plan – School Nurses Leading the Way” A training CD developed by PACNJ and the New Jersey State School Nurse Association. The program focuses on the importance of the AAP. Participants receive a New Jersey State School Nurses Certificate of Professional Development for one continuing education credit.
- ❖ Provided a free video “Asthma Management in the School Setting” to 1,600 schools in New Jersey.
- ❖ Trained a 150 Newark school nurses to provide the faculty in-service on asthma management in their schools.
- ❖ Presentation at PACNJ Statewide meeting on “Cultural and Linguistic Competence: Implications for Asthma Management.” This conference will provide PACNJ membership with the tools required to develop culturally competent asthma material and provide outreach.

New Jersey Cancer Education and Early Detection Program (NJCEED)

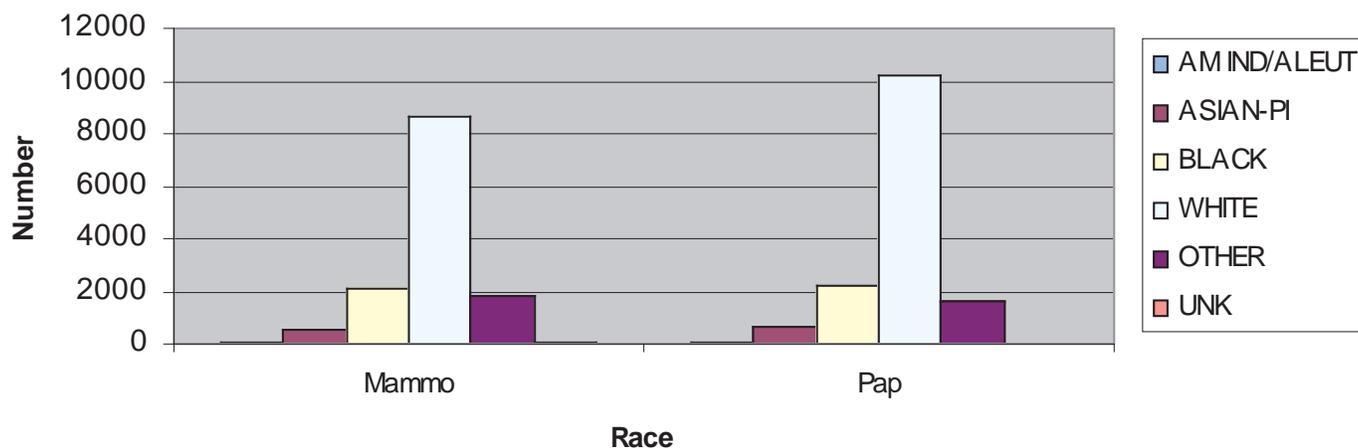
The NJCEED Program uses funding from the Centers for Disease Control and Prevention (CDC) and a State appropriation to support comprehensive breast, cervical, prostate and colorectal cancer outreach, education, screening, tracking, follow-up and case management services in all 21 counties in the State through 25 programs. The goal is to increase the awareness of each person’s risk for breast, cervical, prostate and/or colorectal cancer; and to encourage them to use screening services for early detection and more effective treatment in an effort to decrease morbidity and mortality due to cancer.

Summary of FY 2006 Breast and Cervical Data

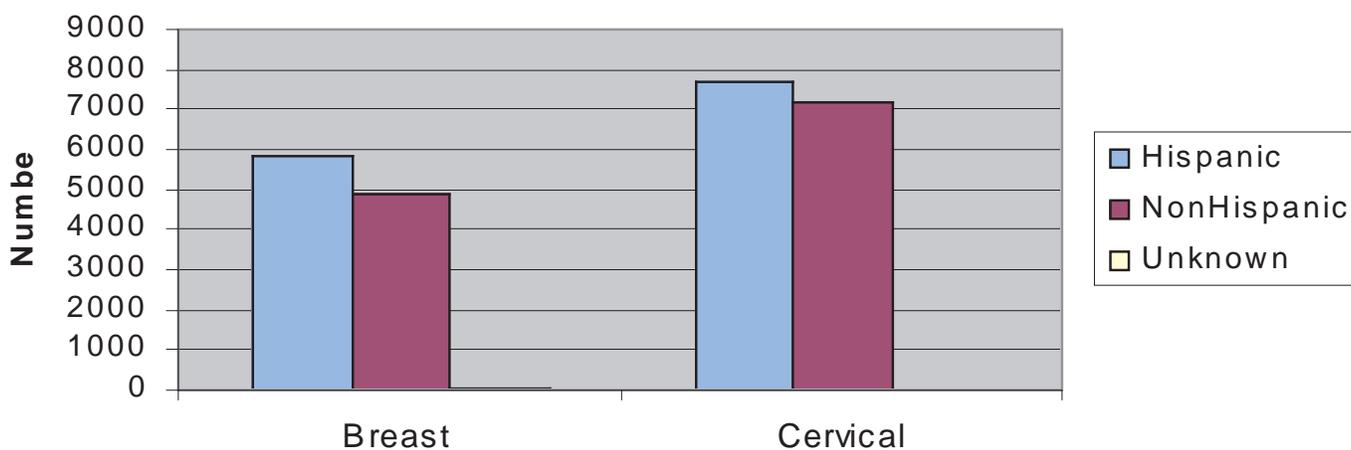
During Fiscal Year 2006, a total of 11,090 new women were enrolled by the lead agencies in the NJCEED Program. This represents a 2.2% increase from the prior fiscal year. Combined screening and diagnostic breast and cervical cancer procedures totaled 55,340. This number represents an increase of 10.7% from the prior year. Screening procedures represented 83.1% of all services provided to program participants during fiscal year 2006. This compares to 85.2% in the prior year.

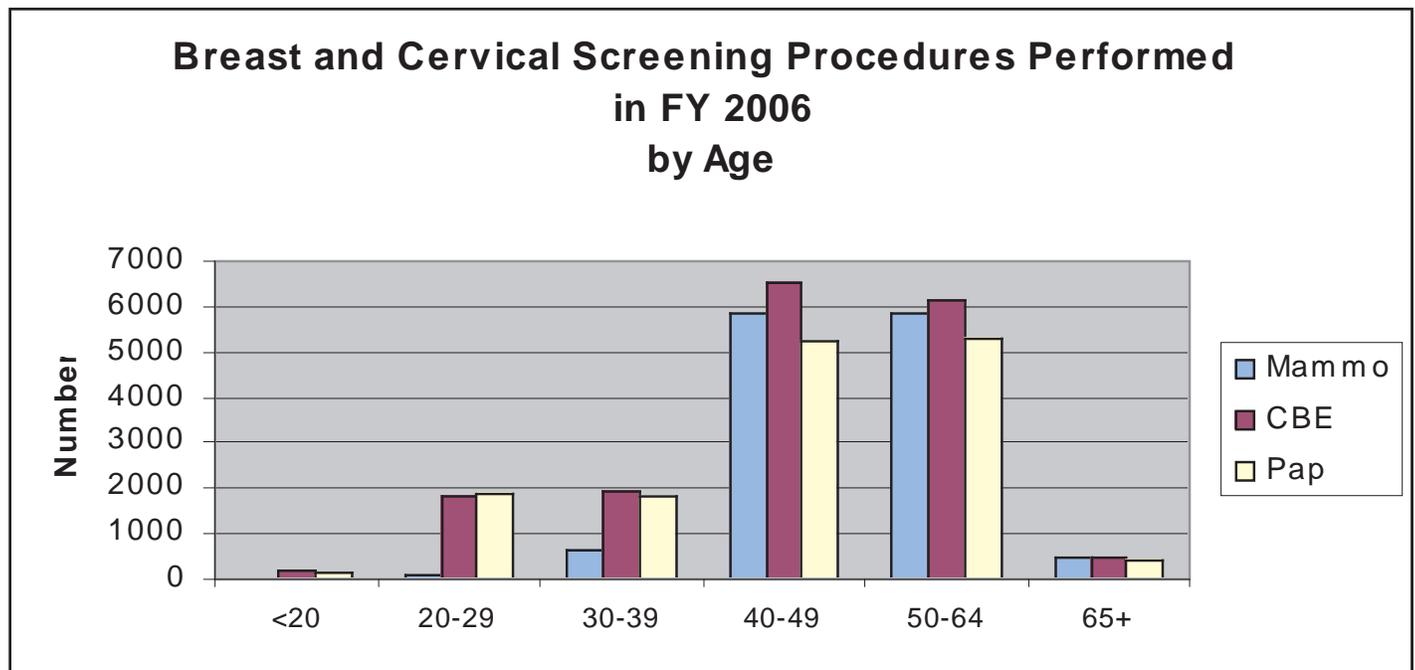


Breast and Cervical Procedures Performed in FY 2006 by Race



Breast and Cervical Procedures in FY 2006 by Ethnicity





All Procedures by Age:

By age category, three-quarters of those women who received screening and diagnostic procedures during FY '06 were in age groups 40 to 49 years and 50 to 64 years.

All Procedures by Race:

As seen in the chart below, African American women who received screening and diagnostic procedures accounted for 15.6 percent of the total. It was noted that 12.4 percent of the women self-reported as "Other" as a race determination. This relatively high proportion of the total may be reflecting the reluctance of either the enrollee or the intake worker at the lead agency to "fit" an enrollee into a racial category.

All Procedures by Ethnicity:

Slightly more than one-half (52.8%) of the screening and diagnostic procedures were provided to Hispanic women. In the prior year, 51.3 percent of these procedures were provided to Non-Hispanic patients.

Screening Procedures:

Three types of screening procedures were offered to enrollees: Clinical Breast Examinations (CBE's), Mammograms and Pap Tests. A total of 46,009 breast and cervical cancer screening procedures were provided to the women enrolled in the Program. Of these, 31,040 (67.4%) were breast cancer screenings and 14,969 (32.6%) were cervical cancer screenings. From the prior year, screenings increased by 8.1 percent.

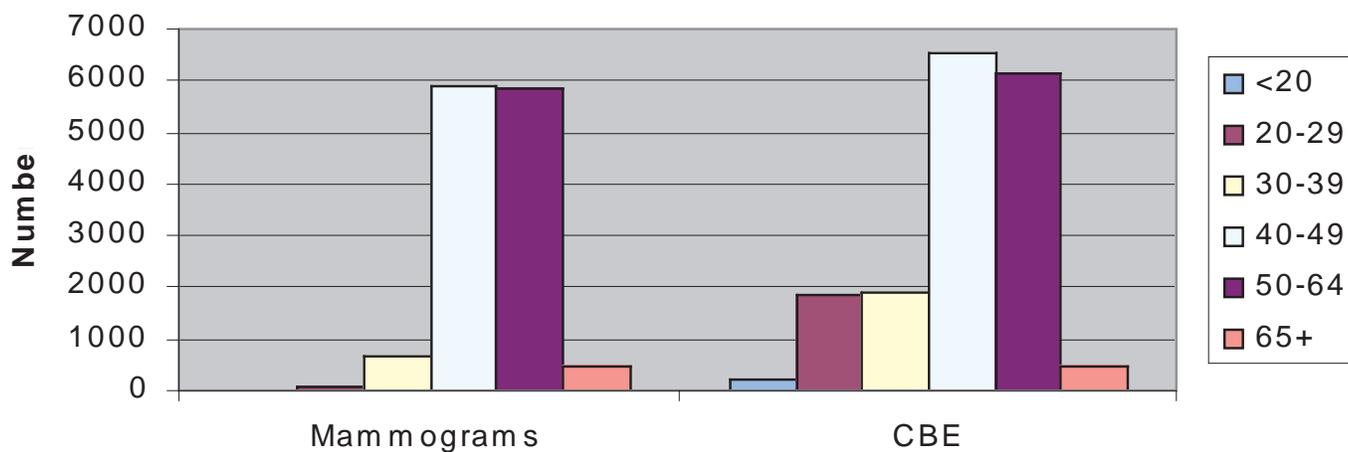
As indicated in the chart above, slightly more screenings for breast and cervical cancer were provided to women in the 40 to 49 year age category. With the exception of the youngest category (less than 30 years of age), clinical breast exams were the most frequently provided screening procedure.

Breast Cancer Screenings:

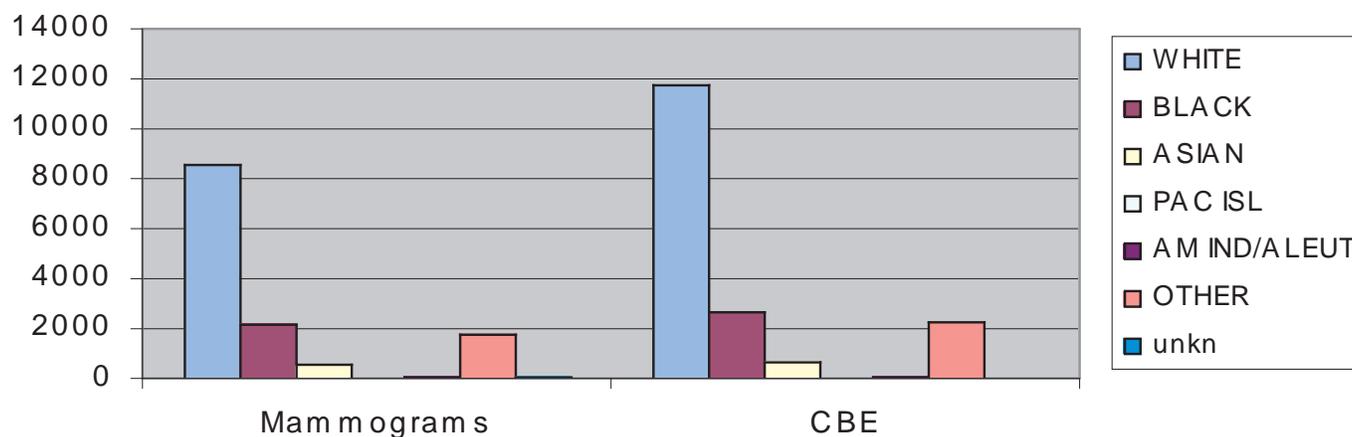
From the prior year, CBE's increased by 9.8 percent, from 16,103 in FY '05 to 17,676 in the current year. Based on the findings of a screening procedure, a program enrollee may be offered one or more diagnostic procedures to determine whether or not a pre-cancerous or cancerous condition exists. In FY '06, these screenings resulted in 7,187 completed breast diagnostic procedures being provided to program participants. Thus 40.6 percent of the screening CBE's resulted in breast diagnostic procedures being provided to enrollees. In the prior year, screening CBE's resulted in 5,617 completed breast diagnostic procedures (34.8% of screenings). The case may be made that by providing more screening Clinical Breast Exam procedures, fewer, more expensive, diagnostic procedures are required.

In FY 2006, 13,364 completed screening Mammograms were provided to women enrolled in the NJCEED program representing an 11.8 percent increase from the prior year. Over 18% of these mammographies resulted in follow-up breast diagnostic procedures. This compares with 16.7% for the prior fiscal year.

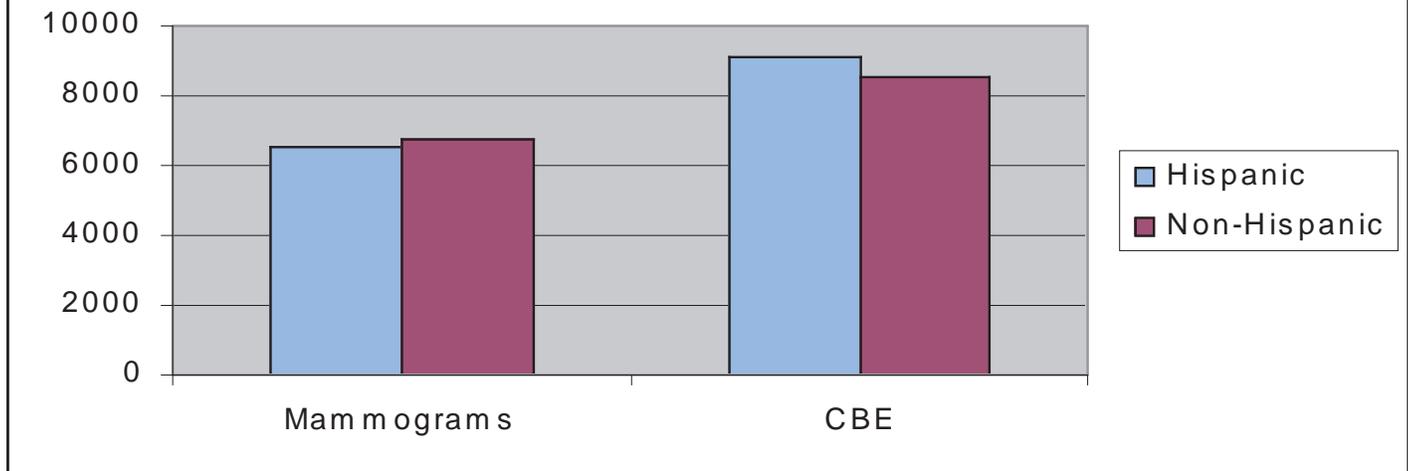
Breast Screening Procedures Performed in FY 2006 by Age



Breast Screening Procedures Performed in FY 2006 by Race*



Breast Screening Procedures Performed in FY 2006 by Ethnicity



The estimated, three year average (1999-2001) population for NJCEED eligible women aged 40 to 64 years is 83,333. Based on this population, 14.1 percent of eligible New Jersey women received screening Mammograms during FY '06. This percentage exceeds the provision of screening that would have been expected, based on the level of funding that the NJCEED program received from the CDC. In the prior year, 14.3 percent of the eligible women were provided Mammograms.

During FY '06, 15.2 percent of eligible female New Jersey residents were provided with Clinical Breast Exams. This is a slight increase from the prior fiscal year when 14.2 percent of the eligible women were served.

For both of the breast screening procedures, the largest proportion of women tested fell into the age category 40 to 49 years. This age category accounted for 41.1% of the breast screenings. When combined with those 50 to 64 years of age, 80.8% of the women fell into these two categories in the current year. In the prior year, these age categories accounted for larger proportions of these procedures; 41.2% for 40 to 49 years and 38.7% for 50 to 64 years. During fiscal year 2006, greater proportions of Mammograms were provided to enrollees in these age categories than for CBE's. Age category 40 to 49 represented 45.2 percent of the Mammograms and category 50 to 64 represented 44.9 percent.

Over two-thirds (66.9%) of the CBE's were provided to White enrollees during the reporting period. African American clients constituted 15.3 percent of those who had this screening procedure. While the proportion of Whites who had screening CBE's was slightly higher in the prior year (65.3%) the percentage of African Americans, at 15.3 percent, was slightly lower. Reflecting these proportions, those program participants who received screening Mammograms were 64.6 percent White and 16.1 percent African American. Again, when compared to the prior fiscal year, a slight increase in the percentage of Whites was noted (63.6% in FY '05), as was a corresponding decrease in African Americans (from 18.2% in FY '05).

Over fifty percent (51.6%) of CBE screening procedures were provided to Hispanic participants and slightly more (50.8%) of mammographies were provided to Non-Hispanics. By way of comparison, in FY '05, 50.1 percent of CBE's were provided to Hispanics. In the prior year, Non-Hispanics accounted for 52.1 percent of mammograms.

Cervical Screenings:

In the current reporting period, 17.9 percent of uninsured/underinsured women who met the income guidelines were provided with Pap tests to screen for cervical cancer. This is an increase over the percentage of eligible women provided cervical screening in the prior fiscal year (15.9%).

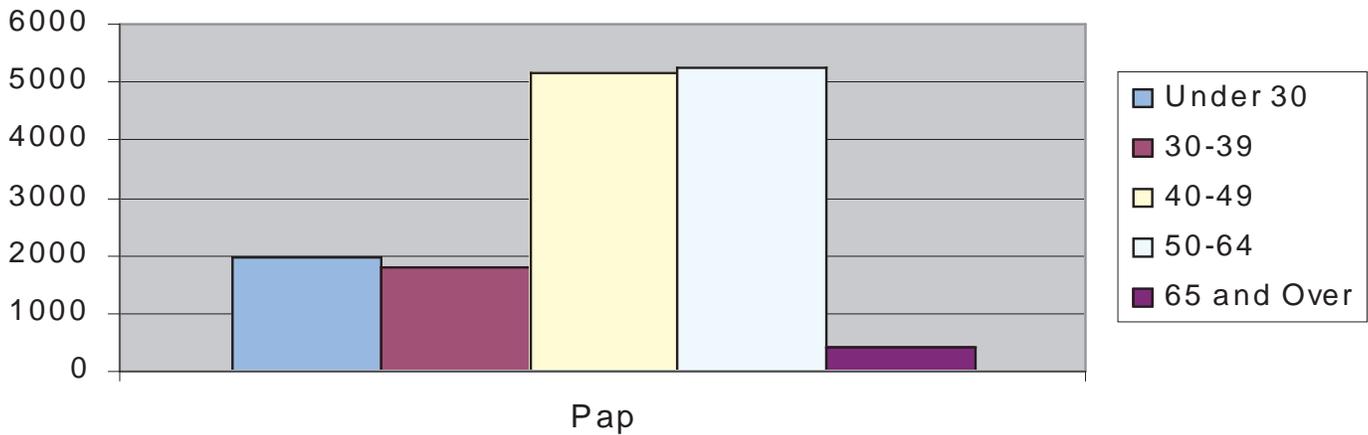
Chronic Disease Prevention and Control—Adult Health

Pap test screening procedures were provided to program participants in the 40 to 49 year category and the 50 to 64 year categories, in nearly equal proportions (35.2% and 35.8%, respectively). In the prior fiscal year, these two age categories accounted for 37.6 percent (40 to 49 years old) and 32.2 percent (50 to 64 years old). It should be noted that those participants under thirty years of age, represented 13.6 percent of those receiving Pap tests in

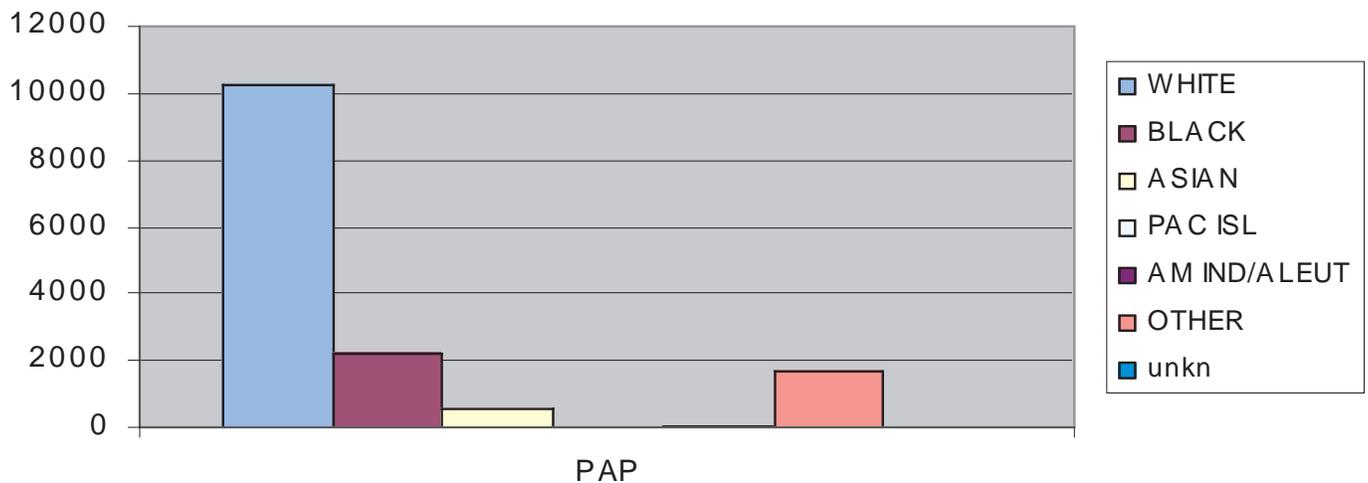
FY '06. This is a significantly lower percentage than was seen in the prior reporting period (15.5% in FY '05).

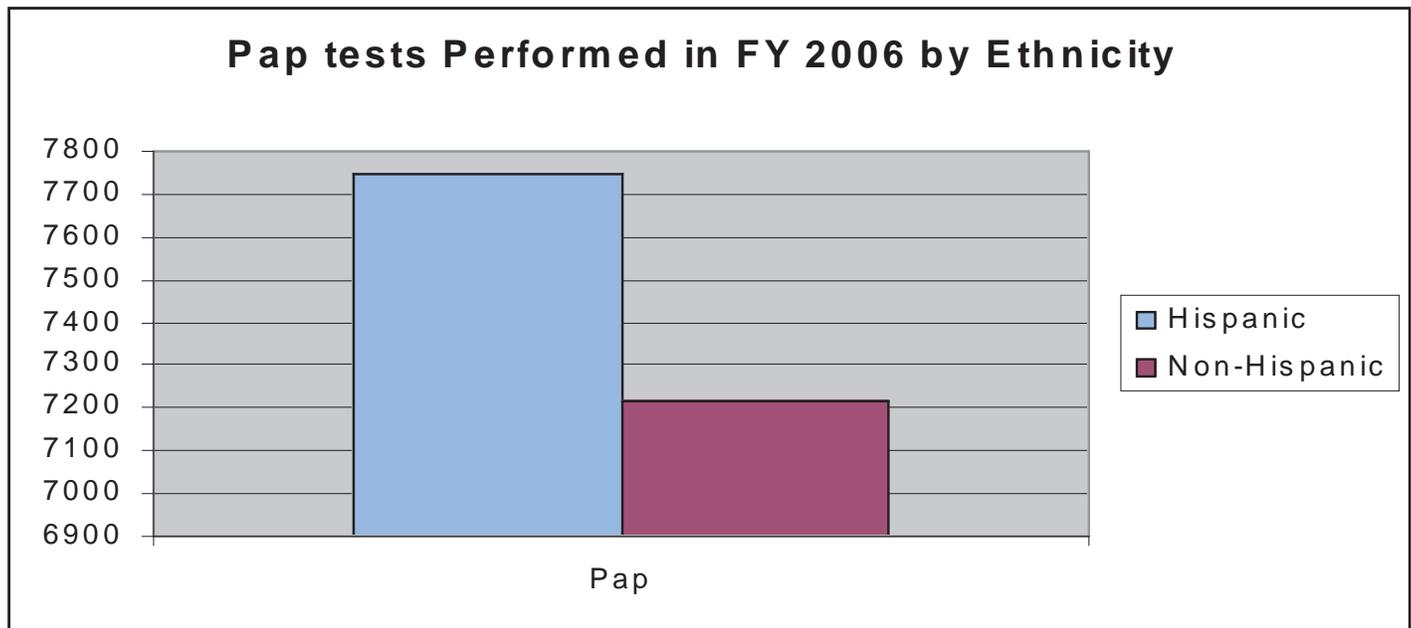
As the figure illustrates, White program participants accounted for most (68.7%) of the Pap test screening procedures in the current reporting period. This proportion of the total as was higher than the prior year (66.8%). African American women who received

Cervical Screening Procedures Performed in FY 2006 by Age



Pap test Performed in FY 2006 by Race





cervical screenings represented 15.2 percent of the total in FY '06. This percentage is a slight decrease from last year's proportion (16.8%).

More than one half (51.8%) of the program enrollees provided cervical screenings were Hispanic in the current reporting year. In FY '05, 49.3 percent of the women who received cervical screening procedures were Hispanic.

Diagnostic Procedures:

During the reporting year, a total of 9,325 breast and cervical diagnostic procedures were provided. This represents a 26.5 percent increase from the last fiscal year. Three quarters (77%) of the diagnostic procedures were breast related procedures in FY '06.

Breast Diagnostic Procedures:

The majority (44.9%) of breast diagnostic procedures were utilized by enrollees between the ages of 40 and 49 years. The next greatest number of procedures were provided to women between the ages of 50 and 64.

Over one-third (40.7%) of the diagnostic procedures provided to program participants were Ultrasounds; about the same percentage as last year. The next most widely utilized diagnostic procedure was "Additional Mammography Views" which represented 24.4 percent of the total, which is a one percent increase from last year. Surgical Consultations made up 18.2 percent of

the diagnostic procedures, which was a slightly smaller proportion of the total than was seen last year (20.2%).

Breast Cancers Diagnosed:

In FY '06 153 breast cancer cases were diagnosed. These cases accounted for 87 invasive and 66 LCIS/DCIS diagnosed breast cancer cases in FY 2006. This was an increase of 30% and 65%, respectively from FY 2005. This increase was the result of a 12.7 percent increase in breast cancer screenings from the prior fiscal year.

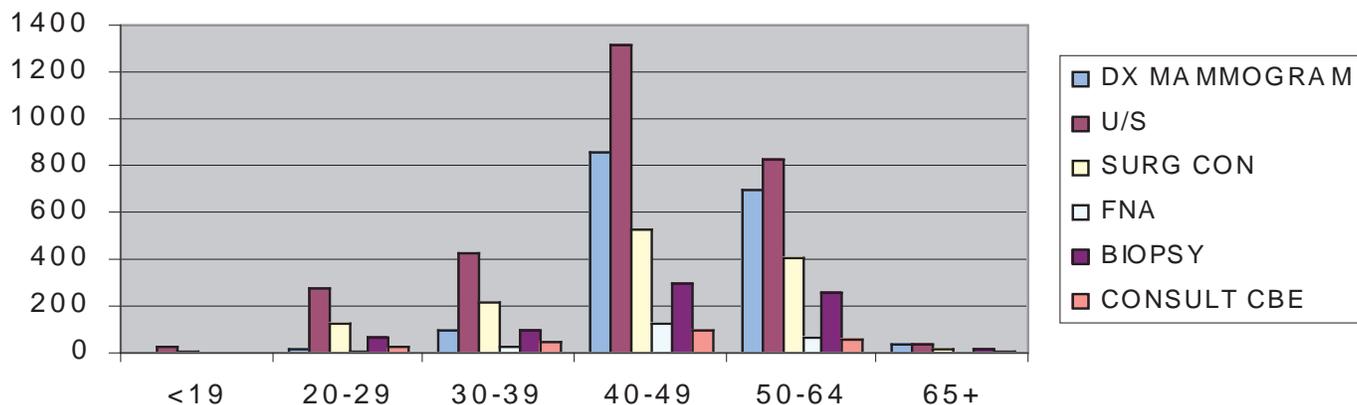
Cervical Diagnostic Procedures:

A total of 2,138 cervical diagnostic procedures were performed in FY '06. Over one-third of these (35.4%) were utilized by women under the age of 30 years. This age population accounted for less than 14% of the total Pap test performed in FY 2006, however the same age group accounted for over forty percent of all Colposcopy with biopsy procedures. Women in the next older age category, 40 to 49 years of age accounted for 27.1 percent of the cervical diagnostic procedures provided by the NJCEED Program.

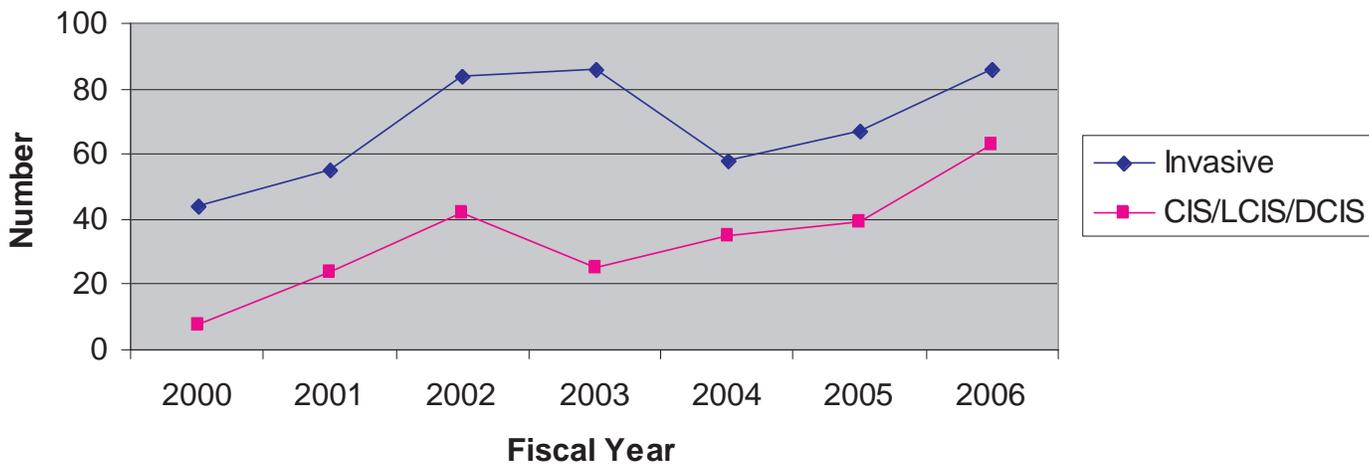
Cervical Cancers Diagnosed:

For fiscal year 2006, there were 9 cases of invasive cervical cancer, and 275 cases of CIN I-III. Compared to fiscal year 2005, there were 6 confirmed cases of invasive cervical cancer, a 50 percent increase in the number of diagnosed and treated cervical cancers.

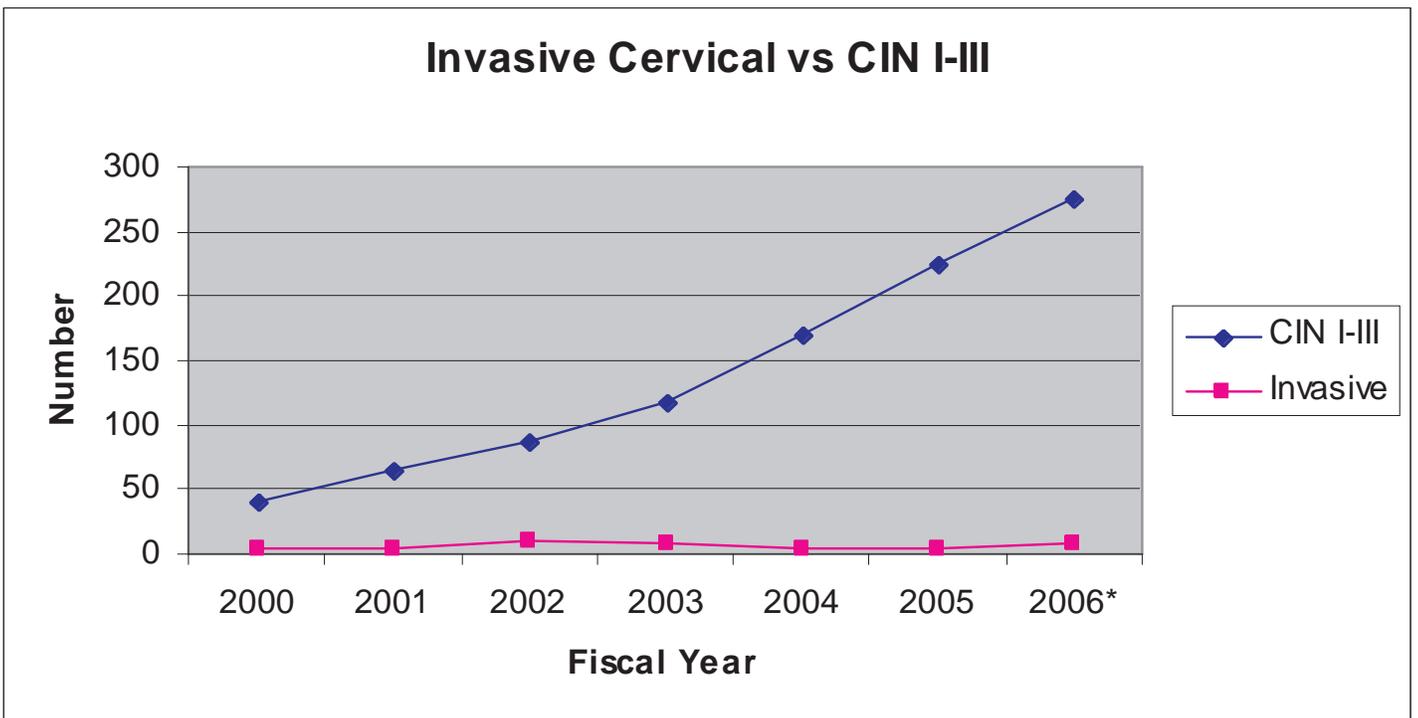
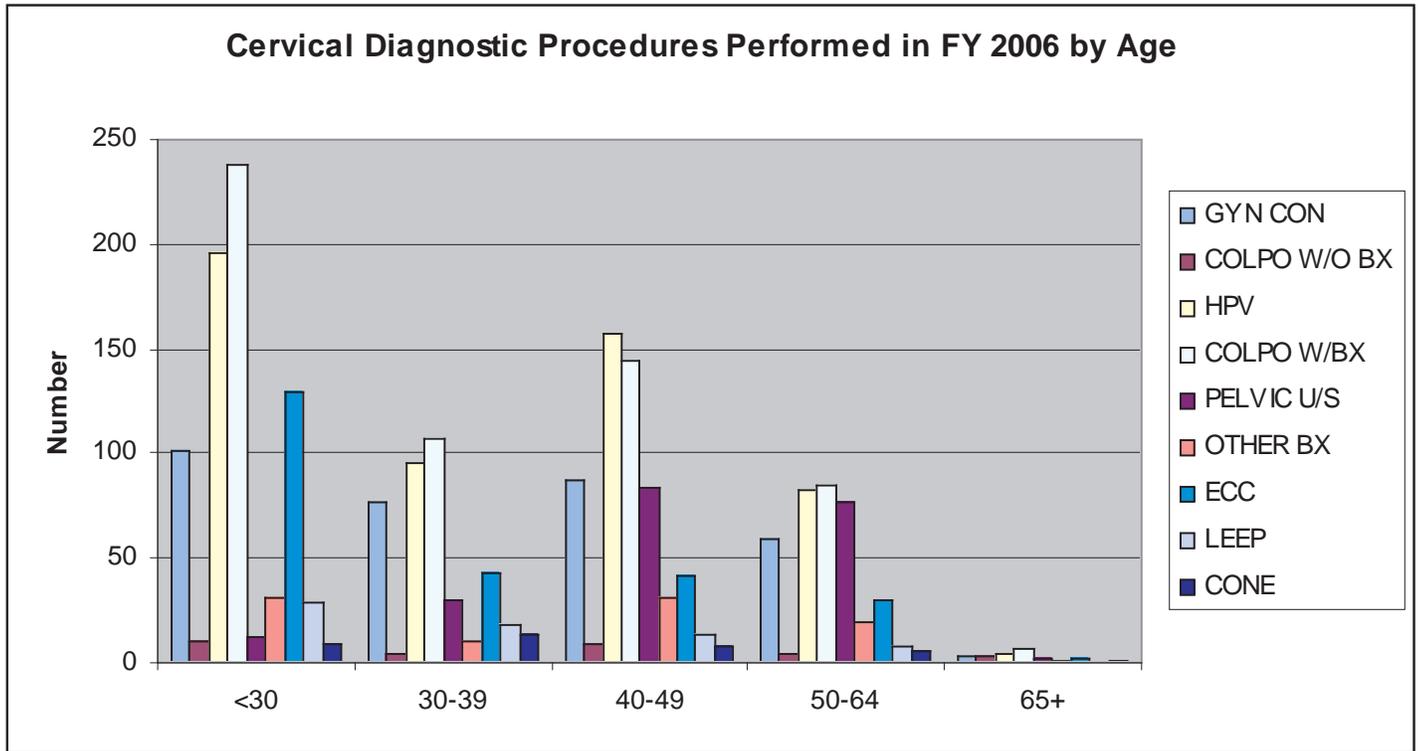
Breast Diagnostic Procedures Performed in FY 2006 by Age



Breast Cancer Cases



Chronic Disease Prevention and Control—Adult Health



Breast and Cervical Cancer Screening Summary:

More eligible women were provided both breast and cervical screenings and diagnostic procedures as a direct result of the increase in State program funding. Compared to the prior fiscal year, significant increases in the screenings provided to program participants were seen for all three screening procedures. Mammograms increased by 12.7 percent, CBE's by 9.8 percent and Pap Tests by 4.1 percent.



While the enrollees served were within the age categories that reflect program guidelines, a slightly larger proportion of women between 40 and 49 years of age were provided with screenings and diagnostic procedures.

By race and ethnicity, enrollees receiving breast and cervical screenings and procedures approximate the demographics of the State of New Jersey, with two-thirds being White and 15.7 percent African American.

However, while State-wide, Hispanics account for 13.3 percent of the population, the percentage of Hispanic participants was slightly higher than the Non-Hispanic group.

The most utilized breast diagnostic procedure was Ultrasound and women in age category between 40 and 49 years were provided this procedure most frequently. However, women in the under-30 age category accounted for the largest proportion that utilized cervical diagnostic procedures. Colposcopy with a biopsy (27.3%) was the cervical cancer diagnostic procedure commonly utilized by program participants.

Increases in funding has allowed for increases in the numbers of screening and diagnostic procedures provided to program participants. As a result, more cases of cancer and pre-cancerous conditions were identified. Increases were noted in in-situ and invasive breast cancers, together with a rise in invasive cervical cancer and 'precancerous' cervical cases.

Invasive breast cancer cases increased by 20 cases, or 30% percent, with an accompanying 65% increase in the number of In-situ breast cancer cases from the prior fiscal year. There were 9 new invasive cervical cancer cases diagnosed and treated, which accounted for an 80% increase. Cervical Intraepithelial Neoplasia (CIN) diagnosed lesions increased by 50 cases to 275 (22.2%) from the previous year.

Summary of FY 2006 Prostate and Colorectal Data:

During Fiscal Year 2006, a total of 5,709 men and women were screened by the NJCEED Program for prostate and/or colorectal cancer. This represents a 3.4% decrease from the prior fiscal year. During this reporting period, administrative transitions disrupted the reporting of screening data in three of the agencies, which historically, screened the largest numbers of program participants. These were agencies in Hudson, Passaic and Union counties. Data reporting has become more reliable with the experience built up by the staff of these three new agencies. The number of prostate cancer screening procedures provided to men in FY06 was 1,431. This is a decrease of 3% from FY 2005. The number of men who received colorectal cancer screening procedures (Fecal Occult Blood Test) in FY06 was 1,132. This was a decrease of 4.6% from the previous fiscal year. The number of enrolled women who received colorectal screening procedures was 3,146, a decrease of 3.2% from FY05.

Prostate Cancer Screenings and Diagnostic Procedures:

Age Category:

Of those men screened for prostate cancer who reported their age when enrolled into the NJCEED Program, 65.8% were between 50 and 64 years, almost eight percent higher in this age category than in the prior fiscal year. The age category 40-49 years accounted for 23.9% of the screenings, six percent less than FY '05. Men over the age of 65 represented 9% of the total prostate screenings, as compared to 10.3% in FY05. These proportions illustrate that the lead agencies are successful in providing more screenings within the program age guidelines.

Race:

Almost two-thirds (59.8%) of the men screened during fiscal year 2006 were White. This proportion of the total may be compared with 60.3% in the prior fiscal year. African American men accounted for 16.2% of the total prostate cancer screenings, a decrease of 3.7% from FY '05. Over eleven percent (11.2%) of the total screening participants reported their race as "Other." This is an increase from the 8.4 percent of total, noted in the prior year. This significant proportion of the total men screened may reflect reluctance on the part of the enrollees to be classified by race.

Ethnicity:

By ethnicity, the men screened for prostate were almost evenly divided between Hispanic (48.1%) and Non-Hispanic (51.9%). In the prior fiscal year, men of Hispanic origin accounted for 46.5 percent of the total. At the various agencies, the breakout of screened men, by ethnicity, was consistent with the target population of each county.

Prostate Diagnostic Procedures:

Diagnostic procedures are performed after prostate screening procedures, when, based on medical necessity, more clinical information is required to determine the patient's morbidity status. These diagnostic procedures are Transrectal Ultrasound, Transrectal Ultrasound with Biopsy, Biopsy, Urological Consultation and other miscellaneous procedures. Demographic data are based on the self-reporting of the NJCEED participant. Thus, the intake worker will record the gender, age, race and ethnicity that the participant provides. In some cases, no report was made for one or more categories.

Age Category:

Over three quarters (75.9%) of NJCEED enrollees receiving prostate diagnostic procedures were between the ages of 50 and 64 years. Those enrollees in the 65+ represented 14.2 percent of the diagnostic prostate procedures and the 40 to 49 category accounted for 7.4 percent. In the prior year, those aged 50 to 64 years were 68.44 percent of the total and those 40-49 years of age were 16 percent of the total.

Race:

Over half (62.8%) of the participants receiving diagnostic procedures were minorities and half of these (33) were African Americans. While a greater proportion of the procedures were provided to minorities, as a category, Whites increased from 51.8 percent of total in FY '05 to 61.4 percent in FY '06.

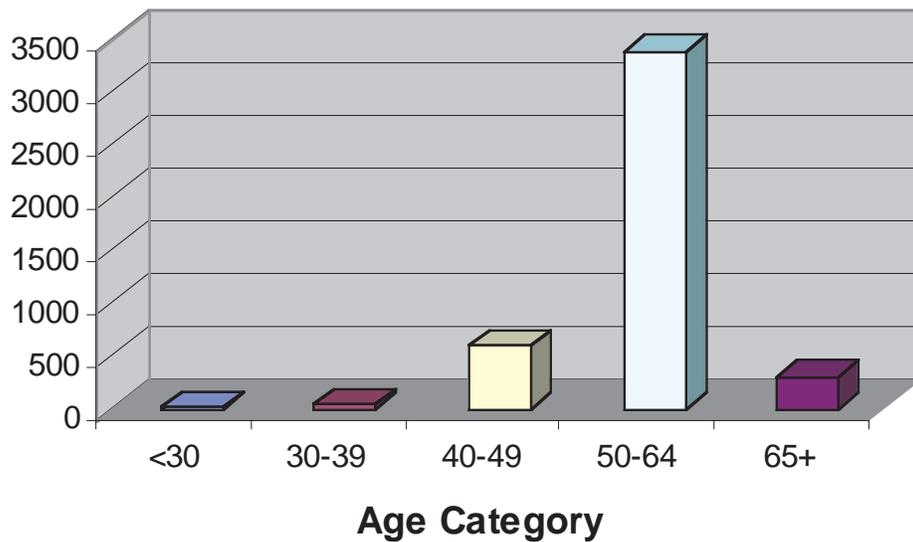
Ethnicity:

While the proportion of male Hispanics who were given diagnostic procedures was higher in FY '06 than in FY '05 (31.3% of total versus 24.6%, respectively), over two-thirds of the procedures were provided to men of Non-Hispanic origin.

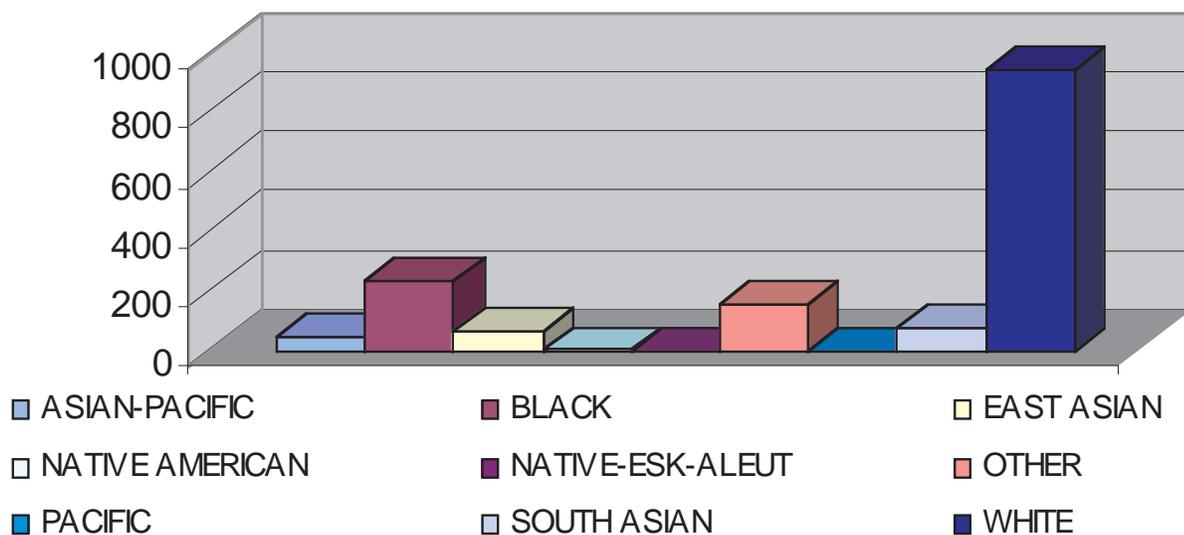
Prostate Cancer Cases:

During this reporting period, abnormal screenings resulted in 164 follow-up procedures being performed on the enrolled men. These procedures, in turn, resulted in thirteen (13) cases of prostate cancer being successfully diagnosed; more than twice as many than in FY '05. Eight of the twenty five lead agencies provided the screening and diagnostic procedures that resulted in these diagnoses. In the prior year, a total of 56 post-screening procedures resulted in seven (7) cases of prostate cancer. By age category, one patient with a prostate cancer diagnosis was between 40 and 49, eleven were between 50 and 64 and one was over 65 years of age. Seven (7) were African American and six (6) were White. All thirteen of the patients were Non-Hispanic.

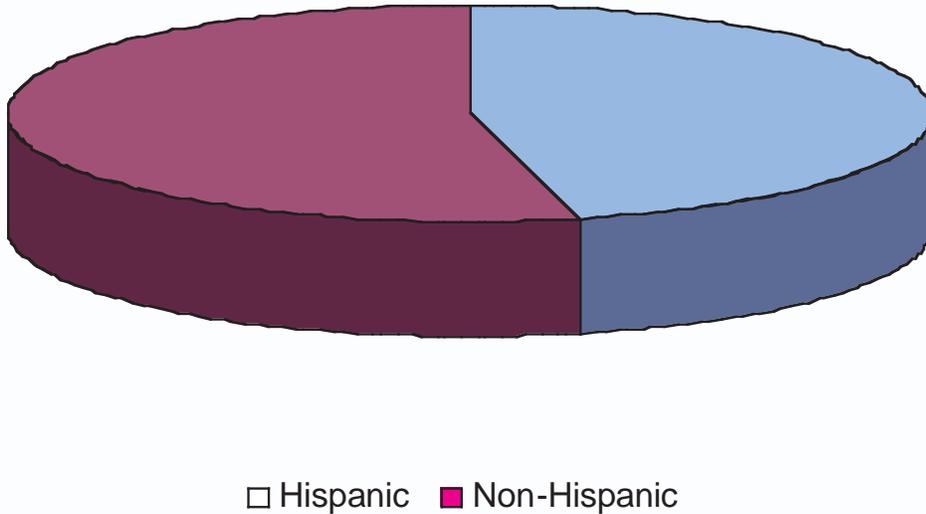
Prostate Screening Procedures in FY 06 by Age Category



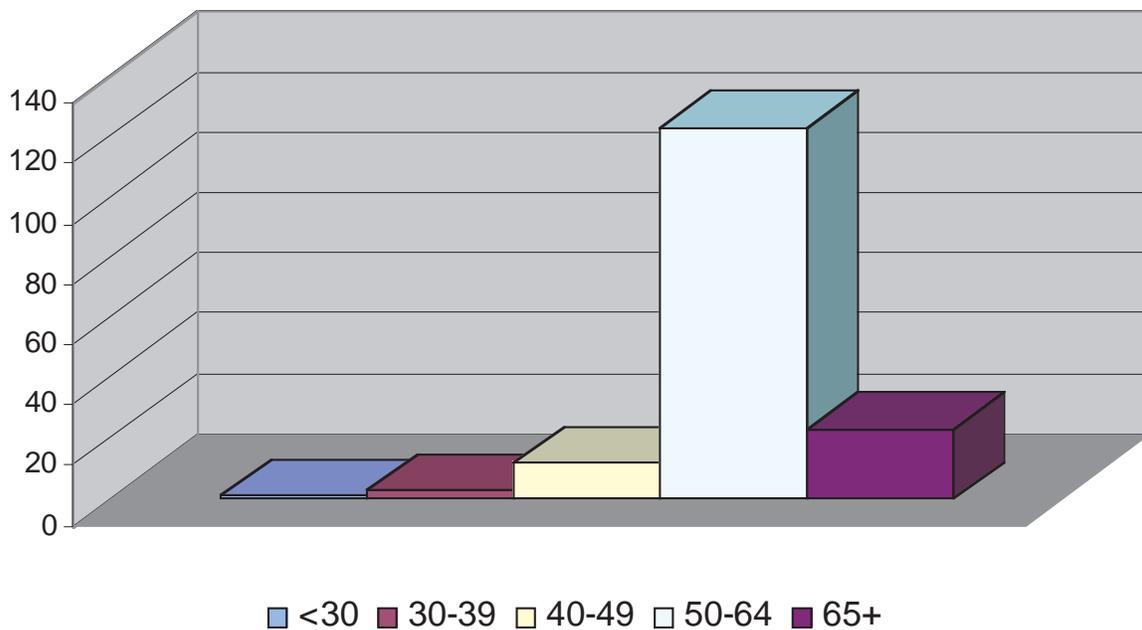
Prostate Screening Procedures in FY '06 by Race



Prostate Screening Procedures in FY '06 by Ethnicity

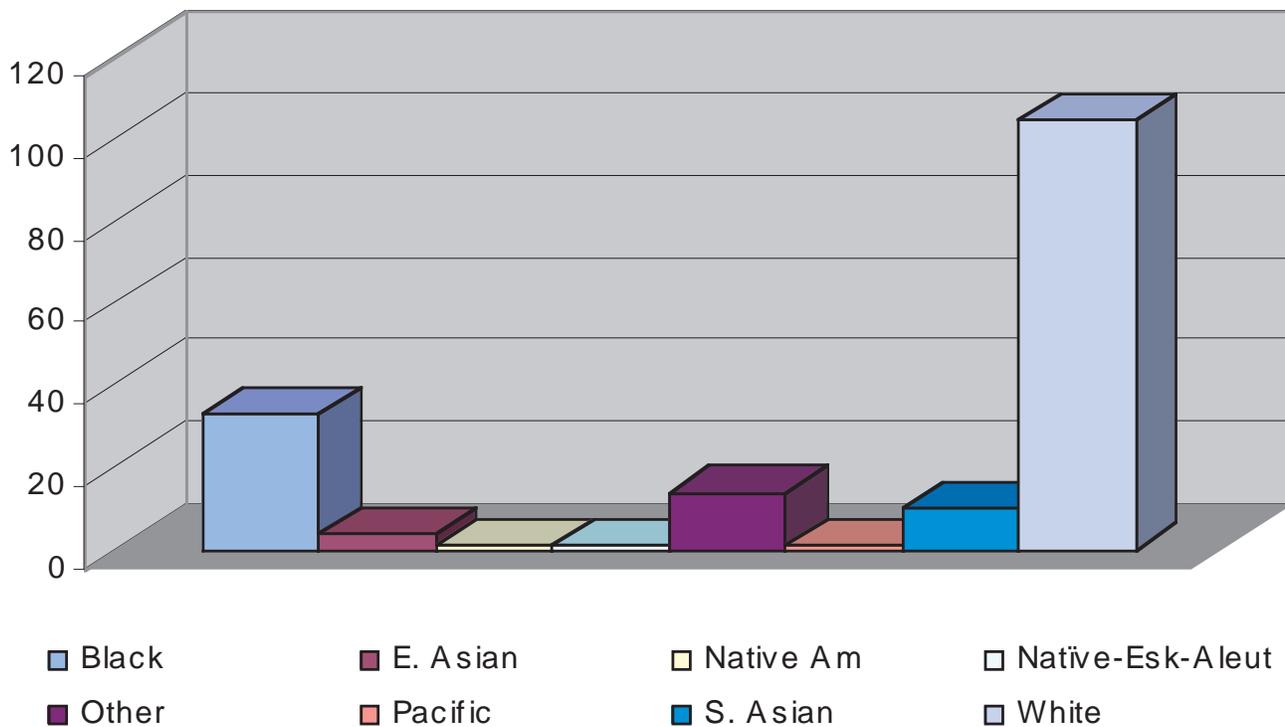


Prostate Diagnostic Procedures in FY' 06 by Age

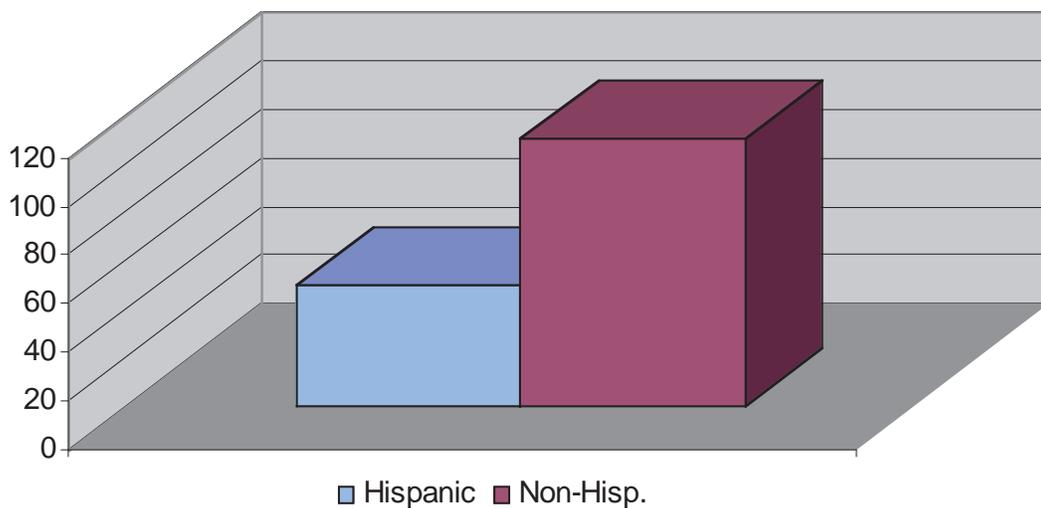


Chronic Disease Prevention and Control—Adult Health

Prostate Diagnostic Procedures in FY '06 by Race



Prostate Diagnostic Procedures in FY '06 by Ethnicity



Colorectal Cancer Screenings and Diagnostic Procedures:

Gender

In this reporting period, 4,278 enrollees were screened for colorectal cancer. This is a decrease of 4.4% from Fiscal Year 2005. Almost three-quarters (73.5%) of those screened for colorectal cancer were women.

Age Category:

For both men and women, over three-quarters (77.4%) of those screened for colorectal cancer were between the ages of 50 and 64 years, which is the age-appropriate screening target. This proportion represents an increase from that seen in the prior fiscal year, (72.7%) and correlates with decreases in age categories 40-49 (1.7% lower) and 65+ (1.2% lower.) Again, these proportions are within anticipated parameters.

Race:

Most (68.6%) of the enrollees reported themselves as being White. This proportion represents a slight increase from last year (68.1%). The next largest racial group (17.4%) was African American and was close to the percentage of the total reported in FY05. As was seen with the prostate cancer screening enrollees, a significant proportion (5.7%) was listed as being in the “Other” racial grouping. This was lower than the prior year which reported 6.8% of all colorectal screenings being performed on enrollees in this category. This decrease resulted in larger proportions in all of the other categories, and reflects closer attention to detail by intake and data processing staff at the agencies. South Asian participants accounted for 4.1 percent of the colorectal screenings, an increase from the 3.3 percent noted in FY '05. The percentage of East Asians also increased slightly, from 2.6 percent to 3.0 percent.

Ethnicity:

Slightly more than half (52.2%) of those given colorectal screenings were reported as being of Hispanic Origin. Once again, this is a slight increase from the prior fiscal year (50.9%) and may be a beneficial result of outreach efforts aimed at Hispanic communities.

Colorectal Diagnostic Procedures:

Similar to prostate screenings, when colorectal screenings result in a need to gain more information about a finding, colorectal diagnostic procedures are performed. Again, it must be noted that demographic data are based on the self-reporting of the NJCEED participant and, in some cases, no data were provided for one or more categories.

Gender:

As may be seen in the above graph, three-quarters (73.2%) of the program participants who received diagnostic procedures were females. This is a slightly smaller (3.8%) proportion of the total diagnostic procedures than was seen last year.

Age Category:

Most of the enrollees provided diagnostic procedures (72.3%) were between the ages of 50 and 64 years. This is a slightly lower proportion (2.7%) of the total than was seen in the previous year. A smaller proportion of older enrollees (65+ years of age) were provided diagnostic procedures in FY '06 than in FY '05, 6.6% compared to 7.5%. Age category 40-49 also decreased, from 14.5% to 11.7%. These decreases were the result of increases in diagnostic procedures that were provided to enrollees in the two youngest age categories.

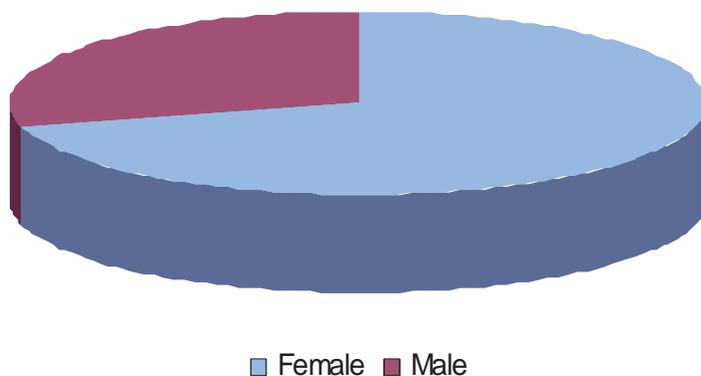
Race:

Over one-third (37.7%) of the colorectal diagnostic procedures were provided to program participants that were members of race categories other than White in FY '06. This represents a larger proportion (by 5.8%) of total than was seen in the prior year. In FY '05, 31.9 percent of the procedures were provided to minorities.

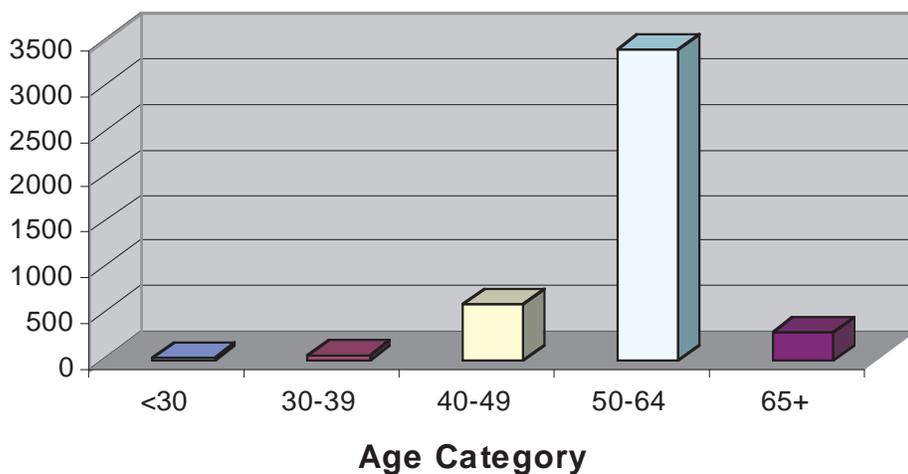
Ethnicity:

Hispanics accounted for 31.3 percent of those participants who received post screening colorectal procedures during the target year. This is an increase from 29.2 percent of total reported in the prior year.

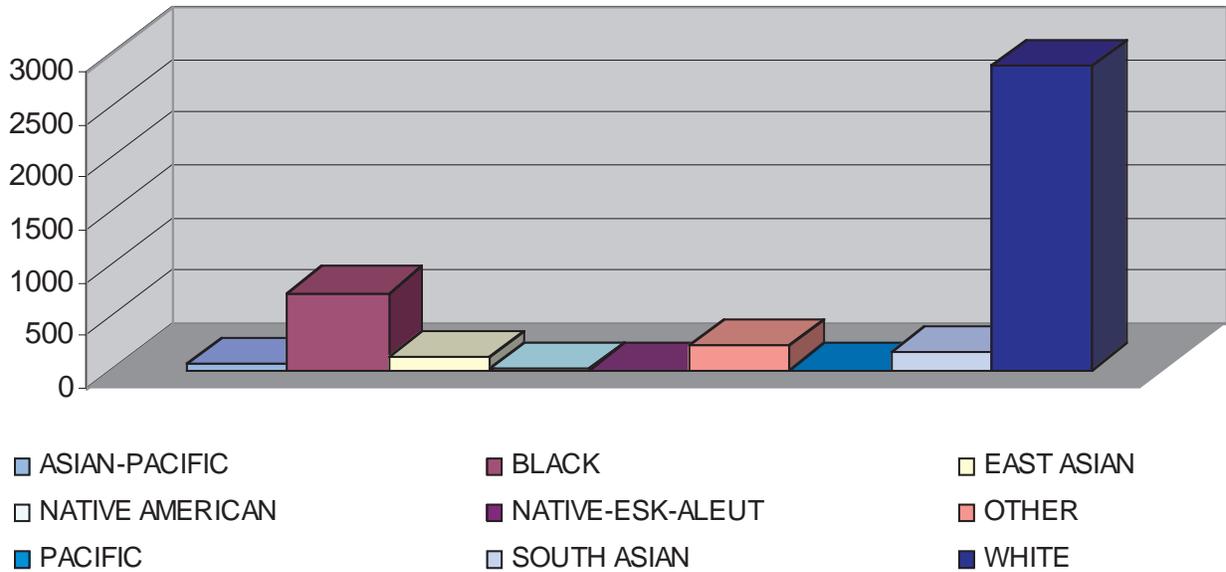
Colorectal Screenings in FY '06 by Gender



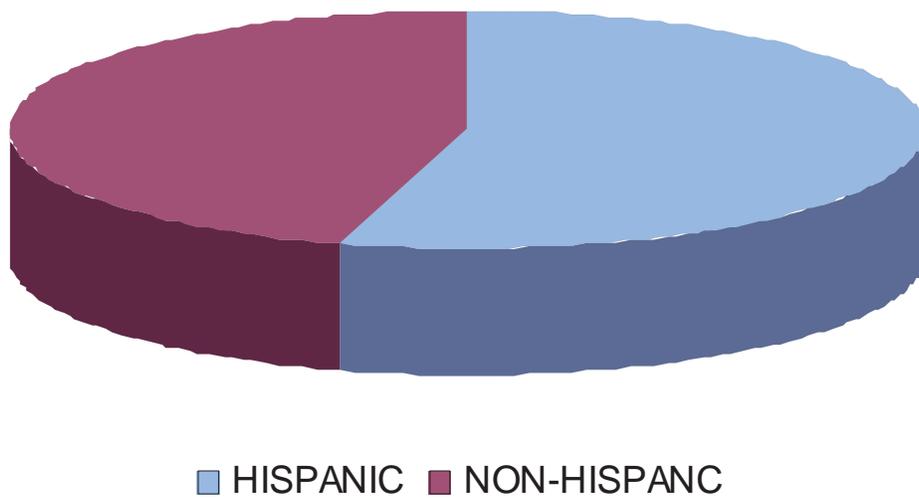
Prostate Screening Procedures in FY 06 by Age Category



Colorectal Screenings in FY '06 by Race

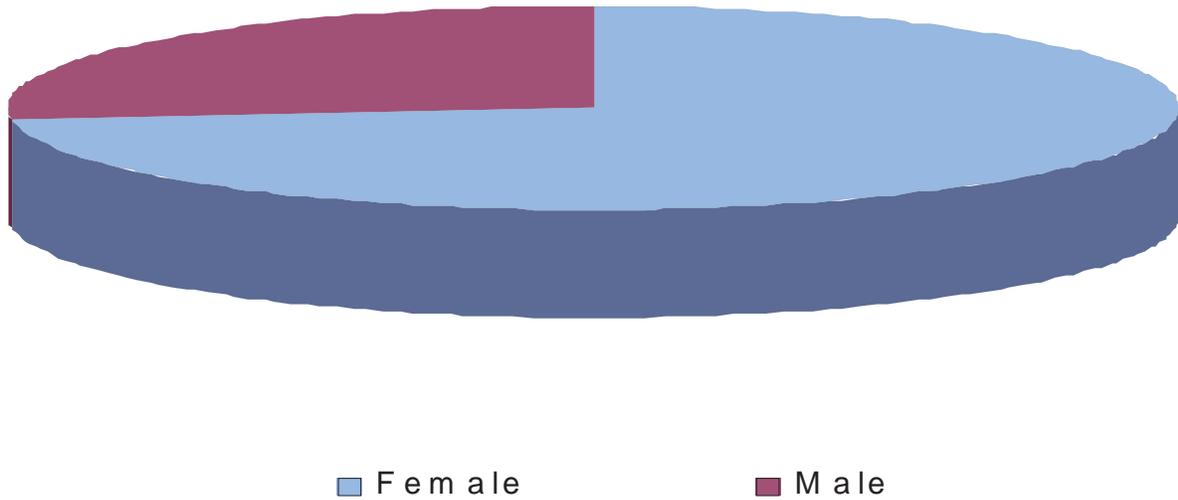


Colorectal Screenings in FY '06 by Ethnicity

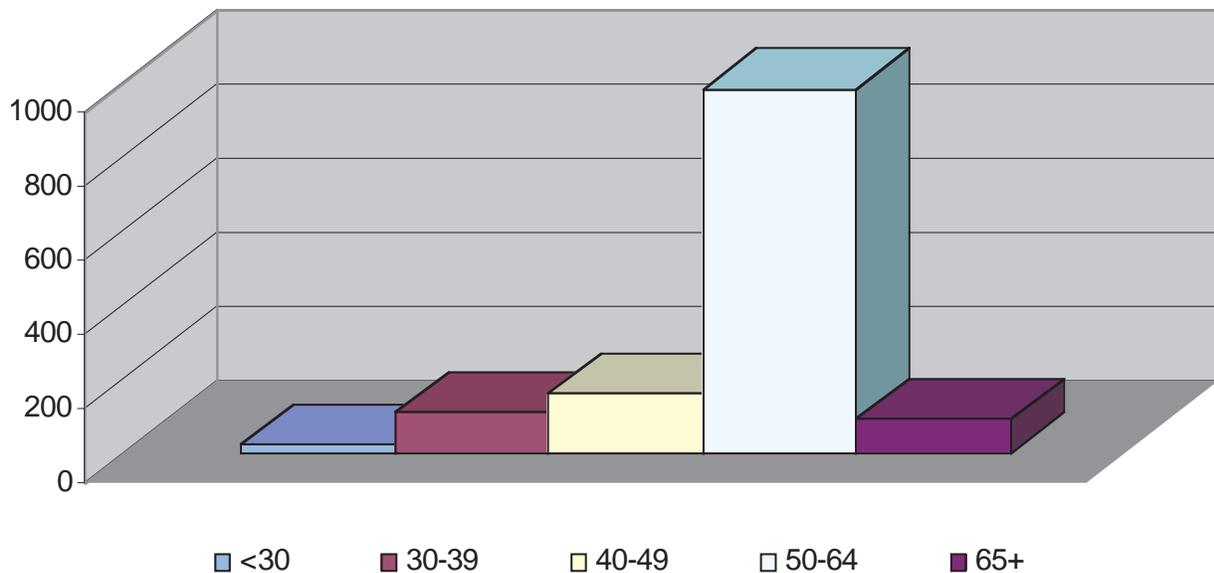


Chronic Disease Prevention and Control—Adult Health

Colorectal Diagnostic Procedures in FY '06 by Gender

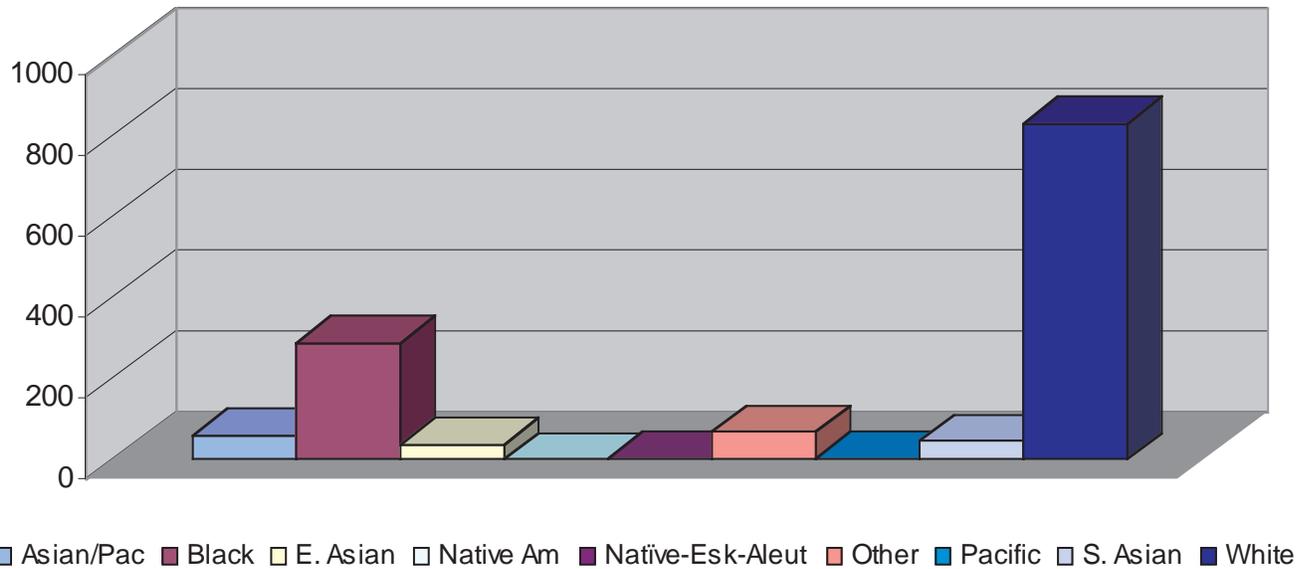


Colorectal Diagnostic Procedures in FY '06 by Age Category

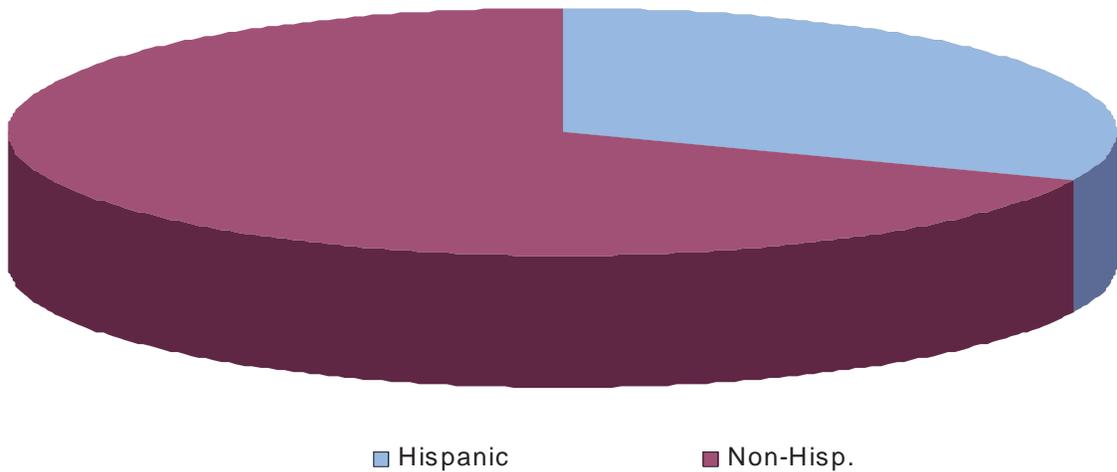


Chronic Disease Prevention and Control—Adult Health

Colorectal Diagnostic Procedures in FY '06 by Race



Colorectal Diagnostic Procedures in FY '06 by Ethnicity



Cancer Cases:

A total of 1,304 colorectal follow-up procedures were performed in FY06, an increase of 76 percent from the year before. Colonoscopies represented the largest number of procedures (493 or 37.8% of total). In the prior year, 43.3 percent of the post-screening procedures were Colonoscopies. Most of these procedures were provided to White females in the 50 to 64 year old category.

As a result of these procedures, 135 cases of colorectal polyps were discovered. This is a significant increase of 60 from the prior fiscal year. Four (4) cases of colorectal cancer were diagnosed in FY06, one more than in the prior fiscal year. Two of cases were diagnosed in men, the other two in women. Three were between 50 and 64 years of age and one was 65 or more years old. Three of the cases were found in Whites and one in an African American. All four were non-Hispanic.

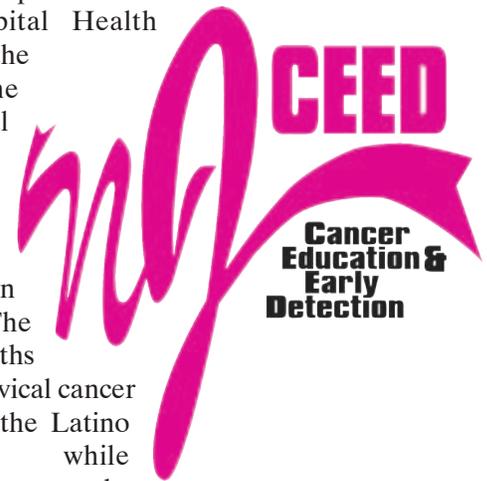
Prostate/Colorectal Cancer Summary:

The NJCEED Program has been successful on several fronts. Its proven outreach efforts, designed to include minorities, have been expanded upon in FY '06. Over forty percent of the enrollees provided screenings for prostate were reported as being minorities. For those enrollees receiving colorectal screenings, 31.4 percent were reported as being members of a minority. The proportion of minority enrollees coming into the program increased slightly. In the current year, nearly one-half (48.15) of the men receiving prostate screenings were of Hispanic origin. This is an increase of 1.1 percent from the prior year. Over one-half (52.2%) of participants receiving colorectal screenings were of Hispanic origin. Again, this was an increase (1.2%) from the prior year. More of the enrollees being screened fell between the ages of 50 and 64 years than did in FY04.

Even though slightly fewer screening procedures were reported in FY '06, more cancer cases were diagnosed than in the prior year. Five more prostate and one more colorectal cancers were discovered as a result of this program.

NJCEED Outreach and Education

In recognition of National Cervical Health Awareness Month (January 2006) the New Jersey Cancer Education and Early Detection (NJCEED) program in collaboration with the Camden County NJCEED Programs at Cooper Medical Center and Capital Health System unveiled the DVD of the Spanish cervical cancer play, "Maria's Story – A Cry for Help" at the Trenton War Memorial on January 13. The DVD explores myths and barriers to cervical cancer screening among the Latino population; while empowering women to take charge of their health. The event was a resounding success with over 145 people in attendance. A resolution, marking the event, was presented to a representative of Cooper Medical Center. Additionally, the Mercer County Brava/NJCEED Program at Capital Health System offered free pap screening on the City of Trenton Project Impact health van to women who were eligible through NJCEED guidelines; 17 women were screened as a result of this event. This DVD was distributed to all 25 NJCEED lead agencies to be distributed in their Latino communities and used as an educational outreach tool.



The New Jersey Department of Health and Senior Services in partnership with the American Heart Association, the Women's Heart Foundation, and the New Jersey State Council and the Trenton Alumnae Chapter of Delta Sigma Theta Sorority, Inc., kicked off New Jersey's first "Go-Red for Women, Love Your Heart Campaign". This rally and health fair was held on February 4, 2006 at the Trenton War Memorial. The goal was to raise heart disease awareness in order to help women take steps to improve their heart health. Over 500 attendees joined skilled health care providers from the community to assist us in promoting change in health care behaviors through education.

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The New Jersey Department of Health and Senior Services', Chronic Disease Prevention and Control Services Program, in partnership with the American Cancer Society, the American Heart Association, the Visiting Nurses Association of Central Jersey and Community Medical Center of Ocean County sponsored a public and professional conference entitled, *"Bridging the Gaps: New Trends in Women's Health."* The target audience included health educators, health care providers, hospital representatives, community members and others who are interested in enhancing partnerships to improve women's health. This conference was held on March 15, 2006, at Rider University in Lawrenceville, New Jersey. There were 130 individuals who attended the conference; participant's evaluations concluded that the overall conference was excellent, extremely informative and it was recommended that there be another conference on women's health.

In recognition of Colorectal Awareness Month (March 2006) the Mercer County Cancer Coalition, in partnership with NJCEED, kicked off New Jersey's first *"Body & Soul: A Celebration of Healthy Living"* program. This event was held on March 31, 2006 at the Trenton War Memorial, West Lafayette Street in Trenton. *Body and Soul* is a pilot program that was presented to four African American churches recruited from the Concerned Pastors of Trenton Interfaith Association: (Shiloh Baptist Church, Grace Cathedral Fellowship Ministries, Macedonia Baptist Church, and Mt. Zion AME Church). The goal of *Body & Soul* is to provide cancer awareness and other chronic disease messages to the congregants of African American churches in order to integrate healthy behaviors into their daily lives. This kick-off event utilized health care professionals and survivors to assist in promoting healthy lifestyle behaviors such as diet and exercise and to utilize available preventive cancer screenings. The City of Trenton's health van was on-site to perform colorectal cancer screenings for the uninsured/underinsured participants, and a resource list was made available to those participants who had medical insurance, but needed help in finding medical resources. Over 70 persons from the Trenton community attended.

The NJCEED Program has partnered with Virgil Simmons and the Prostate

Net to make the Barbershop Initiative a statewide program. The Barbershop Initiative is a nationally recognized community-based model that provides outreach, awareness, education, referral and support services to low income and medically underserved men who need prostate cancer screening services. The partnership between the Prostate Net and the NJCEED Program will enable many New Jersey men to be screened for prostate cancer and ultimately to save lives. The goal of the program is to provide information, educational tools and incentives to local barbers in each county, who in turn will provide education with regard to prostate health to their customers. A list of New Jersey licensed Barbers was provided to all 25 lead agencies as a resource to help with the recruitment of barbers to participate in this initiative. Trainings were held in Burlington, Camden, Essex, Hudson, and Gloucester. Other trainings will be conducted throughout the year with the NJCEED programs.

The NJCEED Program hosted a prostate cancer awareness workshop on April 25, 2006, at the American Cancer Society Regional Office in North Brunswick, New Jersey. The training was conducted by Eugene M. Wheeler, Program Director of Us TOO International, Inc. The purpose of the program was to assist all who are involved with prostate health education and awareness to develop and promote policies and programs that will reduce the morbidity and mortality associated with prostate cancer. The program received an overwhelming positive response from the 75 individuals who attended.



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May 2006 was Breast Cancer Awareness Month in New Jersey. The NJCEED Program continued its “Paint the State Pink” campaign by utilizing pink ribbons strategically placed on light posts, buildings, etc. around the state to bring about breast cancer awareness. A “Tree of Life” was displayed at the food court at Capitol Center where passersby had the opportunity to dedicate “honor cards” to someone they know who has been affected by breast cancer. The 25 NJCEED Lead Agencies provided various educational sessions and activities throughout the month using the State appropriated breast cancer awareness funds.

The Mercer County Brava NJCEED Program at Capital Health System, Mercer Campus in partnership with the NJCEED Program and the Mercer County Cancer Coalition launched off Mercer County’s “Paint the Town Pink Campaign”. The Mercer County kick-off event for the “Paint the Town Pink Campaign” in recognition of Mother’s Day was held on Sunday, May 7, 2006 at Maxine’s 2, 120 South Warren St., Trenton. The event featured a premier of the breast health/breast cancer awareness vignette “MY MOTHER, MY SISTER, MY DAUGHTER, MYSELF - An African American Family of Women, Celebrates and Speaks out about Breast Cancer” developed by Delta Sigma Theta Inc. Trenton Alumnae Fortitude Corporation. Over 150 people attended this event.

The NJCEED Program partnered with the American Cancer Society (ACS) Mercer County program to kick-off the second annual “Real Men Cook” event sponsored under the Trenton’s Crusade against Cancer urban initiative. This event was held on May 21, 2006 at the Trenton War Memorial, West Lafayette Street. This event featured 40 distinguished men from the community who cooked healthy meals which were then enjoyed by the attendees. The meals were judged by prominent professionals and prizes were given to all who participated. The goal was to provide prostate cancer awareness messages to men as well as education and screening. The City of Trenton’s health van as well as Horizon New Jersey provided on-site cancer screenings for both insured and uninsured/underinsured participants. 180 individuals participated in this event.

The first statewide Human Papillomavirus (HPV) Summit was held on May 24, 2006 at the Crowne Plaza Hotel in Jamesburg, New Jersey. Over 300 participants attended this highly informative session which focused on the science, epidemiology and issues surrounding vaccines for HPV prevention.

During the month of June, in recognition of Father’s Day and National Men’s Health Week, the NJCEED Program continued to promote its successful “No Man Left Behind: Blue Ribbon Campaign to End Prostate Cancer” by using blue ribbons strategically placed on lights posts, buildings, etc. throughout the state to increase prostate cancer awareness. A “Tree of Life” was displayed at the food court at Capitol Center where passersby had the opportunity to dedicate “honor cards” to someone they know who has been affected by prostate cancer. The 25 NJCEED Lead Agencies provided



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various prostate-related educational sessions and activities throughout the month.

The NJCEED Program partnered with the American Cancer Society and other sponsors to launch the 4th annual Run for Dad, an event designed to raise awareness about prostate cancer in men. The kick-off event for Run for Dad 2006 was held at KAT MAN DU in Trenton on June 16, 2006 with over 100 supporters attending. The actual Run was held on Father's Day, June 18, 2006, at Mercer County, Park West Windsor. This event drew more than 1,500 participants, including 70 prostate cancer survivors, and more than 200 children. Proceeds from this event will support a grant for prostate cancer research and other prostate cancer projects in New Jersey.

At the request of the Office of Minority Health, NJCEED staff participated in the 2nd Annual Health & Safety Fair at the Naval Air Engineering Station in Lakehurst, New Jersey held on June 29, 2006. Over 1,000 participants attended the event. Most of the participants were military personnel and their family members. This was a great opportunity to educate others about the importance of breast, cervical and prostate and colorectal health issues.

A Collaborative Leadership Retreat between the NJCEED Program and the American Cancer Society was held July 20-21, 2006 at the New Jersey Hospital Association in Princeton. The objectives of the retreat were to mutually: 1) establish goals, 2) define roles and expectations and 3) establish systems for working together. Attendees expressed enthusiasm at the prospect of renewing or entering into new collaborative cancer control efforts.

September was National Prostate Health Awareness Month and the NJCEED Program in collaboration with, the Mercer County Brava/NJCEED Program at Capital Health System and BET (Black Entertainment Television), Luis Lopez and Behind Another Reason Productions highlighted the unveiling of a prostate video called, "No Man Left Behind-

Making Healthy Choices-Prostate Health Awareness". This 30-minute interactive DVD was produced and distributed as an educational tool to raise prostate health awareness and to help alleviate many of the myths and fears that men may have about the screening and detection of prostate cancer. This DVD production will be presented as part of a Men's Health Education Seminar and will be used in conjunction with a panel of health care professionals who will be available to the audience for any questions or concerns that may arise. The event was held on September 27, 2006 at the Trenton War Memorial. Over 200 people attended with 40 men being screened.

The NJCEED Outreach Coordinator presented a poster presentation on "Maria's Story": A Cry for Help" - A Hispanic Monologue About Cervical Cancer & Early Detection" at the CDC's 2006 Health Promotion Conference, September 12-14, 2006 in Atlanta, Georgia. The conference focused on innovations in health promotion and new avenues for collaboration; the presentation highlighted the NJCEED Program's newest outreach tool which targets Latino women.

October was National Breast Cancer Awareness Month and the NJCEED Program worked in partnership with all of the Wal*Mart stores in New Jersey to provide women with an outreach program designed for the retail environment. Posters and educational displays were placed at the front entrances of the store along with flyers distributed in all individuals' bags. The importance of early detection, and information about our "free screenings" was highlighted.

The NJCEED Program partnered again with the American Cancer Society in their annual "Making Strides Against Breast Cancer" during October. The goal continues to be to make all of the "Making Strides" sponsors and participants aware of the resources that NJCEED Programs offer women without health insurance in communities throughout New Jersey.

N J C E E D participated in the



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annual Susan G. Komen, the Race for the Cure on October 29th at Bristol Myers Squibb Headquarters in Princeton. The Department of Health and Senior Services was represented by a team of 25 members. NJCEED also had a health resource exhibit table at the event.

The official kick-off event for the “Reach Out for Life: Somebody Needs You” Campaign was held on November 13, 2006 at the State House in Trenton with Governor Corzine and other partners in attendance to promote this pilot project. This collaborative effort between the NJCEED Program and the Susan G. Komen Foundation – Central and South Jersey Affiliate will enable 14 NJCEED Program Lead Agencies to

provide breast cancer screening services to a broader population of women. The “Reach Out for Life” program will target education and awareness messages to African American women in 13 New Jersey counties. Lower income women, those between 250% and 300% of the Federal Poverty Level, who would not normally meet income eligibility guidelines for participation in the NJCEED Program, will now be able to receive screening services through this collaborative initiative. Training has been conducted with the 2-1-1 Call Center as well as the care managers who will ensure that appointments, services and treatment information are available to all callers.







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