

**DRAFT -- New Jersey
Preventive Health and Health Services
Block Grant**

Application

Original Application for Fiscal Year 2007

Submitted by: New Jersey

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Executive Summary

The Preventive Health and Health Services (PHHS) Block grant supports the New Jersey Department of Health and Senior Services in addressing public health priority areas in New Jersey where either no federal funds exist or where federal categorical funds are grossly insufficient. This includes responding quickly to emerging health issues, addressing public health needs relevant to individuals and communities, and operating emergency medical services.

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

Statutory Information

Dates:

Public Hearing Date(s):
10/17/06

Advisory Committee Date(s):
10/16/06
11/13/06

Current Forms on File with CDC:

Certifications: Yes

Certifications and Assurances: Yes

Budget Information

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Budget Detail	
Total Award (1+6)	\$2,843,269
A. Current Year Annual Basic	
1. Annual Basic Amount	\$2,637,218
2. Annual Basic Admin Cost	(\$263,721)
3. Direct Assistance	\$0
4. Transfer Amount	\$0
(5). Sub-Total Annual Basic	\$2,373,497
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	\$206,051
7. Sex Offense Admin Cost	\$0
(8.) Sub-Total Sex Offense Set Aside	\$206,051
(9.) Total Current Year Available Amount (5+8)	\$2,579,548
C. Prior Year Dollars	
10. Annual Basic	\$0
11. Sex Offense Set Aside (HO 15-35)	\$0
(12.) Total Prior Year	\$0
13. Total Available for Allocation (5+8+12)	\$2,579,548

Summary of Funds Available for Allocation	
A. PHHSBG \$'s Current Year:	
Annual Basic	\$2,373,497
Sex Offense Set Aside	\$206,051
Available Current Year PHHSBG Dollars	\$2,579,548
B. PHHSBG \$'s Prior Year:	
Annual Basic	\$0
Sex Offense Set Aside	\$0
Available Prior Year Dollars	\$0
C. Total Funds Available for Allocation	\$2,579,548

Summary of Allocations by Program and Healthy People 2010 Objective

Program Title	Health Objective	Current Year PHHSBG \$'s	Prior Year PHHSBG \$'s	TOTAL PHHSBG \$'s
Diabetes Outreach and Education System (DOES)	5-1 Diabetes education	\$205,000	\$0	\$205,000
Sub-Total		\$205,000	\$0	\$205,000
Diabetic Eye Disease Detection Program	5-13 Annual dilated eye examinations	\$95,000	\$0	\$95,000
Sub-Total		\$95,000	\$0	\$95,000
FAST Approach to CVD and Stroke Prevention	12-2 Knowledge of symptoms of heart attack and importance of calling 911	\$89,961	\$0	\$89,961
	12-8 Knowledge of early warning symptoms of stroke	\$165,017	\$0	\$165,017
Sub-Total		\$254,978	\$0	\$254,978
HealthEASE: On the Move - Physical Activity Programs for Older Adults	22-1 Physical Activity in Adults	\$123,101	\$0	\$123,101
Sub-Total		\$123,101	\$0	\$123,101
Healthy Adolescents	19-3 Overweight or obesity in children and adolescents	\$200,000	\$0	\$200,000
Sub-Total		\$200,000	\$0	\$200,000
Improved Cancer Surveillance of Minority Populations	3-1 Overall Cancer deaths	\$97,418	\$0	\$97,418
Sub-Total		\$97,418	\$0	\$97,418
Promising Practices to Prevent Adolescent Suicide	18-2 Adolescent suicide attempts	\$159,640	\$0	\$159,640
Sub-Total		\$159,640	\$0	\$159,640
Public Health Performance Improvement and Enhancement	23-8 Competencies for public health workers	\$329,473	\$0	\$329,473
	23-11 Performance standards	\$329,473	\$0	\$329,473

Sub-Total		\$658,946	\$0	\$658,946
	1-11 Emergency Medical Services	\$399,414	\$0	\$399,414
Sub-Total		\$399,414	\$0	\$399,414
State Rape Care Prevention Program	15-35 Rape or attempted rape	\$206,051	\$0	\$206,051
Sub-Total		\$206,051	\$0	\$206,051
Vaccine Preventable Disease Program	14-1 Vaccine-preventable diseases	\$180,000	\$0	\$180,000
Sub-Total		\$180,000	\$0	\$180,000
GRAND TOTAL		\$2,579,548	\$0	\$2,579,548

**Programs, Health Objectives, and
Essential Services**

- Service 1 - Monitor health status**
- Service 2 - Diagnose and investigate**
- Service 3 - Inform and educate**
- Service 4 - Mobilize partnerships**
- Service 5 - Develop policies and plans**
- Service 6 - Enforce laws and regulations**
- Service 7 - Link people to services**
- Service 8 - Assure competent workforce**
- Service 9 - Evaluate health programs**
- Service 10 – Research**

**DRAFT -- New Jersey
Preventive Health and Health Services Block Grant**

Original Application for Fiscal Year 2007

State Program Title: Diabetes Outreach and Education System (DOES)

State Program Strategy:

Using 100% of PHHSBG funding, the Department of Health and Senior Services supports the Southern Jersey Family Medical Center (SJFMC) in conducting the DOES project targeted to a five-county area in southern New Jersey. The goal of the DOES project is to reduce the burden of diabetes in the region by increasing awareness of diabetes and its care and treatment among the general population, high risk groups, people with diabetes and providers. Specific strategies are communications campaigns aimed at the general population and specific sub-populations, community ***State Program: Chronic Disease Prevention and Control National Health Objective(s): 5-5, 19-1*** 76 interventions such as follow-up on a community assessment and planning intervention (Diabetes Today), implementation of the BPHC's Diabetes Collaborative at all SJFMC clinic sites, and educational efforts targeted to consumers and providers.

National Health Objective: HO 5-1 Diabetes education

State Health Objective(s):

By 2010, reduce the age-adjusted death rate from diabetes per 100,000 standard population to:

- 18.4 for the total population, whites, males and females
- 24.5 for Blacks
- 18.4 for Hispanics

By 2010, reduce the age-adjusted death rate from cardiovascular disease in people with diabetes per 100,000 standard population to:

- 15.2 for the total population
- 15.2 for whites
- 18.0 for Blacks
- 15.2 for Hispanics
- 15.2 for males
- 15.2 for females

(Developmental) By 2010, increase the percentage of persons 18 and over with diagnosed diabetes who have been told they have high blood pressure and are currently taking medication for high blood pressure to 85 percent.

By 2010, reduce the incidence of lower extremity amputations per 1,000 persons with diagnosed diabetes to 6.0. By 2010, decrease the incidence of end-stage renal disease due to diabetes per 1,000 persons aged 18 and over with diabetes to:

- 2.7 for the total population with diabetes
- 2.4 for non-Hispanic whites with diabetes
- 3.7 for non-Hispanic Blacks with diabetes
- 3.0 for Hispanics with diabetes
- 2.6 for males with diabetes
- 2.7 for females with diabetes

By 2010, increase the percentage of persons 18 and over with diagnosed diabetes that reported having a glycosylated hemoglobin measurement at least once a year to 90 percent. (Note: BRFSS is the data source for rates of glycosylated hemoglobin testing.)

State Health Problem:

Diabetes is becoming more prevalent in New Jersey. The New Jersey Behavioral Risk Factor Survey data for 2002-2004, indicate that on average about 440,000 adults in New Jersey, or 6.8% of the population, had diagnosed diabetes. Rates were higher for men (7.2%) than for women (6.4%). Rates also increased with age, with the highest percentages of diagnosed diabetes seen in the over 65 population (16.1%). Minority groups had disproportionately high age adjusted rates of the disease.

About 5.3% of non-Hispanic whites had a diagnosis of diabetes as compared to 11.9 % of non-Hispanic Blacks and 7.2 of Hispanics. National data suggests that the Hispanic figure probably underestimates the magnitude of diabetes among persons of that ethnicity. An additional 178,000 New Jerseyans are believed to have diabetes but are unaware that they have it. In 2004, the American Diabetes Association identified pre-diabetes as a condition of individuals with either a fasting glucose test of greater or equal to 100 mg/dl, but less than 120 mg/dl and an oral glucose tolerance test of greater or equal to 140 mg/dl but less than 200 mg/dl. It is estimated that 40 percent of the population 40-74 years of age has pre-diabetes.

Diabetes is also a serious concern in New Jersey. People with diabetes in New Jersey suffer from many diabetes-related complications or conditions. In 2003, these included 553 new case of blindness, 2,969 lower extremity amputations, and 1,362 new cases of end-stage renal disease. In 2003, there were 207,908 diabetes-related hospitalizations, 127,580 of which also had a major cardiovascular disease listed as a diagnosis. In addition, diabetes was the underlying cause of death for 2,532 New Jerseyans in 2002, ranking sixth among the leading causes of death in the state. The over-65 age group and minorities were disproportionately affected, with higher rates of diabetes-related morbidity and mortality. For example, the rate of hospital discharges with any mention of diabetes was 1072.5 per 10,000 population for persons 65 and over compared to 323.5 for persons 45-64. The age adjusted rate of end stage renal disease and diabetes per 10,000 standard population in blacks was nearly than four times that of whites. The age adjusted rate of lower extremity amputations in blacks was nearly than three times that of whites. In 2003, the age-adjusted death rate from diabetes per 100,000 standard population was 55.0 for blacks as compared to 24.0 for whites. A five county area in the southern portion of the state has among the highest percentages of at risk population sub-groups in the state. The burden of diabetes in terms of prevalence rates, morbidity rates, and mortality rates were particularly high in this region.

Studies conducted over the past decade have demonstrated that long-term complications of diabetes, such as heart disease, kidney failure, amputations, and eye disease, are preventable through a combination of a team approach to diabetes care, optimal self-management, and preventive medicine. Centers for Medicare and Medicaid Services data show that for New Jersey, only 72.5% of Medicare recipients with diabetes receive an annual HbA1C test; 71.8 % receive an eye exam every 2 years; and only 80.4 % have a lipid profile done every 2 years.

Target Population:

1. New Jersey Adults (media outreach, Website)

Number: 6,542,820 (Census 2004)

Age Range: 18 and over

Gender: Male and Female

Race/Ethnicity: All

Geographic Location: Statewide

2. New Jerseyans with diabetes (influenza campaign, NDEP materials, Website, media outreach)

Number: 440,000 (BRFSS 2002-2004)

Age Range: 18 and over

Gender: Male and Female

Race/Ethnicity: All

Geographic Location: Statewide

3. Key opinion leaders (New Jersey Diabetes Council and its Task Forces)

Number: 115

Age Range: 18 and over

Gender: Male and Female

Race/Ethnicity: All

Geographic Location: Statewide

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

Age: 18-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

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

Age: 12-19 years, 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Disparate Population:

1. Adult residents of the DOES target area (media outreach, community interventions/events).

Number: 882,768 (Census 2004)

Age Range: 18 and over

Gender: Male and Female

Race/Ethnicity: All

Geographic Location: Ocean, Cape May, Cumberland Salem, and Atlantic Counties

2. Adult residents with diabetes in the DOES target area (influenza campaign, NDEP materials, and community interventions/events)

Number: 72,752 (BRFSS 2002 - 2004)

Age Range: 18 and over,

Gender: Male and Female

Race/Ethnicity: All

Geographic Location: Ocean, Cape May, Cumberland, Salem, and Atlantic Counties

3. DOES target area primary care providers for people with diabetes (provider education program)

Number: 337

Age Range: 18 and over

Gender: Male and Female

Race/Ethnicity: All
Geographic Location: Ocean, Cape May, Cumberland Salem, and Atlantic Counties

4. Key opinion leaders (County coalitions)

Number: 40
Age Range: 18 and over
Gender: Male and Female
Race/Ethnicity: All
Geographic Location: Ocean, Cape May, Cumberland, Middlesex, Essex, Bergen, Salem, and Atlantic Counties

5. Low income, uninsured New Jersey residents who have had type 1 diabetes for 5 years or who have had type 2 diabetes of any duration (DEDD – eye disease screenings)

Number: Not available
Age Range: All
Gender: Male and Female
Race/Ethnicity: All
Geographic Location: Statewide

6. Low income New Jersey residents on dialysis who need assistance with medications and/or nutritional supplements.

Number: 1,300
Age Range: All
Gender: Male and Female
Race/Ethnicity: All
Geographic Location: Statewide

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, Native Hawaiian/Other Pacific Islander, White, Other
Age: 18-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, Native Hawaiian/Other Pacific Islander, White, Other
Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older
Gender: Female and Male
Geography: Rural
Primarily Low Income: Yes

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objective: By June 30, 2008, the "Burden of Diabetes in New Jersey: A Surveillance Report" and "Diabetes-Related Inpatient Hospital utilization in New Jersey" will be updated. The reports will include demographics, prevalence, diabetes and pregnancy, mortality, morbidity, health service utilization, and diabetes self-management data.

Annual Activity Objective for Desired Impact Objective: By March 29, 2007, the updated demographics, prevalence, and diabetes and pregnancy, and prevention chapters of the "Burden of Diabetes in New Jersey: A Surveillance Report" will be revised and posted on the Program's web page.

Essential Service 3 - Inform and Educate:

Desired Impact Objective: By September 30, 2007, increase awareness of complications of diabetes and appropriate preventive measures (e.g. foot exams, hemoglobin A1C testing, and influenza and pneumococcal immunization).

Annual Activity Objectives for Desired Impact Objective:

1. By July 1, 2007, continue funding of the community interventions and health communications project (DOES) in the five-county south Jersey target area.
2. By March 1, 2007, the WPCDP Program and the DOES project will disseminate at least 45,000 diabetes related influenza brochures and 45,000 diabetes related pneumococcal brochures (English and Spanish) to providers and persons with diabetes.
3. By March 1, 2005, the WPCDP Program and the DOES project will place influenza and pneumococcal public service announcements and/or news articles in at least 10 media outlets.
3. By June 30, 2007, the WPCDP Program and DOES project will place ads/news articles promoting control of diabetes and prevention of complications (NDEP) in at least 10 media outlets.
4. By June 30, 2007, the WPCDP Program and DOES project will conduct five (5) community outreach events.
5. By June 30, 2007, the WPCDP Program and the DOES project will conduct a provider education program focused on preventing complications in the five county south Jersey target area.
6. By June 30, 2007, the WPCDP Program and the DOES Project will conduct outreach and continuing education sessions with 50 providers in five (5) counties.
7. Between October 1, 2006 and September 30, 2007, seven hundred and fifty persons screened by the DEDD program will receive information on prevention of diabetes-related complications.
8. By September 30, 2007, seven hundred and fifty persons screened by the DEDD program will be screened for hypertension.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: By September 30, 2007, established partnerships will implement at least one-statewide intervention to improve quality of care and to prevent complications of diabetes.

Annual Activity Objectives for Desired Impact Objective:

1. By June 30, 2007, the New Jersey Diabetes Council will conduct two (2) in-persons meetings of the full Council.
2. By June 30, 2007, the Coordinating Committee and Task Forces of the New Jersey Diabetes Council will meet quarterly.
3. Through June 2007, the WPCDP Program and the DOES project will establish and continue to support a regional coalition for the five county DOES target area.
4. By March 28, 2007, the WPCDP Program will develop a performance improvement plan and a strategic plan.

Essential Service 7 - Link people to services:

Desired Impact Objectives:

By 2007, increase the number of low income, persons with end stage renal disease who are linked to medication and nutritional sources.

Annual Activity Objectives for Desired Impact Objectives:

By September 30, 2007, 1,100 low-income individuals identified as having end stage renal disease and need for a source of medications and/or nutritional supplements will receive assistance.

Essential Service 9 - Evaluate health programs:

Desired Impact Objective: By September 30, 2007, progress toward Healthy New Jersey 2010 objectives will be measured.

Annual Activity Objectives for Desired Impact Objective:

1. By June 30, 2007, an evaluation plan of all WPCDP Program interventions will be established.
2. By December 2007, an evaluation of the DOES project will be complete.
3. By December 2007, progress toward preventive services objectives (hemoglobin A1c testing) specified in Healthy New Jersey will be reevaluated.

PROGRAM PROFILE

1. Program Title: Diabetes Outreach and Education System (DOES)

2. Total Block Grant Funds to Program:

Current Year:

a. HO 5-1	\$205,000
Total:	<u>\$205,000</u>

Prior Year:

a. HO 5-1	\$0
Total:	<u>\$0</u>

3. Total Block Grant Funds to Local Entities for Program:

a. HO 5-1	\$140,000
Total:	<u>\$140,000</u>

4. Total FTE's for Program:

Number:

a. HO 5-1	0.00
Total:	<u>0.00</u>

HEALTH OBJECTIVE PROFILE for HO 5-1 Diabetes education

5a. National Health Objective: 5-1 Diabetes education

Increase the proportion of persons with diabetes who receive formal diabetes education.

45 percent of persons with diabetes received formal diabetes education in 1998 (age adjusted to the year 2000 standard population).

6a. State Health Objective(s):

By 2010, reduce the age-adjusted death rate from diabetes per 100,000 standard population to:

- 18.4 for the total population, whites, males and females
- 24.5 for Blacks
- 18.4 for Hispanics

By 2010, reduce the age-adjusted death rate from cardiovascular disease in people with diabetes per 100,000 standard population to:

- 15.2 for the total population
- 15.2 for whites
- 18.0 for Blacks
- 15.2 for Hispanics
- 15.2 for males
- 15.2 for females

(Developmental) By 2010, increase the percentage of persons 18 and over with diagnosed diabetes who have been told they have high blood pressure and are currently taking medication for high blood pressure to 85 percent.

By 2010, reduce the incidence of lower extremity amputations per 1,000 persons with diagnosed diabetes to 6.0. By 2010, decrease the incidence of end-stage renal disease due to diabetes per 1,000 persons aged 18 and over with diabetes to:

- 2.7 for the total population with diabetes
- 2.4 for non-Hispanic whites with diabetes
- 3.7 for non-Hispanic Blacks with diabetes
- 3.0 for Hispanics with diabetes
- 2.6 for males with diabetes
- 2.7 for females with diabetes

By 2010, increase the percentage of persons 18 and over with diagnosed diabetes that reported having a glycosylated hemoglobin measurement at least once a year to 90 percent. (Note: BRFSS is the data source for rates of glycosylated hemoglobin testing.)

7a. Target and Disparate Population Numbers:

Target Number: 6,542,820
Disparate Number: 880,000

8a. HO Dollars/FTE's:

- (1). Total Current Year: \$205,000
- (2). Total Prior Year: \$0
- (3). Amount to Disparate Population: \$140,000
- (4). Number of FTE's for HO: 0.00
- (5). Amount of \$'s to Local Entities for HO: \$140,000

Description (Optional): The Department of Health and Senior Services allocates this funding to the Southern Jersey Family Medical Center (SJFMC) in conducting the DOES project targeted to a five-county area in southern New Jersey. The goal of the DOES project is to reduce the burden of diabetes in the region by increasing awareness of diabetes and its care and treatment among the general population, high risk groups, people with diabetes and providers. Specific strategies are communications campaigns aimed at the general population and specific sub-populations, community interventions such as follow up on a community assessment and planning intervention (Diabetes Today), implementation of the BPHC's Diabetes Collaborative at all SJFMC clinic sites, and educational efforts targeted to consumers and providers.

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 5-1 100% - Total source of funding

10a. Block Grant Role:

HO 5-1 No other existing federal or state funds

11a. 10 Essential Services

- Essential Service 1 - Monitor health status
- Essential Service 3 - Inform and Educate
- Essential Service 5 - Develop policies and plans
- Essential Service 7 - Link people to services
- Essential Service 9 - Evaluate health programs

State Program Title: Diabetic Eye Disease Detection Program

State Program Strategy:

The Diabetic Eye Disease Detection Program (DEDD) program is funded 100% with PHHSBG dollars and provides screening for diabetic eye disease among persons with diabetes in New Jersey who are uninsured or under-insured. Education on complications of diabetes and prevention of complications is incorporated into each screening session, as is hypertension screening. Screening of the diabetic foot is incorporated into screening events as resources permit. Persons that test positive for eye disease are referred to appropriate sources of care, linked to funding sources, and followed by case managers.

National Health Objective: HO 5-13 Annual dilated eye examinations

State Health Objective(s):

PHHSBG funds are used to partially support the Wellness Promotion and Chronic Disease Prevention (WPCDP) Program's Diabetes Outreach and Education System (DOES) project and the Diabetic Eye Disease Detection Program (DEDD). PHHSBG funds will also be used to support a healthy lifestyles awareness. The WPCDP uses a multidisciplinary team to identify and address the burden of diabetes in New Jersey. It is updating two major reports "The Burden of Diabetes in New Jersey: A Surveillance report" and "Diabetes-Related In-Patient Hospital Utilization in New Jersey." These reports provide data on diabetes prevalence, diabetes-related morbidity and mortality, diabetes in pregnancy, and diabetes-related health services utilization. Other activities include: staff support of the New Jersey Diabetes Council and the Cardiovascular Health Advisory Panel; the Diabetes Outreach and Education System (DOES) project; the Diabetic Eye Disease Detection (DEDD) project; school interventions related to diabetes and asthma; an influenza and pneumococcal campaign targeted to persons with diabetes; provider targeted educational programs and messages; support of the Bureau of Primary Health Care's (BPHC) Diabetes Collaboratives in New Jersey; implementation of the National Diabetes Education Program (NDEP) on the state level; development of a Performance Improvement Plan; and development of a diabetic strategic plan establishment of a statewide asthma collaborative, and administration of an end-stage renal disease assistance program. Building on the experience and the partnerships developed in relation to its diabetes, asthma, and renal disease efforts, the WPCDP Program will focus on enhancing infrastructure for a wellness promotion program.

State Health Problem:

Diabetes is becoming more prevalent in New Jersey. The New Jersey Behavioral Risk Factor Survey data for 2002-2004, indicate that on average about 440,000 adults in New Jersey, or 6.8% of the population, had diagnosed diabetes. Rates were higher for men (7.2%) than for women (6.4%). Rates also increased with age, with the highest percentages of diagnosed diabetes seen in the over 65 population (16.1%). Minority groups had disproportionately high age adjusted rates of the disease. About 5.3% of non-Hispanic whites had a diagnosis of diabetes as compared to 11.9 % of non-Hispanic Blacks and 7.2 of Hispanics. National data suggests that the Hispanic figure probably underestimates the magnitude of diabetes among persons of that ethnicity. An additional 178,000 New Jerseyans are believed to have diabetes but are unaware that they have it. In 2004, the American Diabetes Association identified pre-diabetes as a condition of individuals with either a fasting glucose test of greater or equal to 100 mg/dl, but less than 120 mg/dl and an oral glucose tolerance test of greater or equal to 140 mg/dl but less than 200 mg/dl. It is estimated that 40 percent of the population 40-74 years of age has pre-diabetes.

Diabetes is also a serious concern in New Jersey. People with diabetes in New Jersey suffer from many diabetes-related complications or conditions. In 2003, these included 553 new case of blindness, 2,969 lower extremity amputations, and 1,362 new cases of end-stage renal disease. In 2003, there were 207,908 diabetes-related hospitalizations, 127,580 of which also had a major cardiovascular disease listed as a diagnosis. In addition, diabetes was the underlying cause of death for 2,532 New Jerseyans in 2002, ranking sixth among the leading causes of death in the state. The over-65 age

group and minorities were disproportionately affected, with higher rates of diabetes-related morbidity and mortality. For example, the rate of hospital discharges with any mention of diabetes was 1072.5 per 10,000 population for persons 65 and over compared to 323.5 for persons 45-64. The age adjusted rate of end stage renal disease and diabetes per 10,000 standard population in blacks was nearly four times that of whites. The age adjusted rate of lower extremity amputations in blacks was nearly three times that of whites. In 2003, the age-adjusted death rate from diabetes per 100,000 standard population was 55.0 for blacks as compared to 24.0 for whites. A five county area in the southern portion of the state has among the highest percentages of at risk population sub-groups in the state. The burden of diabetes in terms of prevalence rates, morbidity rates, and mortality rates were particularly high in this region.

Studies conducted over the past decade have demonstrated that long-term complications of diabetes, such as heart disease, kidney failure, amputations, and eye disease, are preventable through a combination of a team approach to diabetes care, optimal self-management, and preventive medicine. Centers for Medicare and Medicaid Services data show that for New Jersey, only 72.5% of Medicare recipients with diabetes receive an annual HbA1C test; 71.8 % receive an eye exam every 2 years; and only 80.4 % have a lipid profile done every 2 years.

Target Population:

Low income, uninsured New Jersey residents who have had type 1 diabetes for 5 years or who have had type 2 diabetes of any duration (DEDD – eye disease screenings)

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

Age: 50-64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Disparate Population:

Low income, uninsured African American New Jersey residents who have had type 1 diabetes for 5 years or who have had type 2 diabetes of any duration (DEDD – eye disease screenings)

Race/Ethnicity: African American or Black

Age: 50-64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

ESSENTIAL SERVICES

Essential Service 2 - Diagnose and Investigate:

Desired Impact Objective: By 2007, increase availability of screening for diabetic eye disease among low income, uninsured persons with diabetes.

Annual Activity Objective for Desired Impact Objective: By September 30, 2006, seven hundred and fifty (750) low-income, uninsured people with diabetes in need of annual eye screening services will receive dilated eye exams through the DEDD Program.

Essential Service 3 - Inform and Educate:

Desired Impact Objective: By September 30, 2007, increase awareness of complications of diabetes and appropriate preventive measures (e.g. eye exams).

Annual Activity Objectives for Desired Impact Objective:

1. Between October 1, 2006 and September 30, 2007, seven hundred and fifty persons screened by the DEDD program will receive information on prevention of diabetes-related complications.
2. By September 30, 2007, seven hundred and fifty persons screened by the DEDD program will be screened for hypertension

PROGRAM PROFILE

1. Program Title: Diabetic Eye Disease Detection Program

2. Total Block Grant Funds to Program:

Current Year:

a. HO 5-13	\$95,000
Total:	\$95,000

Prior Year:

a. HO 5-13	\$0
Total:	\$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 5-13	\$95,000
Total:	\$95,000

4. Total FTE's for Program:

Number:

a. HO 5-13	0.00
Total:	0.00

HEALTH OBJECTIVE PROFILE for HO 5-13 Annual dilated eye examinations

5a. National Health Objective: 5-13 Annual dilated eye examinations

Increase the proportion of adults with diabetes who have an annual dilated eye examination. 47 percent of adults aged 18 years and older with diabetes had an annual dilated eye examination in 1998 (age adjusted to the year 2000 standard population).

6a. State Health Objective(s):

PHHSBG funds are used to partially support the Wellness Promotion and Chronic Disease Prevention (WPCDP) Program's Diabetes Outreach and Education System (DOES) project and the Diabetic Eye Disease Detection Program (DEDD). PHHSBG funds will also be used to support a healthy lifestyles awareness. The WPCDP uses a multidisciplinary team to identify and address the burden of diabetes in New Jersey. It is updating two major reports "The Burden of Diabetes in New Jersey: A Surveillance report" and "Diabetes-Related In-Patient Hospital Utilization in New Jersey." These reports provide data on diabetes prevalence, diabetes-related morbidity and mortality, diabetes in pregnancy, and diabetes-related health services utilization. Other activities include: staff support of the New Jersey Diabetes Council and the Cardiovascular Health Advisory Panel; the Diabetes Outreach and Education System (DOES) project; the Diabetic Eye Disease Detection (DEDD) project; school interventions related to diabetes and asthma; an influenza and pneumococcal campaign targeted to persons with diabetes; provider targeted educational programs and messages; support of the Bureau of Primary Health Care's (BPHC) Diabetes Collaboratives in New Jersey; implementation of the National Diabetes Education Program (NDEP) on the state level; development of a Performance Improvement Plan; and development of a diabetic strategic plan establishment of a statewide asthma collaborative, and administration of an end-stage renal disease assistance program. Building on the experience and the partnerships developed in relation to its diabetes, asthma, and renal disease efforts, the WPCDP Program will focus on enhancing infrastructure for a wellness promotion program.

7a. Target and Disparate Population Numbers:

Target Number: 750
Disparate Number: 300

8a. HO Dollars/FTE's:

- (1). Total Current Year: \$95,000
- (2). Total Prior Year: \$0
- (3). Amount to Disparate Population: \$50,000
- (4). Number of FTE's for HO: 0.00
- (5). Amount of \$'s to Local Entities for HO: \$95,000

Description (Optional): These funds are awarded via a Memorandum of Agreement with the New Jersey Commission for the Blind and Visually Impaired (CBVI).

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 5-13 10-49% - Partial source of funding

10a. Block Grant Role:

HO 5-13 Supplemental Funding

11a. 10 Essential Services

Essential Service 2 - Diagnose and Investigate

Essential Service 3 - Inform and Educate

State Program Title: FAST Approach to CVD and Stroke Prevention

State Program Strategy:

The state has implemented several interventions and pilot studies and policy related activities to improve overall cardiovascular health. This strategy will be using evidence based public health practices to educate the public on the signs and symptoms of heart disease and stroke to decrease the time spent before treatment can be administered.

National Health Objective: HO 12-2 Knowledge of symptoms of heart attack and importance of calling 911

State Health Objective(s):

2010 Objectives

Objective: Reduce the age-adjusted death rate from coronary heart disease per 100,000 standard population to **71.8**.

Populations 1998 Baseline Data - Target/Preferred 2010 Endpoint - Percent Change

Total age-adjusted	92.6	71.8	22.5
White age-adjusted	92.2	71.8	22.1
Black age-adjusted	109.1	71.8	34.2

Asian/Pacific Islander age-adjusted 31.6 DNA

Hispanic age-adjusted DSU

DSU = Data are statistically unreliable. DNA = Data have not been analyzed.

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

Except for a slight increase in 1994, the age-adjusted death rate from coronary heart disease among the total population has declined steadily since 1985, to the point where the 1996 rate represents a more than forty percent reduction in the death rate due to this cause. The 2010 objective is based on continuation of this trend.

State Health Problem:

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

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

Cerebrovascular disease, or stroke is the third leading cause of death not only for the nation, but in New Jersey. A stroke occurs when blood vessels carrying oxygen and nutrients to the brain burst or become clogged by a blood clot or some other particle. It is estimated that half of the 500,000 new stroke cases per year in the United States could be prevented with adequate control of hypertension, the major cause of stroke.¹

In New Jersey mortality due to stroke or cerebrovascular disease has also declined steadily since 1985, although not as quickly as for coronary heart disease. Moreover, the gaps between the total population and minorities are larger for stroke. Despite the progress made, there is room for even more improvement. In particular, closing the gap between minorities and the total population is essential.

The year 2010 objectives measure not only mortality from coronary heart disease and stroke, but also behaviors related to modifiable risk factors.

Target Population:

6,542,820 New Jersey Adults age 18 and over

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

Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

882,768 African-Americans in New Jersey aged 18 and over

Race/Ethnicity: African American or Black, Hispanic

Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objective: By September 30, 2007, continue to define the wellness status of New Jersey adults.

Annual Activity Objectives for Desired Impact Objective:

1. By January 31, 2007, identify data needs for defining wellness and health risks of New Jersey adults.
2. By March 31, 2007, identify sources of data to define wellness and health risk behaviors of New Jersey residents.
3. By June 30, 2007, request 2003 through 2005 aggregated BRFSS data on BMI, physical activity and nutrition, and other wellness/risk indicators, as available.
4. By September 30, 2007, produce a written plan for defining wellness and health risks of New Jersey residents.
5. By December 31, 2006, allocate funding to the Center for Health Stastics to increase the sample size and to potentially add questiins to the Behavioral Risk Factor Survey (BRFS) to encompass the various chronic disease inclusiive of CVD, stroke, diabetes, asthma, etc.

Essential Service 3 - Inform and Educate:

Desired Impact Objective: By September 2007, partnerships will be for the developed with racial/ethnic minority community-based organizations (MCBOs) in New Jersey to promote awareness of healthy lifestyles.

Annual Activity Objectives for Desired Impact Objective:

1. By March 31, 2007, provide support for a coordinated wellness education program infrastructure.
2. By May 31, 2007, develop a workplace wellness model.
3. By June 2007, collaborate with a local entity to implement a workplace wellness project.
4. By September 30, 2007, develop and implement a strategy for science-based nutrition and physical activity health communications intervention targeted to the African American population in New Jersey.

National Health Objective: HO 12-8 Knowledge of early warning symptoms of stroke

State Health Objective(s):

Strengthen prevention efforts through increased awareness and education about risk factor and lifestyle changes that affect high blood pressure, high cholesterol, diabetes, and smoking.

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

State Health Problem:

Cardiovascular disease (CVD), also known as heart and blood vessel disease, is the leading cause of death in the United States and in New Jersey. In 2003 alone, over 26,000 New Jerseyans died from heart disease and stroke combined (NJDHSS, 2005). More than 70 million Americans suffer from heart disease, accounting for approximately one quarter of the entire U.S. population (US Department of Health and Human Services, 2005). Cardiovascular disease is broad-based and can affect individuals from many different backgrounds, ages, races, and lifestyles. Risk factors for cardiovascular disease are varied but many are reducible. In order to address reducible risks, the state of New Jersey employs a broad range of strategies focused on cardiovascular disease and preventive services.

Anyone can have a stroke, but adults ages 65 and older are more likely to have a stroke. Stroke is more common in men than women. However, overall, more women than men die of stroke. In the US, Blacks have higher stroke incidence, severity, and mortality than whites. And despite significant advances in diagnosis, treatment and prevention, stroke remains a common disorder; an estimated 700,000 to 750,000 new and recurrent strokes occur each year in this country; and with the aging of the population, the number of persons who have strokes is projected to increase.

There were 73,410 deaths of New Jersey residents in 2003. The crude death rate was 849.8 per 100,000 population and the age-adjusted death rate was 791.7 per 100,000 population. Age-adjusted death rates were 779.9 for Whites, 1,059.3 for Blacks, 501.7 for Hispanics, and 355.2 for Asians and Pacific Islanders. Life expectancy at birth was 78.5 years and was 18.7 years at age 65. The median age at death for all causes was 78 years. For diseases, the median age at death was 79 and for injuries, the median age at death was 45. The leading causes of death among New Jersey residents in 2003 were heart disease (21,801 deaths), cancer (17,551), stroke (3,914), chronic lower respiratory disease (2,890), diabetes (2,470), and unintentional injuries (2,285).

Target Population:

6,542,820 New Jersey Adults age 18 and over

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

Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:

Race/Ethnicity: African American or Black, Hispanic
Age: 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective:

By September 30, 2007, increase the awareness of the warning signs of stroke in both the general public and at-risk racial-ethnic minority populations.

Annual Activity Objectives for Desired Impact Objective:

By September 30, 2007, sponsor public awareness campaigns to raise awareness about signs and symptoms of heart disease and stroke and the importance of calling 9–1–1 when such symptoms appear.

PROGRAM PROFILE

1. Program Title: FAST Approach to CVD and Stroke Prevention

2. Total Block Grant Funds to Program:

Current Year:

a. HO 12-2	\$89,961
b. HO 12-8	\$165,017
Total:	<u>\$254,978</u>

Prior Year:

a. HO 12-2	\$0
b. HO 12-8	\$0
Total:	<u>\$0</u>

3. Total Block Grant Funds to Local Entities for Program:

a. HO 12-2	\$0
b. HO 12-8	\$125,000
Total:	<u>\$125,000</u>

4. Total FTE's for Program:

Number:

a. HO 12-2	0.75
b. HO 12-8	0.75
Total:	<u>1.50</u>

HEALTH OBJECTIVE PROFILE for HO 12-2 Knowledge of symptoms of heart attack and importance of calling 911

5a. National Health Objective: 12-2 Knowledge of symptoms of heart attack and importance of calling 911

(Developmental) Increase the proportion of adults aged 20 years and older who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911.

Developmental--no baseline.

6a. State Health Objective(s):

2010 Objectives

Objective: Reduce the age-adjusted death rate from coronary heart disease per 100,000 standard population to **71.8**.

Populations 1998 Baseline Data - Target/Preferred 2010 Endpoint - Percent Change

Total age-adjusted	92.6	71.8	22.5
White age-adjusted	92.2	71.8	22.1
Black age-adjusted	109.1	71.8	34.2

Asian/Pacific Islander age-adjusted 31.6 DNA

Hispanic age-adjusted DSU

DSU = Data are statistically unreliable. DNA = Data have not been analyzed.

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

Except for a slight increase in 1994, the age-adjusted death rate from coronary heart disease among the total population has declined steadily since 1985, to the point where the 1996 rate represents a more than forty percent reduction in the death rate due to this cause. The 2010 objective is based on continuation of this trend.

7a. Target and Disparate Population Numbers:

Target Number: 6,542,820

Disparate Number: 882,768

8a. HO Dollars/FTE's:

- (1). Total Current Year: \$89,961
- (2). Total Prior Year: \$0
- (3). Amount to Disparate Population: \$30,000
- (4). Number of FTE's for HO: 0.75
- (5). Amount of \$'s to Local Entities for HO: \$0

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 12-2 100% - Total source of funding

10a. Block Grant Role:

HO 12-2 No other existing federal or state funds

11a. 10 Essential Services

Essential Service 1 - Monitor health status

Essential Service 3 - Inform and Educate

**HEALTH OBJECTIVE PROFILE for HO
12-8 Knowledge of early warning symptoms
of stroke**

5b. National Health Objective: 12-8 Knowledge of early warning symptoms of stroke

(Developmental) Increase the proportion of adults who are aware of the early warning symptoms and signs of a stroke.

Developmental--no baseline.

6b. State Health Objective(s):

Strengthen prevention efforts through increased awareness and education about risk factor and lifestyle changes that affect high blood pressure, high cholesterol, diabetes, and smoking.

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

7b. Target and Disparate Population Numbers:

Target Number: 6,542,820

Disparate Number: 880,000

8b. HO Dollars/FTE's:

(1). Total Current Year: \$165,017

(2). Total Prior Year: \$0

(3). Amount to Disparate Population: \$75,000

(4). Number of FTE's for HO: 0.75

(5). Amount of \$'s to Local Entities for HO: \$125,000

9b. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 12-8 100% - Total source of funding

10b. Block Grant Role:

HO 12-8 Start-up

11b. 10 Essential Services

Essential Service 3 - Inform and Educate

State Program Title: HealthEASE: On the Move - Physical Activity Programs for Older Adults

State Program Strategy:

The infrastructure for local delivery of evidence-based physical activity programs for older adults is built upon a partnership between the NJ Department of Health and Senior Services and community-based health and aging service providers. Through this infrastructure, a variety of physical activity programs (ranging from organized walking sessions to weekly exercise classes) are offered locally for older adults. This model of program delivery was designed/initiated through a grant from the Robert Wood Johnson Foundation. The grant terminated June 30, 2006. The Preventive Health Block grant funds will be used to build upon the infrastructure, expanding capacity for two physical activity programs throughout the state. The two programs are:

- *Move Today*: 12-session program focusing on flexibility, stamina and balance.
- Project Healthy Bones*: A 24-week weight bearing exercise program for people with or at-risk for osteoporosis.

In addition, the Department will encourage older adults to participate in regular physical activity by promoting the availability of these programs through: 1) Implementation of the Chronic Disease Self-Management Program, which promotes physical activity as a primary means of managing chronic disease; and 2) Posting of program materials on the Department of Health and Senior Services' website.

National Health Objective: HO 22-1 Physical Activity in Adults

State Health Objective(s):

By 2010, increase the percentage of persons aged 65 and over who participated in frequent, leisure time physical activity during the past month to 42.5%.

State Baseline: 28.6% of adults 65+ participated in frequent leisure time physical activity during the past month (1996-1998)

State Health Problem:

NJ's current population of 1,495,460 adults 60+ is projected to reach 2,518,734 by 2030, when this cohort will represent 25.7% of the state's population. The largest growth will be within the 85+ cohort. The prevalence of disability increases substantially with age. Within the state's 60-64 age group, 27% of men and 26% of women have a disability. This increases to approximately 64% of men and 73% of women for those 85 and older. The risk and burden of chronic diseases in NJ is directly linked to poor lifestyle choices, including a lack of physical activity and poor nutrition. *The State of Aging and Health in America* (CDC and Merck Institute of Aging and Health, 2004) reports that 68.2% of older New Jerseyans participate in no physical activity, 61.3% are obese, and 28.1% report fair or poor health status. The cost of care health care rises significantly with age, with a 65-year-old costing four times what a 40-year-old costs in terms of health care dollars.

The state's rapidly growing older adult population, projections of continued increases in life expectancy and the escalating cost of care underscores the critical need to assist individuals to maintain good health and independence as late into life as possible. NJ identifies "helping seniors stay active and healthy" as one of five priorities in its State Plan on Aging, 2006-2008.

The Surgeon General's Report on Physical Activity and Health states that the single most important step that most adults, including older adults, can take to improve their overall health is to become more physically active. A number of barriers prevent seniors from engaging in healthy behaviors. On an individual level, many are unaware of the benefits that can be achieved through physical activity, even at a later age. For those who want to be more physically active, local resources are often not available in formats/locations that are attractive or accessible. Other people are uncomfortable participating in programs that are not sensitive to their ethnic/cultural background. The challenge to NJ's public health and aging networks is to foster collaboration between the public and private sectors at all levels to support older adults in being physically active.

Target Population:

Persons aged 60 and older = 1,495,460 (National Center for Health Statistics and U.S. Census Bureau)

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

Age: 50-64 years, 65 years and older

Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

- New Jersey's 60+ population includes 9.8% non-Hispanic blacks (145,809); 7.0% Hispanics (104,365); 3.7% Asian and Pacific Islanders (55,942); and 0.2% American Indians and Alaska Natives (2,367).
- Disparity in health status is evidenced by the 16-year difference in healthy life expectancy at birth between white females (69.6 years) and African American males (53.9 years).
- Median family income declines with age of the householder. Median family income for a householder aged 85 years and over is about half that of families with a householder between 60 and 64 years.

Race/Ethnicity: African American or Black, American Indian/Alaskan Native, Asian, Hispanic, Native Hawaiian/Other Pacific Islander
Age: 50-64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective:

Increase the number of adults age 60+ who participate in state-sponsored physical activity programs by 25% (from 3,197 to 4,650) by September 30, 2007.

Annual Activity Objective for Desired Impact Objective:

By September 30, 2007, the NJ Department of Health and Senior Services (DHSS) will provide regional train-the-trainer programs for community-based agencies to administer local physical activity programs for older adults, including 3 Move Today training sessions and 3 Project Healthy Bones training sessions.

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective:

Annual Activity Objective for Desired Impact Objective:

By January 30, 2007, DHSS will sponsor a 4-½ day Chronic Disease Self-Management Program

(CDSM) master trainer session for 26 health/aging professionals from community-based agencies, DHSS, and the NJ Department of Human Services. From this training, a minimum of 13 six-week CDSM classes will be implemented for at least 150 older adults with chronic disease. Older adults who attend CDSM classes will learn that physical activity is a primary way to manage chronic disease, and they will be provided with information on available local physical activity programs.

PROGRAM PROFILE

1. Program Title: HealthEASE: On the Move - Physical Activity Programs for Older Adults

2. Total Block Grant Funds to Program:

Current Year:

a. HO 22-1	\$123,101
Total:	<u>\$123,101</u>

Prior Year:

a. HO 22-1	\$0
Total:	<u>\$0</u>

3. Total Block Grant Funds to Local Entities for Program:

a. HO 22-1	\$0
Total:	<u>\$0</u>

4. Total FTE's for Program:

Number:

a. HO 22-1	1.00
Total:	<u>1.00</u>

HEALTH OBJECTIVE PROFILE for HO 22-1 Physical Activity in Adults

5a. National Health Objective: 22-1 Physical Activity in Adults

Reduce the proportion of adults who engage in no leisure-time physical activity
40 percent of adults aged 18 years and older engaged in no leisure-time physical activity in 1997.
(age adjusted to the year 2000 standard population).

6a. State Health Objective(s):

By 2010, increase the percentage of persons aged 65 and over who participated in frequent, leisure time physical activity during the past month to 42.5%.

State Baseline: 28.6% of adults 65+ participated in frequent leisure time physical activity during the past month (1996-1998)

7a. Target and Disparate Population Numbers:

Target Number: 1,495,460
Disparate Number: 308,483

8a. HO Dollars/FTE's:

- (1). Total Current Year: \$123,101
- (2). Total Prior Year: \$0
- (3). Amount to Disparate Population: \$0
- (4). Number of FTE's for HO: 1.00
- (5). Amount of \$'s to Local Entities for HO: \$0

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 22-1 100% - Total source of funding

10a. Block Grant Role:

HO 22-1 No other existing federal or state funds

11a. 10 Essential Services

Essential Service 3 - Inform and Educate
Essential Service 4 - Mobilize partnerships

State Program Title: Healthy Adolescents

State Program Strategy:

Adolescence is the period when a person transitions from childhood towards adulthood. This period is usually characterized by challenges involving a changing and developing body, innumerable pressures from peers, and changes in the relationships of adolescents 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 health behavior requires more than the just focusing on the health-related educational activities that have traditionally been used. Strategies for improving adolescent health are now focusing on ways to strengthen resiliency and build the assets of young people. This approach, referred to as "youth development", engages youth in activities that build skills and competencies needed for resiliency and are effective throughout life, not just during adolescence. Additionally, multi-faceted activities or strategies implemented by a variety of key stakeholders within the community are needed to increase the likelihood of a successful outcome.

The Adolescent Health initiative supports community-based health promotion and risk behavior reduction initiatives targeted to adolescents. PHHSBG funds are used to support activities to reduce intentional and unintentional injuries and to promote healthy nutrition and physical activity. PHHSBG funds provide approximately 35-40% of the funding for these initiatives. Grant funds are used to support Community Partnership for Healthy Adolescents in eight communities. These partnership grants provide a forum to develop a community-wide adolescent health plan, identify health and health promotion resources for adolescents in the community, and coordinate health services and health promotion initiatives for adolescents.

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

State Health Objective(s):

None applicable.

State Health Problem:

Physical activity and overweight and obesity are two of the leading health indicators in Healthy People 2010. These indicators have been identified as risk factors for many health problems, including heart disease, stroke, high blood pressure, cancer, diabetes, and osteoporosis. Even though few adolescents develop these conditions, there has been an increase in the incidence of children and adolescents being diagnosed with adult onset diabetes. Eating and exercise habits established in childhood and adolescence influence life-long behaviors, thereby impacting on health in later life. In 2003-2004 academic school year, a retrospective records survey was undertaken to establish a baseline estimate of weight status of school aged children. The study analyzed sixth grade records from 40 randomly selected schools from varying socioeconomic strata. Results show that 40% of New Jersey youth are of abnormal weight.

Target Population:

Adolescents: 1,196,974 (Center for Health Statistics, New Jersey 2003)

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

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

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Adolescents: 1,196,974 (Center for Health Statistics, New Jersey 2003)

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

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

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objective: By October 2007, determine the feasibility of continuing the collection and tracking of height and weight measurements of NJ school aged youth.

Annual Activity Objectives for Desired Impact Objective:

1. By January 2007, identify available resources for continuing the collection and tracking of height/weight data collection.
2. By March 2007, develop a plan to continue height/weight collection in collaboration with NJ DOE.
3. By May 2007, secure the necessary approval for the proposed plan.

Essential Service 3 - Inform and Educate:

Desired Impact Objective: By September 2007, provide leadership for activities and strategies that promotes nutrition and physical activity (including obesity prevention) in NJ public schools and communities.

Annual Activity Objectives for Desired Impact Objective:

1. By September 2007 and on an on-going basis, advocate for environmental change that supports physically active and healthy communities.
2. By September 2007 in collaboration with the NJ Council on Physical Fitness and Sports, continue to advocate for the enforcement of the NJ DOE 150 minutes per week of Health, Physical Education and safety state mandate.
3. By September 2007 collaborate with a regional Metropolitan Planning Organization (MPO) or other entity such as the NJ Council on Physical Fitness and Sports to offer county- and state-wide trainings and forums for communities aimed at increasing physical activity opportunities, pending available funding and mini-grant opportunities.
4. By September 2007, in collaboration with NJ Department of Education, Diabetes Council, Interagency Council on Osteoporosis and the NJ Council on Physical Fitness and Sports, market and distribute KidStrong and Jump Start Your Bones aimed at decreasing obesity by improving nutrition and physical activity behaviors in youth.
5. By December 2006, review results of the 10,000 steps (pedometer pilot initiative) and revise strategies, aimed to decrease obesity by improving nutrition and physical activity behaviors in youth.
6. By January 2007, offer additional 10,000 steps pedometer mini grants for schools and community-based organizations.
7. By January 2007, develop new initiatives and collaboration aimed at decreasing obesity including gardening, library and chefs in the classroom programs.

8. By June 2007, reconvene a statewide Obesity Roundtable aimed at developing strategies to decrease childhood obesity in NJ and to share results and recommendations of the legislated NJ Obesity Prevention Task Force.
9. By September 2007, promote the recommendations of the NJ Obesity Task Force relating to sustainable actions that support and enhance obesity prevention among NJ residents, with particular attention to child and adolescence.
10. By September 2007, conduct regional trainings on the School Health Index to assist communities in assessing current school policies and practices as related to their impact on health.

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective: Annually, maintain Community Partnership for Healthy Adolescents in three New Jersey communities that have identified nutrition and physical activity as a priority adolescent health issue to address.

Annual Activity Objective for Desired Impact Objective: By July 2007, modify funding levels, as needed, in grant awards for continuation of support to three Community Partnership for Healthy Adolescents grantees.

Essential Service 7 - Link people to services:

Desired Impact Objective: By July 2007, each Community Partnership for Healthy Adolescents grantee will have a directory of youth services to link adolescents in need of services to the appropriate agencies in the community that can provide those services.

Annual Activity Objective for Desired Impact Objective: By July 2007, each Community Partnership for Healthy Adolescents grantee will update their directory of community resources & youth service providers using the “Resource Inventory Matrix” form.

Essential Service 9 - Evaluate health programs:

Desired Impact Objective: Annually, each Community Partnership for Healthy Adolescents grantee will evaluate their physical activity initiative and make improvements as indicated.

Annual Activity Objectives for Desired Impact Objective:

1. Quarterly, each Community Partnership for Healthy Adolescents will be monitored for progress toward meeting the objectives identified in their Adolescent Health Plan.
2. By June 2007, the Community Partnership for Healthy Adolescents grantees addressing physical activity and nutrition will have completed an evaluation of their initiatives.

3. By July 2007, improvements to the physical activity and nutrition initiatives will be made based on feedback and evaluation and the incorporation of “best practices” or use of “model” programs will be monitored by the Program Officer.

PROGRAM PROFILE

1. Program Title: Healthy Adolescents

2. Total Block Grant Funds to Program:

Current Year:

a. HO 19-3	\$200,000
Total:	\$200,000

Prior Year:

a. HO 19-3	\$0
Total:	\$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 19-3	\$0
Total:	\$0

4. Total FTE's for Program:

Number:

a. HO 19-3	1.00
Total:	1.00

**HEALTH OBJECTIVE PROFILE for HO
19-3 Overweight or obesity in children and
adolescents**

5a. National Health Objective: 19-3 Overweight or obesity in children and adolescents

Reduce the proportion of children and adolescents who are overweight or obese.
Children aged 6 to 11 was 11 percent in 1988-94. Adolescents aged 12 to 19 was 11 percent in 1988-94.

6a. State Health Objective(s):

None applicable.

7a. Target and Disparate Population Numbers:

Target Number: 1,196,974
Disparate Number: 1,196,974

8a. HO Dollars/FTE's:

- (1). Total Current Year: \$200,000
- (2). Total Prior Year: \$0
- (3). Amount to Disparate Population: \$125,000
- (4). Number of FTE's for HO: 1.00
- (5). Amount of \$'s to Local Entities for HO: \$0

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 19-3 10-49% - Partial source of funding

10a. Block Grant Role:

HO 19-3 Supplemental Funding

11a. 10 Essential Services

Essential Service 1 - Monitor health status
Essential Service 3 - Inform and Educate
Essential Service 4 - Mobilize partnerships
Essential Service 7 - Link people to services
Essential Service 9 - Evaluate health programs

State Program Title: Improved Cancer Surveillance of Minority Populations

State Program Strategy:

National Health Objective: HO 3-1 Overall Cancer deaths

State Health Objective(s):

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

1. Reduce the age-adjusted death rate from female breast cancer per 100,000 female population to 17.0 for all females.
2. Increase the percentage of female breast cancers diagnosed in early (in situ/local) stage of disease to 75 percent.
3. Reduce the age-adjusted death rate from cervical cancer per 100,000 standard population to 1.0 for all females.
4. Reduce the age-adjusted incidence rate of invasive cervical cancer in females per 100,000 standard population to 5.4.
5. Reduce the age-adjusted death rate of males from prostate cancer per 100,000 standard population to 10.0 for total males.
6. Reduce the age-adjusted death rate from colorectal cancer per 100,000 standard population to 10.0 for the total population.
7. Reduce the age-adjusted incidence rate of cancer of the rectum and rectosigmoid per 100,000 standard population to 13.2 for the total population.
8. Reduce the age-adjusted death rate from lung cancer per 100,000 standard population to 28.5 for the total population.
9. Reduce the age-adjusted incidence rate of invasive melanoma per 100,000 standard population to 7.0 for the total population.
10. Reduce the percentage of oral cancer diagnosed in the late regional and distant stages of disease to 40.0 percent for all males and 30% for females.

State Health Problem:

New Jersey has some of the highest cancer rates in the nation with 50,000 cases diagnosed annually. Cancer surveillance strategies are aimed at identifying all newly diagnosed cancers in New Jersey. Data from these efforts are used in cancer control efforts, to monitor trends and evaluate public health programs, to conduct research and to contribute to our understanding of cancer on local, state, regional and national levels. Special efforts are made to identify all cancer cases in a timely manner and accurately record medical and demographic data. Special efforts funded by PHHSBG focus on properly identifying cancers in special populations so that information can be provided for minority and under-served populations. Without these efforts, cancers in these groups would be under counted. Cancer surveillance in New Jersey covers all racial and ethnic groups in a state well recognized for its diversity. Such data provide some of the most complete information on such populations in the country. PHHSBG funding is used to supplement funding from the state, the Centers for Disease Control and Prevention (National Program for Cancer Registries - NPCR) and the National Cancer Institute (Surveillance Epidemiology and End Results).

New Jersey has some of the highest cancer rates in the nation with 50,000 cases diagnosed

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

Target Population:

Surveillance efforts are aimed at the entire state population of 8.4 million

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

Age: All ages

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

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

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

Age: All ages

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objectives:

1. By December 31, 2007, publish at least one report of cancer burden including Incidence and

mortality for various demographic groups including minorities.

2. By December 31, 2007, increase the percentage of cancer cases with valid follow up information to 95% complete.

Annual Activity Objectives for Desired Impact Objectives:

1. In June 2007, obtain certification by the North American Association of Central Cancer Registries for the New Jersey State Cancer Registry for excellence in data quality, timeliness and completeness of cancer surveillance data.
2. Meet contractual obligations to the National Cancer Institute and cooperative agreement obligations to the Centers for Disease Control and Prevention in a timely and satisfactory manner

Essential Service 2 - Diagnose and Investigate:

Desired Impact Objective: Identify all newly diagnosed cancers in New Jersey in accordance with national standards.

Annual Activity Objective for Desired Impact Objective: Obtain NAACCR gold Certification in June 2007.

Essential Service 4 - Mobilize partnerships:

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

Annual Activity Objectives for Desired Impact Objective: By December 2007, staff will have participated in at least three (3) national workgroups to improve cancer surveillance activities.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective: Provide timely and accurate cancer data for the evaluation of cancer control programs, the monitoring of health status (via stage of disease), and to guide resource allocation.

Annual Activity Objective for Desired Impact Objective: By December 2007 provide data to the Office of Cancer Control and Prevention for incorporation into the Comprehensive Cancer Control Plan.

Essential Service 9 - Evaluate health programs:

Desired Impact Objective: Provide timely and accurate cancer data for the evaluation of cancer control programs, the monitoring of health status (via stage of disease), and to guide resource

allocation.

Annual Activity Objective for Desired Impact Objective: To provide data to the Office of Cancer Control and Prevention for incorporation into the Comprehensive Cancer Control Plan.

Essential Service 10 - Research:

Desired Impact Objective: On annual basis and through December, 2006 to participate at all levels in cancer research in New Jersey with state and national collaborators.

Annual Activity Objective for Desired Impact Objective: To participate in at least two (2) research studies using New Jersey data by December 31, 2006.

PROGRAM PROFILE

1. Program Title: Improved Cancer Surveillance of Minority Populations

2. Total Block Grant Funds to Program:

Current Year:

a. HO 3-1	<u>\$97,418</u>
Total:	\$97,418

Prior Year:

a. HO 3-1	<u>\$0</u>
Total:	\$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 3-1	<u>\$0</u>
Total:	\$0

4. Total FTE's for Program:

Number:

a. HO 3-1	<u>1.00</u>
Total:	1.00

<p style="text-align: center;">HEALTH OBJECTIVE PROFILE for HO 3-1 Overall Cancer deaths</p>
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5a. National Health Objective: 3-1 Overall Cancer deaths

Reduce the overall cancer death rate.

202.4 cancer deaths per 100,000 population in 1998 (age adjusted to the year 2000 standard population).

6a. State Health Objective(s):

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

1. Reduce the age-adjusted death rate from female breast cancer per 100,000 female population to 17.0 for all females.
2. Increase the percentage of female breast cancers diagnosed in early (in situ/local) stage of disease to 75 percent.
3. Reduce the age-adjusted death rate from cervical cancer per 100,000 standard population to 1.0 for all females.
4. Reduce the age-adjusted incidence rate of invasive cervical cancer in females per 100,000 standard population to 5.4.
5. Reduce the age-adjusted death rate of males from prostate cancer per 100,000 standard population to 10.0 for total males.
6. Reduce the age-adjusted death rate from colorectal cancer per 100,000 standard population to 10.0 for the total population.
7. Reduce the age-adjusted incidence rate of cancer of the rectum and rectosigmoid per 100,000 standard population to 13.2 for the total population.
8. Reduce the age-adjusted death rate from lung cancer per 100,000 standard population to 28.5 for the total population.
9. Reduce the age-adjusted incidence rate of invasive melanoma per 100,000 standard population to 7.0 for the total population.
10. Reduce the percentage of oral cancer diagnosed in the late regional and distant stages of disease to 40.0 percent for all males and 30% for females.

7a. Target and Disparate Population Numbers:

Target Number: 8,414,350

Disparate Number: 4,000,000

8a. HO Dollars/FTE's:

(1). Total Current Year: \$97,418

(2). Total Prior Year: \$0

(3). Amount to Disparate Population: \$0

- (4). Number of FTE's for HO: 1.00
- (5). Amount of \$'s to Local Entities for HO: \$0

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 3-1 10-49% - Partial source of funding

10a. Block Grant Role:

HO 3-1 Supplemental Funding

11a. 10 Essential Services

- Essential Service 1 - Monitor health status
- Essential Service 2 - Diagnose and Investigate
- Essential Service 4 - Mobilize partnerships
- Essential Service 5 - Develop policies and plans
- Essential Service 9 - Evaluate health programs
- Essential Service 10 - Research

State Program Title: Promising Practices to Prevent Adolescent Suicide

State Program Strategy:

National Health Objective: HO 18-2 Adolescent suicide attempts

State Health Objective(s):

Reduce the death rate from suicide in males aged 15 – 19 to 4.8 per 100,000 population.

State Health Problem:

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

Target Population:

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

Age Range: 10-19

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

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

Gender Female and Male

Geography: Rural and Urban

Primarily Low Income: No

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

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

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

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

Age-Range: 10-19

Race/Ethnicity: African American or Black

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

Gender: Male

Geography: Rural and Urban
Primarily Low Income: No

Race/Ethnicity: African American or Black
Age: 4-11 years, 12-19 years, 20-24 years
Gender: Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Annually, adolescent service providers will have an opportunity to update their knowledge and receive relevant and current information on suicide prevention

Desired Impact Objective 1:

Annually, modify funding level, as needed, in grant award for continuation of support to maintain the Mercer County Traumatic Loss Coalition to maintain prevention, intervention, and post-vention and coordinate adolescent health promotion and services in Mercer County, in accordance with program guidelines.

Annual Activity Objective for Desired Impact Objective 1:

By January 2007, modify funding level, as needed, in grant award for continuation of support to fund the Mercer County Traumatic Loss Coalition.

Desired Impact Objective 2:

Annually, adolescent service providers will have an opportunity to update their knowledge and receive relevant and current information on suicide prevention.

Annual Activity Objectives for Desired Impact Objective 2:

1. By December 2006 conduct an Annual Adolescent Health Institute aimed at promoting recommendations that support suicide prevention policy and practices.
2. By December 2006, in cooperation with the Suicide Prevention Resource Center (SPRC) provide a draft of the New Jersey Suicide Prevention Plan. Annually and ongoing provide recommendations to this draft /plan.

Essential Service 7 - Link people to services:

Desired Impact Objective:

Annually, collaborate with Department of Human Services to maintain and provide technical assistance to the Traumatic Loss Coalitions in all 21 New Jersey counties and provide current information on suicide prevention, intervention and post-vention.

Annual Activity Objectives for Desired Impact Objective:

1. By September 2007 NJDHSS, in cooperation with the Department of Human Services and the University of Medicine and Dentistry of New Jersey (UMDNJ), and pending availability of funds, develop at least one training on injury/violence prevention (including suicide) in at least three locations.
2. By January 2007, modify funding level, as needed, in grant award for continuation of support for the Mercer County Traumatic Loss Coalition as a model county-based suicide prevention program.
3. By January 2007, in collaboration with the New Jersey Department of Human Services, Division of Mental Health, provide technical assistance to the Traumatic Loss Coalitions in all 21 Counties.
4. By January 2007 implement the training of Traumatic Loss Coordinators to begin suicide awareness/prevention curriculum in New Jersey schools. (Assembly No. 3931).
5. Annually, provide adequate resources to support the New Jersey Youth Suicide Prevention Advisory Council.

PROGRAM PROFILE

1. Program Title: Promising Practices to Prevent Adolescent Suicide

2. Total Block Grant Funds to Program:

Current Year:

a. HO 18-2	\$159,640
Total:	<u>\$159,640</u>

Prior Year:

a. HO 18-2	\$0
Total:	<u>\$0</u>

3. Total Block Grant Funds to Local Entities for Program:

a. HO 18-2	\$0
Total:	<u>\$0</u>

4. Total FTE's for Program:

Number:

a. HO 18-2	1.00
Total:	<u>1.00</u>

<p style="text-align: center;">HEALTH OBJECTIVE PROFILE for HO 18-2 Adolescent suicide attempts</p>
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5a. National Health Objective: 18-2 Adolescent suicide attempts

Reduce the rate of suicide attempts by adolescents.

2.6 percent of students in grades 9 through 12 reported suicide attempts that required medical attention in the 12 months preceding the survey in 1999.

6a. State Health Objective(s):

Reduce the death rate from suicide in males aged 15 – 19 to 4.8 per 100,000 population.

7a. Target and Disparate Population Numbers:

Target Number: 1,183,311

Disparate Number: 110,039

8a. HO Dollars/FTE's:

(1). Total Current Year: \$159,640

(2). Total Prior Year: \$0

(3). Amount to Disparate Population: \$0

(4). Number of FTE's for HO: 1.00

(5). Amount of \$'s to Local Entities for HO: \$0

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 18-2 100% - Total source of funding

10a. Block Grant Role:

HO 18-2 No other existing federal or state funds

11a. 10 Essential Services

Essential Service 3 - Inform and Educate

Essential Service 7 - Link people to services

State Program Title: Public Health Performance Improvement and Enhancement

State Program Strategy:

National Health Objective: HO 23-8 Competencies for public health workers

State Health Objective(s):

By September 30, 2007, increase the percentage of local health departments that satisfy staff expertise/competencies as defined in Department public health performance standards to 90.0 percent.

State Health Problem:

New Jersey has 115 local health departments that provide services to more than eight million people. A survey conducted by the Department demonstrated that there are great inconsistencies in the depth and breadth of skills, expertise, and competence among public health professionals employed in the local government public health system. Policy-making local boards of health members do not have a broad enough understanding of the local public health system to assure decision-making which positively impacts health outcomes.

Target Population:

Local health department staff: 2,500
Local boards of health members: 3,500

Group(s) Served: Local Health Departments, Boards of Health

Disparate Population:

Local health department staff: 750
Local boards of health members: 2,000

Group(s) Served: Local Health Departments, Boards of Health

ESSENTIAL SERVICES

Essential Service 8 - Assure competent workforce:

Desired Impact Objective:

Increase from 75 percent to 90 percent the number of local health department staff and local boards of health members who have participated in competency-building training by the end of 2007.

Annual Activity Objectives for Desired Impact Objective:

1. Draft new rules at *N.J.A.C. 8:7, Licensure of Persons for Public Health Positions*, which will serve as the administrative core to the Department's public health workforce agenda. These rules will set forth, in pertinent part, the requirements and standards to which an individual must adhere in order to become licensed as a Registered Environmental Health Specialist or as a Health

Officer. It also will set forth the requirements to retain that licensure through continuing annual continuing public health education. The rules also address such diverse issues as the qualifications to sit for a particular licensing examination, the requirements a licensee must attain in order to maintain an active license, and standards of performance and professional conduct. A draft of these rules will be completed by October 2007 and submitted for public comment prior to adoption.

2. Increase the marketing and use of New Jersey's Learning Management Network (NJLMN) from a baseline estimate of 65 percent to 90 percent by the end of 2007. The Preventive Health and Health Services Block Grant has played an integral part in the initial development of this system. The public health workforce use this one-stop, on-line location for professional and scientific training opportunities. This year marked the roll-out of the system and continued support will help us to prepare a plan for marketing the use of the system to the State-wide academic institutions. The ultimate goal is to provide students seeking a public health degree the option of using credits obtained through the NJLMN on-line courses in partial fulfillment for the desired degree.
3. Pursuant to the provisions of *N.J.A.C. 8:7, Licensure of Persons for Public Health Positions*, by February 2007, review continuing education credits and, if appropriate and adequate, issue license renewals for Health Officers and Registered Environmental Health Specialists and update licensing databases.
4. Collaborate with and provide technical support to Cook College, Office of Continuing Professional Education in updating the Environment and Public Health (EPH) course. This course serves as one means of entrée to sit for the Registered Environmental Health Specialist (REHS) examination. Curricula will be updated as dictated by public health policy and rules and by the changing landscape of public health issues in time for the start of the next session which begins in June 2007.
5. Begin a review of the licensing examination which is used for Registered Environmental Health Specialists (REHS). The examination is given three times per year and the questions must be updated to reflect the current state of the art and state of the science. Review and revisions will be completed by October 2007.

National Health Objective: HO 23-11 Performance standards

State Health Objective(s):

By September 30, 2007, increase the percentage of local health departments performing core public health functions from approximately 50 percent to 80 percent.

State Health Problem:

New Jersey's local public health system is antiquated and ill equipped to respond to the daunting challenges posed by modern society. Presently, there are 115 local health departments that often work independently of one another and report to more than 500 local boards of health. These local boards of health often have policy responsibility for public health services. A study of New Jersey's local public health system revealed a significant lack of expertise in critical public health functions, *viz.*, epidemiology, medicine, and health planning. Further, New Jersey's local public health system performed below 50 percent in four of 10 critical organizational practices of public health and slightly better than 50 percent in two of the three core functions of public health, *i.e.*, assessment, policy development, and assurance.

Target Population:

Local Health Department Staff: 2,500
Local Boards of health members: 3,500

Group(s) Served: Local Health Departments, Boards of Health

Disparate Population:

Local health Department Staff: 750
Local Boards of Health Members: 2,000

Group(s) Served: Local Health Departments, Boards of Health

ESSENTIAL SERVICES

Essential Service 5 - Develop policies and plans:

Desired Impact Objective:

1. Increase the percentage of local health departments that have actively participated in developing a county-wide community health improvement plan (CHIP) that will identify improved health outcomes from essentially zero percent to 100 percent by the end of 2007.
2. Increase local health departments critical organizational skills of assessment from 51.9 percent to 75.0 percent; of policy development from a baseline of 55.1 percent to 75.0; and assurance from a baseline of 73.7 percent to 90.0 percent by the end of 2007.

3. Increase visitation, audit, and consultation and technical services to local health departments and to Governmental Public Health Partnerships from 60 percent to 100 percent by the end of 2007.
4. Evaluate the needs and performance of local health department staff and local boards of health through comparison of local activities with national public health performance standards.
5. By January 2007, conduct a study on the history of local public health in New Jersey, including the organizational structure of its local health departments, their governance structure, financing, and statutory requirements, and present options and recommendations for increased shared services and consolidation that provide opportunities for creating a more effective and efficient local governmental public health system.

Annual Activity Objective for Desired Impact Objective:

1. By January 2007, distribute over \$2.4 million to local health departments in the form of Public Health Priority Funding. These funds are used to build public health infrastructure through organization capacity assessment and development. These funds also support local health department responsibilities for communicable disease control, environmental health, maternal and child health, adult health services, and administration.
2. By February 2007, propose amendments to *N.J.A.C. 8:52, Public Health Practice Standards of Performance for Local Boards of Health in New Jersey*. These amendments, based on our experience in enforcing the original rules, will further encourage, refine, and provide the framework to build the capacity of local health departments to effectively deliver the Ten Essential Public Health Services.
3. By September 2007, continue to collaborate with other State and local health partners to identify Best Practice Standards for local health departments and use them to achieve desired health outcomes through improved, measurable performance.
4. By September 2007, work with the New Jersey Association of Local Boards of Health to update the orientation manual for new board of health members and to participate in its broad dissemination. Seek opportunities to meet with local boards of health to improve their understanding of standards.

PROGRAM PROFILE

1. Program Title: Public Health Performance Improvement and Enhancement

2. Total Block Grant Funds to Program:

Current Year:

a. HO 23-8	\$329,473
b. HO 23-11	<u>\$329,473</u>
Total:	\$658,946

Prior Year:

a. HO 23-8	\$0
b. HO 23-11	<u>\$0</u>
Total:	\$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 23-8	\$0
b. HO 23-11	<u>\$0</u>
Total:	\$0

4. Total FTE's for Program:

Number:

a. HO 23-8	3.00
b. HO 23-11	<u>3.00</u>
Total:	6.00

HEALTH OBJECTIVE PROFILE for HO 23-8 Competencies for public health workers
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5a. National Health Objective: 23-8 Competencies for public health workers

Increase the proportion of Federal, Tribal, and local agencies that incorporate specific competencies in the essential public health services into personnel systems.

An operation definition has not been specified.

6a. State Health Objective(s):

By September 30, 2007, increase the percentage of local health departments that satisfy staff expertise/competencies as defined in Department public health performance standards to 90.0 percent.

7a. Target and Disparate Population Numbers:

Target Number: 6,000

Disparate Number: 2,750

8a. HO Dollars/FTE's:

(1). Total Current Year: \$329,473

(2). Total Prior Year: \$0

(3). Amount to Disparate Population: \$0

(4). Number of FTE's for HO: 3.00

(5). Amount of \$'s to Local Entities for HO: \$0

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 23-8 100% - Total source of funding

10a. Block Grant Role:

HO 23-8 No other existing federal or state funds

11a. 10 Essential Services

Essential Service 8 - Assure competent workforce

HEALTH OBJECTIVE PROFILE for HO 23-11 Performance standards
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5b. National Health Objective: 23-11 Performance standards

Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

An operation definition has not been specified.

6b. State Health Objective(s):

By September 30, 2007, increase the percentage of local health departments performing core public health functions from approximately 50 percent to 80 percent.

7b. Target and Disparate Population Numbers:

Target Number: 6,000

Disparate Number: 2,750

8b. HO Dollars/FTE's:

(1). Total Current Year: \$329,473

(2). Total Prior Year: \$0

(3). Amount to Disparate Population: \$0

(4). Number of FTE's for HO: 3.00

(5). Amount of \$'s to Local Entities for HO: \$0

9b. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 23-11 100% - Total source of funding

10b. Block Grant Role:

HO 23-11 No other existing federal or state funds

11b. 10 Essential Services

Essential Service 5 - Develop policies and plans

State Program Title: Quality EMS Care=People+Education+Regulations

State Program Strategy:

The Office of Emergency Medical Services is the key coordination point for emergency medical services in the state. The program licenses providers and certifies EMS personnel, providing a set of standards for practice in New Jersey.

The personnel funded by the PHHS are used in the Office of Emergency Medical Services to assure that standards are current with national practices and to assure that those standards are maintained consistently throughout the state. The office is divided into two major areas, the Education Unit and the Licensing, Care and Monitoring Unit. The two units are charged respectively with assuring that the EMTs and paramedics are properly trained and certified and that the licensed providers are maintaining proper procedures, equipment and services to the public.

These functions are essential and ongoing. In order to maintain a current, efficient system of EMS, it is necessary to continue to fund a centralized office of emergency medical services.

National Health Objective: HO 1-11 Emergency Medical Services

State Health Objective(s):

There is no specific Emergency Medical Services (EMS) objective in Healthy New Jersey 2010. However, Objectives 1 and 2 work towards ensuring that the population has an improved overall health status and has access to care by competent healthcare providers. EMS is a critical component in both of these objectives. When primary and secondary prevention efforts fail and people become victims of illness or injury, they enter the state's EMS system. EMS is defined as services used in responding to an individual's perceived need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury. The EMS system must have an adequate number of qualified, competent healthcare providers to respond each and every 9-1-1 call. Quick intervention by EMS can be critical in reducing mortality and morbidity.

State Health Problem:

The Office of Emergency Medical Services (OEMS) is the lead agency for emergency medical services (EMS) within the state of New Jersey. The Office licenses providers, certifies EMS personnel, and provides standards of practice and quality oversight for every county.

In 2005, the advanced life support (ALS) component of the New Jersey's EMS system responded to over 388,000 requests for assistance and rendered care for 163,944 patients. Of these patients, over 39,000 patients were treated for heart ailments, while 37,939 patients were treated for respiratory distress. The medical treatment protocols employed by the 31 ALS programs are authorized by Department regulations. This system requires specific medications and treatment protocols to be codified into regulations.

The prevalence of chronic illness in ethnic and low socioeconomic populations as well those at either extreme of the life cycle has been well documented. As New Jersey's population ages, the requests for medical assistance will only increase. The Emergency Department, which serviced 3,076,666 patients in 2002, and the EMS system remain as the safety net for the entire healthcare system

In 2005, 55 number of basic training programs hosted 157 initial training courses, certified 2,250 number of new EMTs and 100 new paramedics. Also in 2005, over 5,000 number of EMT continuing education programs were approved by OEMS staff. Of these, only 75 of programs were audited by OEMS staff. The number of certified Prehospital healthcare providers available to staff basic life support services for volunteer and licensed services has steadily declined. The Advanced Life Support component of the EMS, established by law, mandates that such services be hospital based. Regulations for the certification of EMTs and paramedics as well as the operations of basic, advanced, air-medical and specialty care transport services, are developed, implemented and enforced by OEMS. OEMS personnel funded by the PHHSBG, together with staff that are state supported, are charged with updating training and regulations to ensure that treatment standards are current with national best practices and evidence based medicine (as cited by the National Association of Emergency Medical Physicians; HRSA, Maternal and Child Health, EMS for Children Program; Institute of Medicine "Future of Emergency Care Series, Emergency Medical Services at the Crossroads" report issued in 2006; and the American Heart Association

Target Population:

The New Jersey EMS system responds to over 600,000 requests for assistance.

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

Age: All ages

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Individuals who suffer from chronic illnesses and request EMS for acute care as well as attempted suicides, sexual assaults, and other injuries.

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

Age: All ages

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

ESSENTIAL SERVICES

Essential Service 6 - Enforce laws and regulations:

Desired Impact Objective: By September 30, 2007, adopt a comprehensive set of certification and operational regulations that allow for timely adaptation to treatment protocols based upon sound medical evidence.

Annual Activity Objectives for Desired Impact Objective:

1. By January 31, 2007, publish as a proposal the updated operating regulations for all levels of prehospital emergency medical care.
2. By June 30, 2007, adopt the updated operating regulations for all levels of prehospital emergency medical care.
3. By September of 2007 investigate a more efficient method to make changes to medical treatment protocols, based upon current medical research, within the regulatory system.

Essential Service 8 - Assure competent workforce:

Desired Impact Objective: To increase the number of qualified prehospital providers.

Annual Activity Objective for Desired Impact Objective:

1. By January 1, 2007, implement the new Mid-Atlantic Emergency Medical Technician-Basic certification examination to replace the current National Registry Examination.
2. By September 30, 2007, increase the number of Emergency Medical Technician-Basic trainees that are successful in passing the certification examination by 10% over the number of 2006 trainees certified.
3. By September 30, 2007, increase the number of Emergency Medical Technician-Basic instructors from 525 to 575.
4. By September 30, 2007, implement the distance learning/traditional Emergency Medical Technician-Paramedic program in Camden County College.
5. By January 1, 2007, implement the newly redesigned Emergency Medical Technician-Basic recertification program.
6. By August 31, 2007, increase the number of EMT continuing education programs audited by OEMS by 10% over those audited in 2005.

PROGRAM PROFILE

1. Program Title: Quality EMS Care=People+Education+Regulations

2. Total Block Grant Funds to Program:

Current Year:

a. HO 1-11	\$399,414
Total:	\$399,414

Prior Year:

a. HO 1-11	\$0
Total:	\$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 1-11	\$0
Total:	\$0

4. Total FTE's for Program:

Number:

a. HO 1-11	5.00
Total:	5.00

HEALTH OBJECTIVE PROFILE for HO 1-11 Emergency Medical Services
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5a. National Health Objective: 1-11 Emergency Medical Services

Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services.

An operational definition has not been specified.

6a. State Health Objective(s):

There is no specific Emergency Medical Services (EMS) objective in Healthy New Jersey 2010. However, Objectives 1 and 2 work towards ensuring that the population has an improved overall health status and has access to care by competent healthcare providers. EMS is a critical component in both of these objectives. When primary and secondary prevention efforts fail and people become victims of illness or injury, they enter the state's EMS system. EMS is defined as services used in responding to an individual's perceived need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury. The EMS system must have an adequate number of qualified, competent healthcare providers to respond each and every 9-1-1 call. Quick intervention by EMS can be critical in reducing mortality and morbidity.

7a. Target and Disparate Population Numbers:

Target Number: 653,676

Disparate Number: 115,000

8a. HO Dollars/FTE's:

- (1). Total Current Year: \$399,414
- (2). Total Prior Year: \$0
- (3). Amount to Disparate Population: \$0
- (4). Number of FTE's for HO: 5.00
- (5). Amount of \$'s to Local Entities for HO: \$0

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 1-11 100% - Total source of funding

10a. Block Grant Role:

HO 1-11 No other existing federal or state funds

11a. 10 Essential Services

Essential Service 6 - Enforce laws and regulations
Essential Service 8 - Assure competent workforce

State Program Title: State Rape Care Prevention Program

State Program Strategy:

The State Rape Care and Prevention Program is housed in the New Jersey Department of Community Affairs' Division on Women's Office on the Prevention of Violence Against Women. The program funds, monitors and provides technical assistance to county-based rape care centers in each of the state's 21 counties. The primary objective of each county-based rape care center is the provision of direct services to primary and secondary survivors of sexual assault, abuse and rape who are at least 12 years of age. Direct services must include but are not limited to the following: 24 hour crisis/informational hotline; 24 hour victim accompaniment through medical procedures, law enforcement interviews, investigative procedures and court proceedings; individual counseling for victims and significant others; group counseling for victims and significant others, victim advocacy and support, and provision of referrals and information.

PHHSBG funds combined with an annual state appropriation are the only sources of funding available for the provision for the above services to victims.

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

State Health Objective(s):

No objective listed in Healthy New Jersey 2010.

State Health Problem:

An alarming number of women, men and children become victims of sexual violence, including rape, each year. Based on a limited definition of rape, the New Jersey Uniform Crime Report states that there were 1,204 rapes in 2005, the last year for which information is available. In contrast, New Jersey Rape Care Centers funded by PHHSBG funds provided services to 4,091 new victims age 12 and older in 2005. New Jersey receives \$206,000 for the State Rape Care and Prevention Program to address this issue; these funds are granted to county-based rape care centers to impact the prevalence of sexual violence by providing needed counseling services to victims of sexual violence.

Target Population:

County-based rape care centers that receive PHHSBG funds are required to serve all victims of sexual violence age 12 and older regardless of race, ethnicity or gender. Services are provided at no cost regardless of a victim's economic status. Of the estimated 4,091 victims (based on 2005 statewide statistics from 21 county-based rape care programs), these funds will target 525 victims or their significant others to receive individual counseling. Each PHHSBG funded rape care center will provide counseling services to approximately 25 victims of sexual assault, abuse and rape or their significant others for an average of 6 sessions.

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

Age: 12-19 years, 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

It is estimated that in New Jersey, over 73% of the population of 8,604,674 is age 12 or older. Additionally, New Jersey demographics reflect that 76.9% of those that reside in the state are White; 14.5% are African American or Black; .3% are American Indian and Alaska Native; 7% are Asian and 14.9% are Hispanic. Slightly more than half of the population is female.

Based on these percentages, 105 of the 525 target population (or 20%) will be members of a protected class or minority group and/or will experience physical or emotional disabilities.

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

Age: 12-19 years, 20-24 years, 25-34 years, 35-49 years, 50-64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

ESSENTIAL SERVICES

Essential Service 7 - Link people to services:

Desired Impact Objective:

From October 1, 2006 to September 30, 2007, provide approximately 3,169 individual counseling sessions to victims of sexual assault, abuse and rape and to significant others. In each of the 21 county rape care centers, 151 hours of counseling at a cost of \$65 per session will be provided, which is approximately 2.9 hours per week in a 52 week year. Each PHHSBG funded rape care center will provide counseling services to approximately 25 victims of sexual assault, abuse and rape or their significant others for an average of 6 sessions.

Annual Activity Objective for Desired Impact Objective:

1. All PHHSBG funded rape care centers will offer crisis and short term counseling to primary and secondary victims of sexual assault and abuse during this time period.
2. All PHHSBG funded rape care centers will report quarterly to the State Rape Care and Prevention Program on this provision of service.

PROGRAM PROFILE

1. Program Title: State Rape Care Prevention Program

2. Total Block Grant Funds to Program:

Current Year:

a. HO 15-35	\$206,051
Total:	<u>\$206,051</u>

Prior Year:

a. HO 15-35	\$0
Total:	<u>\$0</u>

3. Total Block Grant Funds to Local Entities for Program:

a. HO 15-35	\$206,051
Total:	<u>\$206,051</u>

4. Total FTE's for Program:

Number:

a. HO 15-35	0.00
Total:	<u>0.00</u>

HEALTH OBJECTIVE PROFILE for HO 15-35 Rape or attempted rape

5a. National Health Objective: 15-35 Rape or attempted rape

Reduce the annual rate of rape or attempted rape.
0.8 rapes or attempted rapes per 1,000 persons aged 12 years and older in 1998.

6a. State Health Objective(s):

No objective listed in Healthy New Jersey 2010.

7a. Target and Disparate Population Numbers:

Target Number: 525
Disparate Number: 105

8a. HO Dollars/FTE's:

- (1). Total Current Year: \$206,051
- (2). Total Prior Year: \$0
- (3). Amount to Disparate Population: \$0
- (4). Number of FTE's for HO: 0.00
- (5). Amount of \$'s to Local Entities for HO: \$206,051

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 15-35 10-49% - Partial source of funding

10a. Block Grant Role:

HO 15-35 Supplemental Funding

11a. 10 Essential Services

Essential Service 7 - Link people to services

State Program Title: Vaccine Preventable Disease Program

State Program Strategy:

The Vaccine Preventable Disease Program is collaboration between the New Jersey Department of Health and Senior Services and agencies in four urban initiative cities throughout the state. Newark, New Brunswick, Asbury Park/Long Branch, and Vineland, represent pockets of need within our State. These agencies are funded directly by the PHHSBG to raise the immunization level of racial/ethnic minority and medically under-served children in those cities between the ages of 0 months and 2 years to 90%. By identifying, offering, administering and referring children to a medical home for immunization services; providing immunization education and outreach to the areas hard-to-reach population; and increasing parental awareness of the need to have their children vaccinated on time every time. Categorical funding cannot meet the needs of these Centers for Disease Control and Prevention designated pocket-of-need areas. The agencies establish liaisons with New Jersey FamilyCare, private providers, community-based organizations, and local health departments to ensure follow-up of immunization activities. The PHHS block grant is the only source of funds for this program that enabling them to meet the many needs of the target population in the identified communities.

National Health Objective: HO 14-1 Vaccine-preventable diseases

State Health Objective(s):

11 – Increase the percentage of two year old children receiving DTaP, polio, MMR, and varicella, vaccines separately and as part of the 4-3-1-3 -3-1 series, to 80.0 percent among all children 2 years and under by December 31, 2007.

National Immunization Survey 2005: 78.3 percent - 2010 Target: 90 percent

12 – By December 31, 2007 increase by 10 percent the number of children less than 6 years of age that participate in the New Jersey Immunization Information System to 45 percent.

New Jersey Immunization Information System 2006: 35 percent

14-1 – By December 31, 2007 reduce or eliminate indigenous cases of the following vaccine-preventable diseases in New Jersey by 5 percent.

Pertussis among children under age 7 years
1998 Baseline: 7,405 - 2007 Target: 31- 2010 Target: 18

(MMWR) Summary of Notifiable Diseases, United States, 1998

State Health Problem:

64 percent fewer confirmed and probable pertussis occurred in 2006, due to better reporting, increased laboratory screening, improved specimen collection and increased surveillance that helped identify cases indicators of preventive health program success. According to the 2005 National Immunization Survey (NIS), New Jersey's series-complete vaccination rates for 4-3-1-3-3-1 are 11.8 percent (the state) and 17.4 percent (Newark) below the HP 2010 Objective of 90 percent for all two-year olds to be age-appropriately immunized. The NIS for 2005 also finds that 78.0 percent of New Jersey's children, and 72.6 percent of children in Newark, were age-appropriately immunized by age two. In the urban areas, where the majority of the State's minority and medically under-served children reside, some areas still have low rates. Pertussis rates are decreasing but still remain too high with 84.4 percent of 2 year old children vaccinated with DTaP by 12 months of age and only .4 of a percent above the 1998 NIS national baseline of 84 percent. Varicella rates are 68.3 percent for the 4-3-1-3-3-1 series that CDC will focus on in 2007 and beyond. The purpose being to assess state progress toward meeting the HP 2010 Objective of 90 percent for all of the universally recommended childhood vaccines. In NJ varicella is not reportable therefore it will be difficult to acquire accurate coverage data.

Several factors continue to contribute to slowly increasing immunization rates among children such as provider practices missing opportunities to vaccinate children and societal attitudes. In the urban areas, outreach workers have reported that in addition to the above factors, parents/guardians view immunization as a low priority when compared to food, housing, and safety issues. Vaccine cost

however, does not appear to be a major barrier because of the Vaccines For Children Program, first dollar vaccine coverage law, and children’s medical insurance programs such as NJ FamilyCare.

9,300 hard to reach racial/ethnic minority and medically under-served children two years of age and younger are the targets of the initiative cities of Vineland, Newark, Asbury Park/Long Branch, and New Brunswick in which it is estimated that 13,211 children two years of age and younger reside.

Target Population:

Children ages 0-2 years who reside in Newark, New Brunswick, Asbury Park/Long Branch, and Vineland are the target population. The following is the estimated number of children aged 0-2 years residing in each of the target areas:

Newark	8,625
New Brunswick	1,530
Asbury Park/Long Branch	1,680
Vineland	1,376
<u>Total</u>	<u>13,211</u>

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

Age: Under 1 year, 1-3 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

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

Age: Under 1 year, 1-3 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Disparate Population:

9,300 hard to reach racial/ethnic minority and medically under-served children two years of age and younger are the targets of the initiative cities of Vineland, Newark, Asbury Park/Long Branch, and New Brunswick.

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

Age: Under 1 year, 1-3 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

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

Age: Under 1 year, 1-3 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objective 1:

By September 30, 2007, 397 of 13,211 or 30 percent of 2 year old children are enrolled in the immunization registry of the four community action agencies in the target cities of Newark, Vineland, Asbury Park/Long Branch, and New Brunswick and age-appropriately immunized.

Annual Activity Objective for Desired Impact Objective 1:

1. Conduct tracking and follow-up to each 2 year old child to ensure age-appropriate immunizations
2. Ensure 2 year old is enrolled in immunization registry by conducting provider practice site audits
3. Develop and implement a plan to coordinate immunization efforts with WIC, NJ FamilyCare and other programs to enhance, not duplicate, existing immunization initiatives.

Essential Service 3 - Inform and Educate:

Desired Impact Objective 1:

By September 30, 2007 conduct direct, intensive outreach efforts by increasing awareness of immunization benefits for the target population in three venues in the target areas.

Annual Activity Objectives for Desired Impact Objective 1:

By March 31, 2007, establish liaisons in the four (4) urban initiative cities to support the following outreach activities:

1. Between October 1, 2006 and September 30, 2007 identify, develop, and disseminate at least two immunization and health-related materials in each of the four (4) target areas that are literally and culturally appropriate for the target population.
2. Between October 1, 2006 and September 30, 2007 identify and collaborate with at least two existing community-based organizations in each of the four (4) urban initiative cities that agree to support immunization outreach activities.
3. By April 30, 2007 develop a work plan for a major immunization initiative in each community, identifying an event that is of cultural significance to the target population.
4. By August 30, 2007, sponsor a major outreach initiative for the target population in each community that has the support and participation of community members representative of the racial/ethnic minority target group.

PROGRAM PROFILE

1. Program Title: Vaccine Preventable Disease Program

2. Total Block Grant Funds to Program:

Current Year:

a. HO 14-1	\$180,000
Total:	\$180,000

Prior Year:

a. HO 14-1	\$0
Total:	\$0

3. Total Block Grant Funds to Local Entities for Program:

a. HO 14-1	\$0
Total:	\$0

4. Total FTE's for Program:

Number:

a. HO 14-1	0.00
Total:	0.00

<p style="text-align: center;">HEALTH OBJECTIVE PROFILE for HO 14-1 Vaccine-preventable diseases</p>
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5a. National Health Objective: 14-1 Vaccine-preventable diseases

Reduce or eliminate indigenous cases of vaccine-preventable diseases.

Congenital rubella syndrome-- 7; Diphtheria (persons under age 35 years)--1; Haemophilus influenzae type b* (children under age 5 years)-- 253; Hepatitis B (persons aged 2 to 18 years) -- 945; Measles-- 74; Mumps-- 666; Pertussis (children under age 7 years) -- 3,417; Polio (wild-type virus) -- 0; Rubella -- 364; Tetanus (persons under age 35 years)-- 14; Tetanus (persons under age 35 years) -- 4 million.

6a. State Health Objective(s):

11 – Increase the percentage of two year old children receiving DTaP, polio, MMR, and varicella, vaccines separately and as part of the 4-3-1-3 -3-1 series, to 80.0 percent among all children 2 years and under by December 31, 2007.

National Immunization Survey 2005: 78.3 percent - 2010 Target: 90 percent

12 – By December 31, 2007 increase by 10 percent the number of children less than 6 years of age that participate in the New Jersey Immunization Information System to 45 percent.

New Jersey Immunization Information System 2006: 35 percent

14-1 – By December 31, 2007 reduce or eliminate indigenous cases of the following vaccine-preventable diseases in New Jersey by 5 percent.

Pertussis among children under age 7 years
1998 Baseline: 7,405 - 2007 Target: 31- 2010 Target: 18

(MMWR) Summary of Notifiable Diseases, United States, 1998

7a. Target and Disparate Population Numbers:

Target Number: 13,211

Disparate Number: 9,300

8a. HO Dollars/FTE's:

- (1). Total Current Year: \$180,000
- (2). Total Prior Year: \$0
- (3). Amount to Disparate Population: \$0
- (4). Number of FTE's for HO: 0.00

(5). Amount of \$'s to Local Entities for HO: \$0

9a. Percent of Block Grant Funds Relative to Other State Health Department Funds for HO:

HO 14-1 75-99% - Primary source of funding

10a. Block Grant Role:

HO 14-1 Supplemental Funding

Description (Optional): Decreasing federal immunization 317 funds and limited state COLA dollars contribute to the health objectives in the four target cities/areas. PHHSBG funds supplement our statewide efforts.

11a. 10 Essential Services

Essential Service 1 - Monitor health status

Essential Service 3 - Inform and Educate

