



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

DIVISION OF FAMILY HEALTH SERVICES

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Governor

HEATHER HOWARD
Commissioner

TO: ALL PARTIES INTERESTED IN THE NEW JERSEY PREVENTIVE HEALTH AND HEALTH SERVICES (PHHS) BLOCK GRANT

**FROM: Karen Walsh Pappas
PHHS Block Grant Coordinator
Division of Family Health Services**

DATE: November 2009

SUBJECT: PUBLIC NOTICE - NEW JERSEY PREVENTIVE HEALTH AND HEALTH SERVICES (PHHS) BLOCK GRANT/ WORKPLAN

Available for your review on our New Jersey Department of Health and Senior Services website (<http://www.nj.gov/health/fhs/>) is an electronic copy in PDF format of the Preventive Health and Health Services (PHHS) Block Grant Application for Federal Fiscal Year 2010. The Executive Summary shows the eleven proposed funded programs and the workplan document also shows the funding allocations. The application supports continuation activities. The \$2.9 million reflects level funding. The application supports programmatic activities in chronic disease prevention and control (asthma; diabetes; heart disease and stroke; and nutrition and physical fitness). Also supported are infrastructure and public health activities including workforce development, EMS and immunizations/vaccines.

If you have any questions or comments, please contact me at 609.292.4043. Written comments should be sent by December 10, 2009 to:

Karen Pappas, P.O. Box 364, Trenton, New Jersey 08625 or
Karen.pappas@doh.state.nj.us.

Thank you.

**New Jersey 2009 Preventive Health and
Health Services Block Grant Application
Preventive Health and Health Services
Block Grant**

Work Plan

Original Work Plan for Fiscal Year 2010

Submitted by: New Jersey

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Executive Summary

This is New Jersey's application for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Fiscal Year 2010. The PHHSBG is administered by the United States Department of Health and Human Services through its administrative agency, the Centers for Disease Control and Prevention (CDC). The New Jersey Department of Health and Senior Services (NJDHSS) is designated as the principal state agency for the allocation and administration of the PHHSBG within the State of New Jersey.

Funding Assumptions

The Preventive Health and Health Services Block Grant (PHHSBG) funding is \$2,933,959.

Proposed Funded Programs

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

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

Funding Rationale: Under or Unfunded, Data Trend, State Plan (2010)

Statutory Information

Advisory Committee Member Representation:

College and/or university, County and/or local health department, Dental organization, Elected official, Schools of public-health

Dates:

Public Hearing Date(s):

Advisory Committee Date(s):

9/14/2009

Current Forms signed and attached to work plan:

Certifications: Yes

Certifications and Assurances: Yes

Budget Detail for NJ 2010 V0 R0	
Total Award (1+6)	\$2,933,959
A. Current Year Annual Basic	
1. Annual Basic Amount	\$2,727,908
2. Annual Basic Admin Cost	(\$259,774)
3. Direct Assistance	\$0
4. Transfer Amount	\$0
(5). Sub-Total Annual Basic	\$2,468,134
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)	\$2,674,185
C. Prior Year Dollars	
10. Annual Basic	\$225,000
11. Sex Offense Set Aside (HO 15-35)	\$0
(12.) Total Prior Year	\$225,000
13. Total Available for Allocation (5+8+12)	\$2,899,185

Summary of Funds Available for Allocation	
A. PHHSBG \$'s Current Year:	
Annual Basic	\$2,468,134
Sex Offense Set Aside	\$206,051
Available Current Year PHHSBG Dollars	\$2,674,185
B. PHHSBG \$'s Prior Year:	
Annual Basic	\$225,000
Sex Offense Set Aside	\$0
Available Prior Year PHHSBG Dollars	\$225,000
C. Total Funds Available for Allocation	\$2,899,185

Summary of Allocations by Program and Healthy People 2010 Objective

Program Title	Health Objective	Current Year PHHSBG \$'s	Prior Year PHHSBG \$'s	TOTAL Year PHHSBG \$'s
Asthma Awareness and Education	7-10 Community health promotion programs	\$50,000	\$0	\$50,000
Sub-Total		\$50,000	\$0	\$50,000
Chronic Disease Self-Management (CDSM) Program	7-12 Older adult participation in community health promotion activities	\$146,252	\$0	\$146,252
Sub-Total		\$146,252	\$0	\$146,252
Immunization/Vaccine Preventable Disease Program	14-1 Vaccine-preventable diseases	\$0	\$225,000	\$225,000
Sub-Total		\$0	\$225,000	\$225,000
Mercer County Traumatic Loss Coalition	18-2 Adolescent suicide attempts	\$70,000	\$0	\$70,000
Sub-Total		\$70,000	\$0	\$70,000
New Jersey Diabetes Prevention and Control Program (DPCP)	5-5 Diabetes	\$328,718	\$0	\$328,718
	5-13 Annual dilated eye examinations	\$95,000	\$0	\$95,000
Sub-Total		\$423,718	\$0	\$423,718
New Jersey Division on Women (DOW) Rape Care Prevention Program	15-35 Rape or attempted rape	\$206,051	\$0	\$206,051
Sub-Total		\$206,051	\$0	\$206,051
New Jersey Heart Disease and Stroke Prevention (NJHDSP) Program	12-2 Knowledge of symptoms of heart attack and importance of calling 911	\$40,000	\$0	\$40,000
	12-8 Knowledge of early warning symptoms of stroke	\$73,803	\$0	\$73,803
Sub-Total		\$113,803	\$0	\$113,803
New Jersey Nutrition, Physical Activity & Obesity Prevention Program (NPAO)	19-3 Overweight or obesity in children and adolescents	\$263,433	\$0	\$263,433
Sub-Total		\$263,433	\$0	\$263,433
New Jersey State Cancer Registry (NJSCR)	3-1 Overall Cancer deaths	\$120,005	\$0	\$120,005
Sub-Total		\$120,005	\$0	\$120,005
Public Health Infrastructure	23-8 Competencies for public health	\$402,380	\$0	\$402,380

Development	workers			
	23-11 Performance standards	\$402,379	\$0	\$402,379
Sub-Total		\$804,759	\$0	\$804,759
Quality Emergency Medical Services Care	1-11 Emergency Medical Services	\$476,164	\$0	\$476,164
Sub-Total		\$476,164	\$0	\$476,164
Grand Total		\$2,674,185	\$225,000	\$2,899,185

State Program Title: Asthma Awareness and Education

State Program Strategy:

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

Program Health Priority: Health Promotion/Education

Program Primary Strategic Partners:

Internal

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

External

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

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

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

State Program Setting:

Child care center, Community based organization, Schools or school district, Other: Conferences

FTEs (Full Time Equivalent):

Full Time Equivalent positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO 7-10 Community health promotion programs

State Health Objective(s):

Between 10/2008 and 09/2010,

1. By 2010, reduce the annual asthma hospital admission rate per 100,000 population to 150 for the total population, to 250 for Black, non-Hispanic residents, and to 150 for Hispanic residents.

Baseline:

1. **Baseline:** 163 per 100,000 for the total population (1998), 412 per 100,000 for Black population (1998), 231 per 100,000 for Hispanic population (1998)

Data Source:

Healthy New Jersey 2010: Updated 2005

State Health Problem:

Health Burden:

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

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

- In 2006, there were 15,665 asthma hospitalizations among New Jersey residents representing about 1 of every 100 hospitalizations in the State.
- In 2006, black residents were nearly three times more likely to be hospitalized for asthma when compared to white residents and Hispanic residents were almost one and a half times more likely to be hospitalized for asthma when compared to non-Hispanic residents.
- Children less than five years of age are the most likely to be hospitalized for asthma. School age children experience seasonal peaks in asthma hospitalizations during the fall and spring months. Among adults, women are more likely to be hospitalized for asthma and are hospitalized longer for asthma when compared to men.
- Asthma hospitalization rates vary among the 21 counties of New Jersey with average annual rates in 2003-2006 ranging from about 68 asthma discharges per 100,000 residents (Hunterdon County) to about 337 asthma discharges per 100,000 residents (Essex County).

- In 2006, there were 52,628 ED discharges for asthma among New Jersey residents representing about 2 of every 100 ED discharges statewide.
- In 2006, black residents were nearly four times more likely to be discharged from the ED for asthma when compared to white residents and in 2006, Hispanic residents were more than one and a half times more likely to be discharged from the ED for asthma when compared to non-Hispanic residents.
- Children under five years of age are the most likely to be discharged from the ED for asthma when compared to other age groups. Annual asthma ED discharge rates for asthma during 2004-2006 ranged from about 218 per 100,000 residents (Hunterdon County) to about 1,365 per 100,000 residents (Essex County).

While death from asthma is uncommon, 106 deaths with an underlying cause of asthma were reported among New Jersey residents in 2005 and the extent to which asthma played a role in other instances of mortality is unknown. Higher age adjusted death rates are found among black residents and Hispanic residents as compared to white residents and non-Hispanic residents. The national burden of asthma signifies multiple opportunities for intervention. Health care providers, public health professionals, health insurers, employers, schools, child care centers, caregivers, and patients with asthma must collaborate to reduce barriers and promote asthma control through appropriate medical assessment, patient monitoring, adherence to treatment recommendations, control of environmental factors, management of co-morbid conditions, and improved access to self-management education and resources.

Target Population:

Number: 5,000

Ethnicity: Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, White

Age: 1 - 3 years, 4 - 11 years, 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:

Number: 5,000

Ethnicity: Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, White

Age: 1 - 3 years, 4 - 11 years, 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

Location: Entire state

Target and Disparate Data Sources: National Guideline Clearinghouse (Agency for healthcare Research and Quality)

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

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

Total Current Year Funds Allocated to Health Objective: \$50,000

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$25,000

Funds to Local Entities: \$50,000

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 3 – Inform and Educate

Objective 1:

Develop program that educates physicians on EPR3-key messages

Between 10/2009 and 09/2010, The PACNJ Coalition will develop tools to educate physicians on the six (6) key messages for EPR-3, and identify/implement mechanism to disseminate tools to physicians statewide.

Annual Activities:

1. Research effective tools and dissemination for physicians

Between 10/2009 and 11/2009, Literature review, utilize CDC Asthma Listserv and consult physicians in order to determine most effective educational tools and dissemination plan.

2. Present findings to Quality Care Task Force and finalize educational program

Between 12/2009 and 02/2010, Meet with Quality Care Task Force to agree upon Development & Dissemination Plan

3. Implement the Development & Dissemination Plan to reach physicians statewide

Between 02/2010 and 05/2010, Work with key partners to implement identified plans and evaluate program effectiveness.

State Program Title: Chronic Disease Self-Management (CDSM) Program

State Program Strategy:

By 2011, NJ will have a sustainable delivery system for CDSMP, providing statewide access to the program, with an emphasis on reaching minorities and those in urban communities. NJ's sustainability is built upon a strong collaboration between the aging services network and public health, as well as strategic alliances with statewide associations and local partners. By 2011, CDSMP workshops will be conducted for a total of 1,200 older adults including 900 aged 65+, 220 African-Americans, 100 Hispanics and 60 Asians.

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

Program Health Priority: Health Promotion/Education

Program Primary Strategic Partners:

Internal

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

External

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

State Program Setting:

Community based organization, Local health department, Senior residence or center, Other: Libraries, senior housing, clinics, hospitals

FTEs (Full Time Equivalent):

Full Time Equivalent positions that are funded with PHHS Block Grant funds.

Position Title: Program Manager

State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1

Total FTEs Funded: 1.00

National Health Objective: HO 7-12 Older adult participation in community health promotion activities

State Health Objective(s):

Between 10/2008 and 12/2010, Increase the days able to do usual activities, due to good physical or mental health, among persons 65+ to 28.7%.

Baseline:

27.2%

Data Source:

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

State Health Problem:**Health Burden:**

The state's rapidly growing older adult population, projections of continued increases in life expectancy and the escalating cost of care underscores the critical need to assist older adults to maintain good health as late into life as possible. NJ's current population of 1,565,195 adults 60+ grew by 8.4% from 2000 to 2007 with the largest population growth during this period among the youngest (ages 60-64, 30%) and oldest (people aged 85 and over, 24%), reflecting the aging of the baby boomers and their parents. By 2030 the number of people 60 and older is projected to reach 2.5 million, when this cohort will represent 25.7% of the state's population.[1] As the state's population ages, the projected cost of health care also increases. Nationally, health care expenditures are anticipated to increase 25% due to the aging population. Chronic conditions can significantly impact quality of life, causing individuals to suffer pain, loss of function and reduced independence. The risk and burden of chronic diseases in NJ is directly linked to poor lifestyle choices, including a lack of physical activity, poor nutrition and the failure to have recommended screenings/immunizations. *The State of Aging and Health in America* (CDC and Merck Institute of Aging and Health, 2007) reports that older New Jerseyans have an average of 5.4 physically unhealthy days per month. Nearly 1/3 participate in no leisure-time physical activity, only 64.3% receive an annual flu shot, and 29.6 report a disability. Eighty percent of older adults have at least one chronic condition and 50% have at least two. Disparity in health status is evidenced by the 16-year difference in healthy life expectancy at birth between white females (69.6 years) and African American males (53.9 years).[2] In addition, there are significant racial and ethnic differences in rates of preventable hospitalizations among older adults. For example, rates for Latinos with hospitalizations for diabetes are five times higher than for whites, and both African-Americans and Latinos are three times more likely than white adults to be admitted for hypertension.[3]

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

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

[1] New Jersey State Strategic Plan on Aging, New Jersey Department of Health and Senior Services, 2009.

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

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

Target Population:

Number: 1,200
Ethnicity: Hispanic
Race: African American or Black, Asian
Age: 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Number: 400
Ethnicity: Hispanic
Race: African American or Black, Asian
Age: 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: New Jersey State Strategic Plan on Aging, New Jersey Department of Health and Senior Services, 2009.

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: National Council on Aging

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

Total Current Year Funds Allocated to Health Objective: \$146,252
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$0
Funds to Local Entities: \$0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 3 – Inform and Educate**Objective 1:****Conduct CDSM Workshops**

Between 01/2010 and 12/2010, the New Jersey Department of Health and Senior Services and its community partners will conduct 100 CDSM workshops for a total of 1,200 older adults including 900 aged 65+, 220 African-Americans, 100 Hispanics, and 60 Asians.

Annual Activities:**1. Coordinate Local Workshops and Provide TA**

Between 01/2010 and 12/2010, Coordinate the local delivery of a minimum of 100 CDSMP workshops and provide technical assistance/training to local partners to foster program delivery, including a minimum of 2 face-to-face in-service sessions and 3 conference calls.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Expand the Infrastructure for CDSMP Workshop Delivery

Between 11/2009 and 10/2010, New Jersey Department of Health and Senior Services will increase the number of infrastructure for CDSMP workshop delivery, resulting in local capacity in multiple sites in each of the state's 21 counties from 150 to 200.

Annual Activities:

1. Facilitate Training

Between 11/2009 and 10/2010, Sponsor a Master Training Course for 26 individuals from targeted community-based organizations, including minority community-based agencies; and oversee the training of an additional 40 local peer leaders, include those representing African-American (10), Latino (6) and Asian (6) communities.

State Program Title: Immunization/Vaccine Preventable Disease Program

State Program Strategy:

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

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

Primary Strategic Partners:

External

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

Internal

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

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

State Program Setting:

Business, corporation or industry, Child care center, Community based organization, Community health center, Local health department, Medical or clinical site, Other: Social Service Referral Centers

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

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

State Health Objective(s):

Between 01/2010 and 12/2010,

1. Increase the percentage of two year old children receiving DTaP, polio, MMR, and varicella, vaccines separately and as part of the 4-3-1-3 -3-1 series, to 90.0 percent among all children 2 years and under.
2. Increase by 5 percent the number of children 2 years of age that participate in the New Jersey Immunization Information System to 90 percent.
3. Reduce or eliminate indigenous cases of the following vaccine-preventable diseases in New Jersey by 5 percent.

Baseline:

1. **Baseline data:** 2010 Target: 90 percent- NIS: 68.5 percent
2. **Baseline data:** 95 percent- NJIIS: 96 percent
3. **Baseline data:** 95 percent- NJIIS: 90 percent Baseline data: Pertussis among children under age 7 years. 2007 Baseline: 10,454 - 2010 Target: 18. 12 confirmed cases of Pertussis were reported in 2008

Data Source:

1. **Data Source:** National Immunization Survey 2008.
2. **Data Source:** New Jersey Immunization Information System 2008
3. **Data Source:** (MMWR) Summary of Notifiable Diseases, United States, 2008

State Health Problem:

Health Burden:

68 percent fewer confirmed and probable cases of pertussis occurred in 2007, due to better reporting, increased laboratory screening, improved specimen collection, development of disease guidelines for public reference and increased surveillance that helped identify case indicators of preventive health program success. According to the 2008 National Immunization Survey (NIS), New Jersey's vaccination rates for 4-3-1-3-3-1 series is 68.5 percent. That is 9.5 percent below the HP 2010 Objective of 90 percent for all two-year olds who are age-appropriately immunized. In the urban areas, where the majority of the State's minority and medically under-served children reside, some areas still have low rates. The purpose being to assess state progress toward meeting the HP 2010 Objective of 90 percent for all of the universally recommended childhood vaccines. In 2009 for the first time in NJ, varicella has become a reportable disease.

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

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

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

Population with Disparate Need: The Vaccine Preventable Disease Program is a collaboration between the New Jersey Department of Health and Senior Services and agencies in four urban initiative cities throughout the state. Newark, New Brunswick, Asbury Park/Long Branch, and Vineland, represent pockets of need within our State. These agencies will be directly funded by the PHHSBG to raise the immunization level of racial/ethnic minority and medically under-served children in those cities between the ages of 0 months and 2 years to 90 percent. By identifying, offering, administering and referring children to a medical home for immunization services; providing immunization education and outreach to the area's hard-to-reach population; and increasing parental awareness of the need to have their children vaccinated on time every time. Categorical funding cannot meet the needs of these Centers for Disease Control and Prevention designated pocket-of-need areas. The agencies establish liaisons with New Jersey FamilyCare, private providers, community-based organizations, and local health departments to

ensure follow-up of immunization activities. The estimated number will be 9,300, which includes: Hispanic and non Hispanic, African American or Black, Native Hawaiian Pacific Islander, American Indian/Alaskan Native, White and Asian from 0 to under 3 years covering both urban and rural, males and females in primarily low income communities in Cumberland, Essex, Middlesex and Monmouth Counties.

Target Population:

Number: 9,300

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or 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:

Number: 9,300

Ethnicity: Hispanic, Non-Hispanic

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

Age: Under 1 year, 1 - 3 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Specific Counties

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

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

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

Total Current Year Funds Allocated to Health Objective: \$0

Total Prior Year Funds Allocated to Health Objective: \$225,000

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

75-99% - Primary source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 1 – Monitor health status

Objective 1:

Increase the percent of 2 year old children enrolled in the immunization registry.

Between 01/2010 and 09/2010, the Vaccine Preventable Disease Program will increase the percent of children 0 months to 2-year old 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 from 80.5% to 90%.

Annual Activities:

1. Ensure Age Appropriate Immunizations

- Between 01/2010 and 09/2010, 1. Conduct tracking and follow-up to each 2 year old child to ensure age-appropriate immunizations
2. Ensure 2 year old is enrolled in immunization registry by conducting provider practice site audits
3. Educate the communities about importance of vaccination by coordinating with local health departments, WIC, NJ Family Care and other community based organizations to improve immunization rates in the pocket of needs areas.

Essential Service 3 – Inform and Educate

Objective 1:

Conduct Outreach and Awareness Activities

Between 01/2010 and 09/2010, the Vaccine Preventable Disease Program will conduct 4 intensive outreach efforts by increasing awareness of immunization benefits for the target population in three venues in the target areas.

Annual Activities:

1. Establish liaisons in the 4 urban initiative cities to support outreach activities

Between 01/2010 and 09/2010, 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. Identify and Collaborate

Between 01/2010 and 09/2010, 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. Disseminate Materials

Between 01/2010 and 09/2010, 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.

4. Develop a Workplan

Between 01/2010 and 04/2010, Develop a work plan for a major immunization initiative in each community, identifying an event that is of cultural significance to the target population.

5. Sponsor a major outreach initiative

Between 01/2010 and 08/2010, 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.

State Program Title: Mercer County Traumatic Loss Coalition

State Program Strategy:

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

Program Health Priority: Health Promotion/Education

Program Primary Strategic Partners:

Internal

DHSS, Child and Adolescent Health
DHSS, Maternal Child and Community Health

DHSS, Office of Women's Health
DHSS, Occupational Health
DHSS, Public Employees Occupational Safety and Health (PEOSH)
DHSS, Center for Health Statistics

External

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

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

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

State Program Setting:

Local health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO 18-2 Adolescent suicide attempts

State Health Objective(s):

Between 01/2009 and 12/2009, Reduce the death rate of suicide in males aged 15-19 through public awareness regarding suicide prevention, education targeting aged 15-19 to 4.8 per 100,000 population for New Jersey residents.

Baseline:

Reduce the death rate from suicide for 15-19 year old males. Baseline 6.1 per 100,000

Data Source:

New Jersey Center for Health Statistics

State Health Problem:

Health Burden:

Suicide is the third leading cause of death among adolescents in New Jersey. Suicide rates are highest among non Hispanic whites. The death rate from suicide for 15-19 year old males is 6.1 per 100,000. The causes of suicide are complex, and have to do with mental illness, particularly depression and/or adverse circumstances. Suicide attempts among younger people tend to be impulsive and communicative acts, often involving non-lethal means. Nearly one third of New Jersey suicide victims in 2003 had diagnosed mental illness at the time of the suicide and about one fifth were reported to have symptoms of depression at the time of their suicide. The major mechanisms used in suicides in New Jersey are firearms, suffocation (usually hanging), and poisoning, although mechanisms varies with age. Firearms and suffocation are the two most lethal means. Females are far more likely than males to use poisoning. Prevention does work. Prevention efforts are increasingly focused on restricting access to lethal means of suicide, especially, but not exclusively, firearms. The Traumatic Loss Coalition services all of Mercer County. It began in 1995 as a result of several suicides (eight students and one teacher) that took place there. None of the victims ever had any form of mental health treatment. The Coalition, which is comprised of members of various sectors of the community, widen its scope and provides a coordinated response to traumatic loss incidents. In addition it seeks to address prevention of destructive behaviors of Mercer County adolescents and their families. Specific events are suicides, homicides, motor vehicle crashes, natural and man-made disasters including terrorist attacks and the recent economic down trend.

Target Population:

Number: 100,849

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or 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:

Number: 8,116

Ethnicity: Non-Hispanic

Race: White

Age: 12 - 19 years

Gender: Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Specific Counties

Target and Disparate Data Sources: New Jersey Center for Health Statistics

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

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

Total Current Year Funds Allocated to Health Objective: \$70,000

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$70,000

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 3 – Inform and Educate

Objective 1:

Adolescent Health Institute

Between 01/2009 and 12/2009, the New Jersey Department of Health and Senior Services will provide an Adolescent Health Institute with suicide prevention presentations to 300 health providers.

Annual Activities:

1. Prevention/Awareness Curriculum and Technical Assistance

Between 01/2009 and 12/2009, The New Jersey Department of Health and Senior Services will conduct an annual Adolescent Health Institute that includes a suicide prevention presentation to 200 health providers. The AHI provides information to youth serving individuals across the state that includes information about awareness programs that are engaging and safe to use to educate teachers and other school personnel, parents, and providers about what to do if they or someone they care about is struggling with symptoms or is at risk for suicide. In addition, we discuss a safe and appropriate way for schools to memorialize a student who has died by suicide. The New Jersey Suicide Prevention quilt is displayed in a resource room and brochures with suicide prevention information and contacts are available. Information is based on Best Practice information and evaluations are distributed.

1. Revised edition of "Managing Sudden Traumatic Loss in Schools" will be in print and on-line.
2. Finalize suicide prevention/awareness curriculum in New Jersey schools (Assembly No. 3931).
3. Provide two presentations to staff to Mercer County schools "When the Worst Happens: How Schools Can Traumatic Loss."
4. Hold ten monthly Traumatic Loss meetings.
5. 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.

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

State Program Strategy:

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

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

Program Primary Strategic Partners:

Internal

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

External

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

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

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

State Program Setting:

Community based organization, Community health center, Medical or clinical site

FTEs (Full Time Equivalent):

Full Time Equivalent positions that are funded with PHHS Block Grant funds.

Position Title: Program Manager

State-Level: 50% Local: 0% Other: 0% Total: 50%

Total Number of Positions Funded: 1

Total FTEs Funded: 0.50

National Health Objective: HO 5-5 Diabetes

State Health Objective(s):

Between 01/2009 and 12/2010,

1. By 2010, reduce the age-adjusted death rate from cardiovascular disease in people with diabetes to 15.2 per 100,000 standard population.
2. By 2010, reduce the incidence of lower extremity amputations to 6.0 per 1,000 persons with diagnosed diabetes.
3. By 2010, increase the percentage of persons 18 and over with diagnosed diabetes that reported having a glycosylated hemoglobin measurement at least once a year to 90 percent. (Note: BRFSS is the data source for rates of glycosylated hemoglobin testing.)

Baseline:

1. Baseline Data: 19.0 data year 1999
2. Baseline Data: 9.0 data year 1998
3. Baseline Data: 81.2% data year 2000

Data Source:

1. Data Source: New Jersey Vital Statistics
2. Data Source: New Jersey Hospital Discharge data
3. Data Source: New Jersey

State Health Problem:

Health Burden:

Diabetes is becoming more prevalent in New Jersey. The New Jersey Behavioral Risk Factor Survey data for 2005-2007, indicate that on average about 524,000 adults in New Jersey, or 7.9% of the population, had diagnosed diabetes. Percentages were higher for men (8.2%) than for women (7.6%). Rates also increased with age, with the highest percentages of diagnosed diabetes seen in the over 65 population (19.0%).

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

Target Population:

Number: 6,605,343

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or 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 and Urban

Primarily Low Income: No

Disparate Population:

Number: 2,425,119

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander
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
Location: Specific Counties
Target and Disparate Data Sources: US Census Data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

Total Current Year Funds Allocated to Health Objective: \$328,718
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$200,000
Funds to Local Entities: \$0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 1 – Monitor health status

Objective 1:

Update Diabetes Surveillance Report

Between 12/2009 and 11/2010, the Diabetes Prevention and Control Program Epidemiologist will publish 1 diabetes burden report.

Annual Activities:

1. Publish and Post The Burden of Diabetes Report

Between 12/2009 and 11/2010,

1. 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.
2. 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

Objective 1:

Increase Awareness of Diabetes

Between 01/2010 and 12/2010, the Diabetes Outreach and Education (DOES) project will increase the percent of percent of individuals reached through screening, referral, and materials increase awareness of complications of diabetes and appropriate preventive measures (e.g. foot exams, hemoglobin A1C testing, and influenza and pneumococcal immunization) from Data Year 2001 foot exams – 63.2, flu shots

– 55.2, eye exam – 75.3, A1c – 77.7, pneumococcal – 42.4 to Foot 70%, flu 70%, eye 78%, A1c 80%, Pneu 50%.

Annual Activities:

1. Diabetes Outreach and Awareness

Between 01/2010 and 09/2010,

1. By July 1, 2009, continue funding of the community interventions and health communications project (DOES) in the five-county south Jersey target area.
2. By March 1, 2010, the DPCP Program and the DOES project will disseminate at least 45,000 diabetes related influenza brochures and 45,000 diabetes related pneumococcal brochures (English and Spanish) to providers and persons with diabetes.
3. By March 1, 2010, the DPCP Program and the DOES project will place influenza and pneumococcal public service announcements and/or news articles in at least 10 media outlets.
4. By June 30, 2010, the DPCP Program and DOES project will conduct five (5) community outreach events.
5. By June 30, 2010, the DPCP Program and the DOES project will conduct a provider education program focused on preventing complications in the five county south Jersey target area.
6. By June 30, 2010, the DPCP Program and the DOES Project will conduct outreach and continuing education sessions with 50 providers in five (5) counties.
7. Between October 1, 2010 and September 30, 2010, seven hundred and fifty persons screened by the DEDD program for A1C and high blood pressure, will receive information on prevention of diabetes-related complications and referrals for care.

Essential Service 5 – Develop policies and plans

Objective 1:

Develop Quality of Care Intervention

Between 01/2010 and 09/2010, New Jersey Chronic Disease Advisory Council and the New Jersey Chronic Disease Steering Committee will develop 1 statewide intervention to improve quality of care and to prevent complications of diabetes.

Annual Activities:

1. Update Strategic Plan

Between 01/2010 and 06/2010,

1. By June 30, 2009, the New Jersey Chronic Disease Advisory Council will conduct two (2) in-persons meetings of the full Council.
2. By March 28, 2009, the DPCP Program will develop a performance improvement plan and update the strategic plan.

Essential Service 7 – Link people to services

Objective 1:

Link Persons with Diabetes to Medications

Between 01/2009 and 12/2009, the Diabetes Prevention and Control Program will increase the percent of individuals referred with ESRD to access for medication from 0% to 10%.

Annual Activities:

1. Assist people with End Stage Renal Disease

Between 01/2009 and 12/2009, 1,100 low-income individuals identified as having end stage renal disease and need for a source of medications and/or nutritional supplements will receive assistance.

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

State Health Objective(s):

Between 01/2009 and 09/2010, Increase the percentage of persons 18 and over with diagnosed diabetes that have had a dilated eye exam within the past year.

Baseline:

Baseline Data: 71.6% Year 1998 data

Data Source:

Data Source: New Jersey BRFSS

State Health Problem:**Health Burden:**

Minority groups with diabetes in New Jersey had disproportionately high age adjusted rates of the disease. About 6.0% of non-Hispanic whites had a diagnosis of diabetes as compared to 11.3 % of non-Hispanic Blacks and 10.3 of Hispanics. National data suggests that the Hispanic figure probably underestimates the magnitude of diabetes among persons of that ethnicity. An additional 193,000 New Jerseyans are believed to have diabetes but are unaware that they have it. In 2004, the American Diabetes Association identified pre-diabetes as a condition of individuals with either a fasting glucose test of greater or equal to 100 mg/dl, but less than 120 mg/dl and an oral glucose tolerance test of greater or equal to 140 mg/dl but less than 200 mg/dl. It is estimated that 40 percent of the population 40-74 years of age has pre-diabetes.

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

Target Population:

Number: 6,662,131

Ethnicity: Hispanic

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

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 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:

Number: 250,000

Ethnicity: Hispanic

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

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
Location: Specific Counties
Target and Disparate Data Sources: New Jersey Commission of the Blind and Visually impaired

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

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

Total Current Year Funds Allocated to Health Objective: \$95,000
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$95,000
Funds to Local Entities: \$95,000
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 2 – Diagnose and Investigate

Objective 1:

Screen and Diagnose Diabetic Eye Disease

Between 01/2010 and 09/2010, New Jersey Commission of the Blind and Visually Impaired will increase the number of screenings for diabetic eye disease among low income, uninsured persons with diabetes from 0 to 750.

Annual Activities:

1. DEDD Screenings

Between 01/2010 and 09/2010, By September 30, 2010, 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

Objective 1:

Increase Awareness

Between 01/2010 and 06/2010, the Commission for the Blind and Visually Impaired will increase the number of persons receiving awareness messages on the complications of diabetes and appropriate preventive measures (e.g. eye exams). from 0 to 750.

Annual Activities:

1. DEDD Education

Between 01/2010 and 06/2010,

1. Between October 1, 2008 and June 30, 2010, seven hundred and fifty persons screened by the DEDD program will receive information on prevention of diabetes-related complications.
2. By September 30, 2010, seven hundred and fifty persons screened by the DEDD program will be screened for hypertension.

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

State Program Strategy:

State Program Strategy:

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

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

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

Primary Strategic Partnerships

Internal

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

External

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

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

Evaluation Methodology: All Sexual Violence Programs subgrantees are required to submit various quarterly programmatic and fiscal monitoring reports as listed below. All reports are reviewed by the DOW Rape Care and Prevention Program staff. Included with these reports are summaries of each subgrantees’ efforts to evaluate their educational presentations. Other methods of program evaluation include site visits and technical assistance meetings and trainings. The program manager will summarize and analyze data from these reports to document progress.

State Program Setting:

Business, corporation or industry, Child care center, Community based organization, Community health center, Faith based organization, Home, Medical or clinical site, Rape crisis center, Schools or school district, Senior residence or center, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

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

State Health Objective(s):

Between 10/2009 and 09/2010, Between 10/2009 and 09/2010, in a committed effort to reduce sexual violence in New Jersey, the DOW Rape Care and Prevention Program, housed in the New Jersey Department of Community Affairs and in partnership with the New Jersey Department of Health and Senior Services, will conduct individual and organizational capacity building and comprehensive primary prevention program planning for PHHSBG subgrantees over the next several years. These efforts will seek to facilitate the shift from current prevention activities that focus on awareness/risk reduction to a primary prevention focus utilizing a social ecological approach.

Baseline:

Based on a limited definition of rape, the New Jersey Uniform Crime Report states that there were 1,029 rapes in 2007, the last year for which information is available. In contrast, New Jersey Rape Care Centers funded by PHHSBG funds provided services to 4,091 new victims age 12 and older in 2007.

Data Source:

NJ Uniform Crime Report

State Health Problem:

Health Burden:

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

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

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

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

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

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

Sexual violence primary prevention is concerned with stopping initial acts of perpetration before they occur. This sexual violence primary prevention effort is based on addressing all levels of the social ecology and targeted populations are identified through risk and protective factors. Since each PHHSBG subgrantee is afforded the opportunity to address multiple strategies of the state's primary prevention plan, the total population is listed because any segment may be selected.

Also, some primary prevention strategies address attachment and empathy development which accounts for the earlier ages in the life span to be included. Again, this is directly related to identified risk and protective factors against perpetration of sexual violence. The current data looks primarily at victimization because that is mostly the data that is available.

Target Population:

Number: 8,625,920

Ethnicity: Hispanic

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

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 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:

Number: 1,600,000

Ethnicity: Hispanic

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

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: Census Data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Nine Principles of Effective Prevention Planning (Wasserman)

Getting to Outcomes (CDC, USC, Wasserman)

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

Creating Safer Communities: Rape Prevention Education Model of Community Change

Activities Model for Primary Prevention of Sexual Violence

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

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

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

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 5 – Develop policies and plans

Objective 1:

Develop a primary prevention planning committee and implement meetings of the committee

Between 10/2009 and 09/2010, each PHHSBG subgrantee will develop 1 primary prevention planning committee to address individual county needs in the area of prevention and engage essential stakeholders. PHHSBG subgrantees will begin meeting with the committee.

Annual Activities:

1. Prevention Planning Committee

Between 10/2009 and 09/2010, 1. **Begin meeting with Planning Committee** - From October 1, 2009 to September 30, 2010 each PHHSBG subgrantee will begin meeting with said committee.

2. **Begin to plan prevention strategies** - From October 1, 2009 to September 30, 2010 each PHHSBG subgrantee will address individual and organizational capacity building considering identified areas from the prior needs assessment as part of the work with the VERA. This will support work in selected areas of primary prevention.

Essential Service 8 – Assure competent workforce

Objective 1:

Technical assistance training to Increase Individual and Organizational Capacity Building

Between 10/2009 and 09/2010, the NJ Rape Care and Prevention Program itself or through NJCASA will provide technical assistance training to increase individual and organizational capacity building to 21 PHHSBG subgrantee to develop individual and organizational capacity building involving primary prevention.

Annual Activities:

1. Technical Assistance Trainings

Between 10/2009 and 09/2010,

1. 1. **Attend training institute of NJCASA** - From October 1, 2009 to September 30, 2010 each PHHSBG subgrantee will be encouraged to attend trainings with identified experts who will provide individual and organizational capacity building technical assistance specific to identified needs of PHHSBG subgrantees.

2. **Attend regularly scheduled technical assistance training provided by the DOW Rape Care and Prevention Program** - From October 1, 2009 to September 30, 2010 each PHHSBG subgrantee will attend regularly scheduled technical assistance meetings that will address key areas to increase individual and organizational capacity building in the area of sexual violence

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

State Program Strategy:

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

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

Program Primary Strategic Partners:

Internal

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

External

American Heart Association
NJ Hospital Association
NJ Health Institute
American Stroke Association
Blue Cross Blue Shield
NJ Primary Care Ass.
Preventive Cardio Nurse

Program Evaluation Methodology:

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

State Program Setting:

Community based organization, Community health center, Home, Medical or clinical site, Senior residence or center, Work site

FTEs (Full Time Equivalent):

Full Time Equivalent positions that are funded with PHHS Block Grant funds.

Position Title: Service Director

State-Level: 50% Local: 0% Other: 0% Total: 50%

Total Number of Positions Funded: 1

Total FTEs Funded: 0.50

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

State Health Objective(s):

Between 10/2009 and 09/2020, Reduce the age-adjusted death rate from coronary heart disease to 165 per 100,000 standard population.

Baseline:

213.7 per 100,000 population

Data Source:

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

State Health Problem:

Health Burden:

Heart disease remains the leading cause of death in the United States as a whole and in New Jersey, where it accounted for over 20,000 deaths in 2005, about 30 percent of all deaths. It is estimated that nationally one in five people has some form of cardiovascular disease including coronary heart disease. Coronary artery disease is the most common form of heart disease and remains the number one cause of death for both men and women. This type of heart disease is caused by a narrowing of the coronary arteries that supply blood to the heart.

From 2000 to 2005 the age-adjusted death rate in New Jersey from coronary heart disease fell by 20.0 percent, mirroring the decline nationally. The decrease in death rates occurred for minorities as well, although gaps still persist.

Target Population:

Number: 6,605,343

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or 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 and Urban

Primarily Low Income: No

Disparate Population:

Number: 699,164

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, Other

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

Location: Entire state

Target and Disparate Data Sources: US Census Data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Guide to Community Preventive Services (Task Force on Community Preventive Services)

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

Total Current Year Funds Allocated to Health Objective: \$40,000

Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$20,000
Funds to Local Entities: \$0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 3 – Inform and Educate

Objective 1:

Inform and Educate

Between 10/2009 and 09/2010, Heart Disease and Stroke Prevention (HDSP) Program staff will increase the percent of partnerships established to raise awareness in affected communities from 0 to 5.

Annual Activities:

1. Establish Partnerships

Between 10/2009 and 09/2010, By September 2010, partnerships will be developed with racial/ethnic minority community-based organizations (MCBOs) in New Jersey to promote awareness of healthy lifestyles.

2. Infrastructure

Between 10/2009 and 09/2010, Provide support for a coordinated wellness education program infrastructure.

3. Worksite Program

Between 10/2009 and 09/2010, Collaborate with a local entities to implement and maintain a workplace wellness project.

4. Evidence based Intervention for African Americans

Between 10/2009 and 09/2010, Develop and implement and maintain a strategy for science-based nutrition and physical activity health communications intervention targeted to the African American population in New Jersey.

Essential Service 9 – Evaluate health programs

Objective 1:

Maintain Surveillance Data Collection

Between 10/2009 and 09/2010, Research Scientist (HDSP Program) will maintain 2 sources of data to define wellness and health risk behaviors of New Jersey residents, including requesting 2006 through 2008 aggregated BRFSS data on BMI, physical activity, and nutrition, and other wellness/risk indicators, as available.

Annual Activities:

1. Identify Data Sources and Develop a Plan

Between 10/2009 and 09/2010,

1. By December 31, 2009, allocate funding to the Center for Health Statistics to increase the sample size and to potentially add questions to the Behavioral Risk Factor Survey (BRFSS) to collect data concerning the various chronic diseases inclusive of CVD, stroke, diabetes, asthma, etc.
2. By March 31, 2010, identify sources of data to define wellness and health risk behaviors of New Jersey residents, including requesting 2006 through 2008 aggregated BRFSS data on BMI, physical activity, and nutrition, and other wellness/risk indicators, as available.

3. By September 30, 2010, produce a plan for reducing wellness and health risks of New Jersey residents.

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

State Health Objective(s):

Between 10/2008 and 09/2010,

1. To strengthen prevention efforts through increased awareness and education about risk factor and lifestyle changes that affect high blood pressure, high cholesterol, diabetes, and smoking.
2. To utilize population-based public health approaches to increase public awareness of the urgency of addressing CVD, the signs and symptoms of heart disease and stroke, and the need to call 9-1-1.

Baseline:

Populations 1998 Baseline Data - Target/Preferred 2010 Endpoint

Data Source:

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

State Health Problem:

Health Burden:

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

The minority residents are more likely to have heart disease and stroke. About 6.8 percent of black non-Hispanic adults (48,000 people) have a history of myocardial infarction (MI), angina/coronary heart disease (CHD). For non-Hispanic whites, the estimated percentage of adults with a history of myocardial infarction (MI), angina/coronary heart disease (CHD) is 5.8 percent or 287,000 people. About 11,000 non-Hispanic Asian adults have a history of myocardial infarction (MI), angina/coronary heart disease (CHD), and accounting for about 5.1 percent of that population. For Hispanics, the estimated percentage of adults with a history of myocardial infarction (MI), angina/coronary heart disease (CHD) is 7.6 percent or 64,000 people. About 4.2 percent of black non-Hispanic adults (13,000 people) have a history of stroke. For non-Hispanic whites, the estimated percentage of adults with a history of stroke is 2.3 percent or 45,000 people. About 2,000 non-Hispanic Asian adults have a history of stroke, accounting for about 1 percent of that population. For Hispanics, the estimated percentage of adults with a history of stroke is 1.1 percent or 6,000 people.

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

The trend indicating the increasing rates of two major risk factors, obesity and diabetes, may impact the rates of incidence and prevalence of cardiovascular disease in the future. Obesity rates, as estimated by

the BRFSS, went from 9.9% of the New Jersey population in 1991 to 21.8% in 2005, a 120.0% increase in the rate of obesity. Nationally, the median obesity rate went from 12.6% to 23.9%, an increase of 96.8%. (2) National BRFSS diabetes data show that the crude rate of diagnosed diabetes in New Jersey's population 18 years and older went from 4.3% in 1991 (the first year the BRFSS was administered in New Jersey) to 7.7% in 2005; a 79.1% rate increase. Median rates of diabetes for the nation as a whole for those years were 4.8% and 7.3%, respectively; a 52.1% increase. This comparison suggests a greater increase of diabetes rates in New Jersey than in the nation as a whole.

Target Population:

Number: 6,542,820

Ethnicity: Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or 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:

Number: 880,000

Ethnicity: Non-Hispanic

Race: African American or Black

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

Location: Entire state

Target and Disparate Data Sources: US Census Data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Guide to Community Preventive Services (Task Force on Community Preventive Services)

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

Total Current Year Funds Allocated to Health Objective: \$73,803

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$20,000

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 3 – Inform and Educate

Objective 1:

Increase Awareness

Between 10/2009 and 09/2010, HDSP Program Staff will increase the percent of individuals that receive information about the warning signs and symptoms of heart disease and stroke from 60% to 65%.

Annual Activities:

1. Awareness Campaign

Between 10/2009 and 09/2010,

1. By September 30, 2010, increase the awareness of the warning signs of heart disease and stroke in both the general public and at-risk racial-ethnic minority.
2. By September 30, 2010, sponsor public awareness campaigns to raise awareness about signs and symptoms of heart disease and stroke and the importance of calling 9–1–1 when such symptoms appear.

State Program Title: New Jersey Nutrition, Physical Activity & Obesity Prevention Program (NPAO)

State Program Strategy:

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

Program Health Priority: New Jersey has the nation's highest obesity rate for WIC children of those states and US territories that report this data (NJ PedNSS 2007). The prevalence of obesity among Hispanic children exceeds national rates. In addition, the 2005 New Jersey Student Health Survey, based on self reported information, indicated that about three in 10 middle- and high-school students were either overweight or at-risk of being overweight based on their calculated Body Mass Index (BMI).

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

To address obesity, A **NEW** Jersey...Shaping the Way We Live! was launched to enlist the commitment of diverse partners from across the state that will address obesity through nutrition and physical activity. By June 2010, a new state partner plan will be completed, approved and submitted to the Centers for Disease Control and Prevention.

The success of this state partnership is founded on the state health department building and infrastructure to support its development. Partners will work within seven work groups that they created to address obesity; increased physical activity; increased fruit and vegetable consumption; increased breastfeeding initiation, duration and exclusivity; decreased TV viewing; decreased energy dense foods and sugar sweetened beverages; partnership development and sustainability; and surveillance and evaluation. These work groups will focus on policy and environmental change so that the healthy choice becomes the easy choice for New Jersey residents, use resources to target those at greatest risk for obesity and other chronic disease and health disparities and utilize evidenced based strategies. Each work group will develop targeted priorities with data needs identified and measurable outcomes determined. Implementation of the strategies by partners will be undertaken once this year long phase is completed.

Program Strategic Partners:

Internal

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

External

Department of Agriculture
Department of Education
Department of Transportation
State partners – A NEW Jersey...Shaping the Way We Live!

Program Evaluation Methodology: Community Partnership for Healthy Adolescents grantees addressing physical activity and nutrition are monitored quarterly by the Program Officer for progress toward meeting the objectives identified in their Adolescent Health Plans. Improvements to the physical

activity and nutrition initiatives will be made by the incorporation of “best practices” or use of “model” programs. The NPAO will utilize evidence based strategies or best informed practice.

State Program Setting:

Child care center, Community based organization, Schools or school district

State Program Setting:

Child care center, Community based organization, Schools or school district

FTEs (Full Time Equivalent):

Full Time Equivalent positions that are funded with PHHS Block Grant funds.

Position Title: Public Health Consultant (Nutrition)

State-Level: 50% Local: 0% Other: 0% Total: 50%

Position Title: Program Manager, Child and Adolescent Health

State-Level: 50% Local: 0% Other: 0% Total: 50%

Total Number of Positions Funded: 2

Total FTEs Funded: 1.00

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

State Health Objective(s):

Between 10/2009 and 09/2020, To prevent and control obesity through healthful eating and physical activity. New Jersey has the nation’s second highest obesity rate for WIC children (of those states and US territories that report this data). The prevalence of obesity among Hispanic children exceeds national rates. In addition, the 2005 New Jersey Student Health Survey, based on self reported information, indicated that about three in 10 middle- and high-school students were either overweight or at-risk of being overweight based on their calculated Body Mass Index (BMI).

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

Baseline:

1996-99 Overweight but not Obese = 36.7; Obese = 15.5

Data Source:

NJDHSS, Center for Health Statistics

State Health Problem:

Health Burden:

Obesity is a growing, global public health crisis and New Jersey is not exempt. Physical activity and overweight/obesity are two of the 10 top leading indicators of health identified in Healthy People 2010. Excess weight is the nation’s second leading cause of death, after smoking. Obesity increases blood pressure and cholesterol levels placing children at risk for early heart disease. Excess body fat increases resistance to insulin causing Type II diabetes in children. Other physical health problems may include asthma, sleep apnea, menstrual abnormalities, orthopedic problems and risk for certain cancers. In

addition to physical health problems, there are emotional and social consequences including depression, suicide ideation, bullying, discrimination and poorer academic performance.

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

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

Target Population:

Number: 6,662,131

Ethnicity: Hispanic

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

Age: 1 - 3 years, 4 - 11 years, 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:

Number: 1,600,000

Ethnicity: Hispanic

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

Age: 1 - 3 years, 4 - 11 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: WIC PedNSS 2007 Data; NJDHSS Center for Health Statistics

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Guidelines for School Health Programs to Promote Lifelong Healthy Eating

www.cdc.gov/mmwr/preview/mmwrhtml/00042446.htm or

www.cdc.gov/nccdphp/dash/publications/index.htm#guidelines

Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health (DASH)

www.cdc.gov/nccdphp/dash/index.htm

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

www.cdc.gov/mmwr/preview/mmwrhtml/00046823.htm or

www.cdc.gov/nccdphp/dash/publications/index.htm#guidelines

Promoting Physical Activity: A Guide for Community Action
www.cdc.gov/nccdphp/dnpa/pahand.htm

Effective Population Level Strategies to Promote Physical Activity
www.cdc.gov/nccdphp/dnpa/physical/recommendations.htm

Promoting Better Health for Young People Through Physical Activity and Sports
[www.cdc.gov/nccdphp/dash/physicalactivity/promoting health/index.htm](http://www.cdc.gov/nccdphp/dash/physicalactivity/promoting%20health/index.htm)

Physical Activity Guidelines – October 7, 2008
www.health.gov/paguidelines

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

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

NAPSACC Nutrition and Physical Activity for Child Care, www.napsacc.org

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

Total Current Year Funds Allocated to Health Objective: \$263,433

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 1 – Monitor health status

Objective 1:

Monitor Change in BMI

Between 10/2009 and 09/2010, Child and Adolescent Health will review 1 the change in BMI and other NPA self-reported behaviors by students.

Annual Activities:

1. Monitor and Report BMI

Between 10/2009 and 09/2010, By September 2010, the program will monitor and report the change in BMI and other N-PA self reported behaviors by young children and students.

2. Annual Activity Objective

Between 10/2009 and 09/2010, Review and identified appropriate nutrition and physical activity questions for use in the data collection.

Essential Service 3 – Inform and Educate

Objective 1:

Annual Activity Objective

Between 10/2009 and 09/2010, Child and Adolescent Health will increase the number of policies and environmental supports that are in place in New Jersey that encourage and support physical activity and healthy eating in communities and NJ public schools so that healthy choices are easier. from Increase from 42 mini grants and 2 trainings to 62 mini grants and 3 trainings.

Annual Activities:

1. Expand Collaborations

Between 10/2009 and 09/2010,

1. Collaborate with the NJ Council on Physical Fitness and Sports to offer state-wide Healthy Community Development trainings for community teams aimed at increasing access to physical activity and healthy food opportunities.
2. Collaborate with DOE CSH to conduct trainings and support staff on the use of School Health Index to assess current school policies and practices in 8 areas of health.

2. Collaborate with NJ Council on Physical Fitness and Sports

Between 10/2009 and 09/2010, By September 2010 collaborate with the NJ Council on Physical Fitness and Sports to offer state-wide Healthy Community Development trainings for community teams aimed at increasing access to physical activity and healthy food opportunities.

3. Collaborate with DOE CSH

Between 10/2009 and 09/2010, By September 2010, collaborate with DOE CSH to conduct trainings and support staff on the use of School Health Index to assess current school policies and practices in 8 areas of health.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Community Partnership for Healthy Adolescents

Between 10/2009 and 09/2010, Child and Adolescent Health will provide oversight of the Community Partnership for Healthy Adolescents grantees to 3 New Jersey communities that have identified nutrition and physical activity as a priority adolescent health issue to address.

Annual Activities:

1. Monitor Grantees

Between 10/2009 and 09/2010, By September 2010, monitor reports for three Community Partnership for Healthy Adolescents grantees.

2. Increase Partner Base

Between 10/2009 and 09/2010, Annually, increase the number of statewide organizations from 45 to 60 that have signed partner agreements to collaborate on solutions to address obesity in the state.

Essential Service 5 – Develop policies and plans

Objective 1:

Obesity Action Plan

Between 10/2009 and 09/2010, ONF and State Partners will develop 1 NJ Nutrition, Physical Activity and Obesity State Plan.

Annual Activities:

1. Create Goals and Objectives

Between 10/2009 and 09/2010, The ONF will collaborate with state partners to review data, target disparate populations and create goals, objectives and strategies that reflect policy and environmental change.

2. Develop Plan

Between 10/2009 and 09/2010, Develop and submit a nutrition, physical activity and obesity plan that meet CDC State Obesity Plan index criteria.

3. Provide Input for Healthy New Jersey 2020

Between 10/2009 and 09/2010, Provide input into the development of Healthy New Jersey 2020.

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

State Program Strategy:

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

State Program Strategy:

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

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

Program Primary Strategic Partners:

Internal

NJ Office of Cancer Control
NJ Commission on Cancer Research

External

CDC, National Program of Cancer Registries
American Cancer Society

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

Program Evaluation Methodology:

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

State Program Setting:

Community based organization, Local health department, Senior residence or center

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Public Health Representative 1
 State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1
Total FTEs Funded: 1.00
National Health Objective: HO 3-1 Overall Cancer deaths

State Health Objective(s):

Between 01/2009 and 12/2009,

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 67% in 2005.
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 6.9.
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 recto sigmoid per 100,000 standard population to 12.3 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 17.0 for the total population. (1970 standard)
10. Reduce the percentage of oral cancer diagnosed in the late regional and distant stages of disease to 67.0 percent for all males and 51% for females.

Baseline:

Baseline and Data Source:

New Jersey Cancer Mortality Rates and Counts

	2002-2006		2006	
	Rate	Count	Rate	Count
1) Female Breast	27.4	7,246	27.0	1,450
3) Female Cervical	2.6	663	2.9	148
5) Male Prostate	24.5	4,238	21.2	764
6) Both Sexes Colorectal	20.1	9,315	18.7	1,773
8) Both Sexes Lung	49.2	22,548	47.3	4,403

Rates are per 100,000 and age-adjusted to the 2000 US Std Population standard.
 New Jersey cancer mortality data were obtained through the NCI's Surveillance, Epidemiology, and End Results (SEER) Program from the National Center for Health Statistics (NCHS) and tabulated using SEER*Stat.
 Underlying mortality data provided by NCHS (www.cdc.gov/nchs).

New Jersey Invasive Incidence Rates and Counts

	2002-2006		2006	
	Rate	Count	Rate	Count
4) Female Invasive Cervical	9.2	2,183	9.4	447

7) Both Sexes Invasive Rectum and Recto sigmoid	15.5	7,123	14.2	1,332
9) Both Sexes Invasive Melanoma	20.5	9,348	21.4	1,976

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

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

	2002-2006	2006
2) Female Breast	28,075 68.2%	5,845 69.5%

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

Male Oral Cavity & Pharynx	1,856	60.3%	384	57.5%	1,856
Female Oral Cavity & Pharynx	761	48.8%	148	45.0%	761

Data Source:

New Jersey cancer incidence data were taken from the January 2008 analytic file of the New Jersey State Cancer Registry. All the counts and rates were tabulated using SEER*Stat Version 6.5 (<http://www.seer.cancer.gov/seerstat/>), a statistical software package distributed by the National Cancer Institute.

State Health Problem:

Health Burden:

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

Number: 8,414,350

Ethnicity: Hispanic

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

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 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:

Number: 4,000,000
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 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
Location: Entire state
Target and Disparate Data Sources: New Jersey Center for Health Statistics

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

Total Current Year Funds Allocated to Health Objective: \$120,005
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$0
Funds to Local Entities: \$0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 50-74% - Significant source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Impact Objective: Assess the Burden of Cancer in New Jersey

4-Between 01/2009 and 12/2009, The New Jersey State Cancer Registry will publish 1 report of cancer burden including incidence and mortality for various demographic groups including minorities.

Completed. Published Adolescent and Young Adult Cancer in New Jersey, 1979-2006

2-1. By December 31, 2008, increase the percentage of cancer cases with valid follow up information to 95% or higher complete.

Completed.

Annual Activities:

1. In June 2009, 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.

Completed. Gold certification awarded April 2009

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.

Completed.

Essential Service 2 - Diagnose and Investigate:

Impact Objective: Investigate New Cancer Cases

Identify all newly diagnosed cancers in New Jersey in accordance with national standards.

Completed.

Annual Activity: Obtain NAACCR gold Certification in June 2009.

Completed.

Essential Service 4 - Mobilize partnerships:

Impact Objective: Develop Partnerships

Participate in national workgroups to improve cancer surveillance.

Annual Activity: Between 01/2009 and 12/2009, Staff will have participated in at least three (3) national workgroups to improve cancer surveillance activities.

Staff participated in the NAACCR's Uniform Data Standards Committee Dr Maria Halama, Dr. Kevin Henry and Ms. Xiaoling Niu on NAACCR's Data Use and Research Committee Survival Analysis Work Group and Dr. Kevin Henry on the GIS Komen Foundation Grant Advisory Committee

Essential Service 5 - Develop policies and plans:

Impact Objective: Provide Data for Comprehensive Cancer Control Plan

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: By December 2008 provide data to the Office of Cancer Control and Prevention for incorporation into the Comprehensive Cancer Control Plan.

Completed.

Essential Service 9 - Evaluate health programs:

Impact Objective: Evaluate Cancer Control Efforts

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: To provide data to the Office of Cancer Control and Prevention for incorporation into the Comprehensive Cancer Control Plan.

Completed.

Essential Service 10 - Research:

Impact Objective: Conduct Research Studies

On annual basis and through December, 2009 to participate at all levels in cancer research in New Jersey with state and national collaborators.

Annual Activity Objective for Desired Impact Objective: Between 01/2009 and 12/2009 to participate in at least two (2) research studies using New Jersey data.

Participated: Cancer Survival Disparities by Race/Ethnicity and Socioeconomic Status in New Jersey (PI Xiaoling Niu, MS, CES, NJDHSS) paper published in the journal Participating . Race and Risk Factors for Early/Aggressive Breast Cancer (PI Christine Ambrosone, PhD, Roswell Park Cancer Institute)

State Program Setting:

State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Public Health Representative 1
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1

Total FTEs Funded: 1.00

National Health Objective: HO 3-1 Overall Cancer deaths

State Health Objective(s):

Between 01/2009 and 12/2009,

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 67% in 2005.
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 6.9.
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 recto sigmoid per 100,000 standard population to 12.3 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 17.0 for the total population. (1970 standard)
10. Reduce the percentage of oral cancer diagnosed in the late regional and distant stages of disease to 67.0 percent for all males and 51% for females.

Baseline:

**Baseline and Data Source:
New Jersey Cancer Mortality Rates and Counts**

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

Rates are per 100,000 and age-adjusted to the 2000 US Std Population standard. New Jersey cancer mortality data were obtained through the NCI's Surveillance, Epidemiology, and End Results (SEER) Program from the National Center for Health Statistics (NCHS) and tabulated using SEER*Stat. Underlying mortality data provided by NCHS (www.cdc.gov/nchs).

New Jersey Invasive Incidence Rates and Counts

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

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

New Jersey Invasive Incidence Rates and Counts

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

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

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

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

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

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

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

Data Source:

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

State Health Problem:

Health Burden:

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

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

Target Population:

Number: 8,414,350

Ethnicity: Hispanic

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

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 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:

Number: 4,000,000

Ethnicity: Hispanic

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

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 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
Location: Entire state
Target and Disparate Data Sources: New Jersey Center for Health Statistics

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

Total Current Year Funds Allocated to Health Objective: \$120,005
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$0
Funds to Local Entities: \$0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 3 – Inform and Educate

Objective 1:

Increase Percentage of Follow-Up

Between 01/2009 and 12/2009, The New Jersey State Cancer Registry will publish 1 report of cancer burden including incidence and mortality for various demographic groups including minorities.

Annual Activities:

1. Publish Cancer Burden Report

Between 01/2009 and 12/2009,

1. 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. **Annual Activity:** Obtain NAACCR gold Certification in June 2009.

Completed.

2. Publish at least one report of cancer burden including Incidence and mortality for various demographic groups including minorities. **Completed. Published Adolescent and Young Adult Cancer in New Jersey, 1979-2006**

Essential Service 4 – Mobilize Partnerships

Objective 1:

Participate in National Work Groups

Between 01/2009 and 12/2009, the New Jersey State Cancer Registry will increase the number of national workgroups to participate in from 2 to 3.

Annual Activities:

1. Participate in National Workgroups

Between 01/2009 and 12/2009, Staff will have participated in at least three (3) national workgroups to improve cancer surveillance activities.

State Program Title: Public Health Infrastructure Development

State Program Strategy:

Program Goals: To foster accessible and high-quality health promotion and disease prevention services by building and strengthening the local public health system and improving the performance and practice of local health departments.

Program Health Priority: To assure a competent local public health workforce and to build core organization capacities of local health departments.

Program Primary Strategic Partners:

Internal: NJ Department of Health and Senior Services -- All Divisions and Programs

External: NJ Health Officer's Association, NJ Association of County Health Officers, NJ Environmental Health Association, NJ Society for Public Health Education, NJ State Nurses Association, NJ Association of Public Health Nurse Administrators, PHACE (Public Health Association's Collaborative Effort), Rutgers University/Cook College, University of Medicine and Dentistry of NJ/School of Public Health, NACCHO, ASTHO, NALBOH, CDC.

Program Evaluation Methodology: Number of candidates for NJ public health officials licensure who pass the State examination, number of licensed officials who meet workforce development requirements for annual license renewal, number of public health professionals who use the NJ Learning Management Network to access education/training, number of education/training programs attended, number of local health departments that meet the standards set forth at *N.J.A.C 8:52, Public Health Practice Standards of Performance for Local Boards of Health in New Jersey*.

State Program Setting:

Local health department, State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Research Scientist 2

State-Level: 50% Local: 50% Other: 0% Total: 100%

Position Title: Director

State-Level: 50% Local: 50% Other: 0% Total: 100%

Position Title: Research Scientist 1

State-Level: 50% Local: 50% Other: 0% Total: 100%

Position Title: Program Development Specialist

State-Level: 50% Local: 50% Other: 0% Total: 100%

Position Title: Contract Administrator 2

State-Level: 50% Local: 50% Other: 0% Total: 100%

Position Title: Principal Tech MIS

State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 6

Total FTEs Funded: 6.00

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

State Health Objective(s):

Between 10/2009 and 09/2010,

1. Increase the proportion of local health department public health professionals that participate in competency-building education and training through the NJ Learning Management Network from 47 percent to 60 percent.

2. Assure that the proportion of public health professionals meeting competency-based education and training for active NJ licensure is maintained at 100 percent.

Baseline:

1. Proportion of local health department public health professionals that participate in competency-building education and training through the NJ Learning Management Network. Baseline 2009: 47 percent.

2. Proportion of public health professionals meeting competency-based education and training for active NJ licensure. Baseline 2008: 100 percent.

Data Source:

NJ Learning Management Network and NJ Public Health Officials Licensure databases.

State Health Problem:

Health Burden:

New Jersey has 110 local health departments that provide services to over eight million people. These local health departments employ over 3,300 professionals having the responsibility to promote and protect the public's health. While many participate in the NJ Learning Management Network to access education and training which assures competence within their respective areas of responsibility, there continues to be room for improvement in the proportion that participate and in the breadth and depth of available educational opportunities.

Target Population:

Number: 3,300

Infrastructure Groups: Other

Disparate Population:

Number: 1

Infrastructure Groups: Other

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Model Practices Database (National Association of County and City Health Officials)

Other: N.J.A.C. 8:7, Licensure of Persons for Public Health Positions

N.J.A.C. 8:52, Public Health Practice Standards of Performance for Local Boards of Health in New Jersey

National Public Health Model Performance Standards (Centers for Disease Control and Prevention)

Core Competencies for Public Health Professionals (Council on Linkages Between Academia and Public Health Practice)

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

Total Current Year Funds Allocated to Health Objective: \$402,380

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 8 – Assure competent workforce

Objective 1:

Assure a competent workforce through professional licensure

Between 10/2009 and 09/2010, the Office of Public Health Infrastructure will evaluate 100 percent of Health Officers and Registered Environmental Health Specialists to ensure that they meet NJ standards for professional licensure.

Annual Activities:

1. Public Health Professional Licensure

Between 10/2009 and 09/2010,

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.
2. Pursuant to the provisions of *N.J.A.C. 8:7, Licensure of Persons for Public Health Positions*, review continuing education credits and, if appropriate and adequate, issue license renewals for Health Officers and Registered Environmental Health Specialists and update licensing databases.
3. Review and revise licensing examination which is used for Registered Environmental Health Specialists (REHS).
4. Review and revise the licensing examination which is used for Health Officers (HO).
5. Conduct examinations for licensure three times per year and evaluate licensee success in meeting criteria for re-licensure annually.
6. Collaborate with and provide technical support to Rutgers University/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.

Objective 2:

Assure the provision of workforce development opportunities

Between 10/2009 and 09/2010, the Office of Public Health Infrastructure will increase the percent of local health department professional staff who have participated in competency-building education and training through the NJ Learning Management Network from 47 percent to 60 percent.

Annual Activities:

1. Access to Competency-based Education and Training Opportunities

Between 10/2009 and 09/2010, the New Jersey Learning Management Network will serve as a sophisticated web-based system that provides one stop access to a wide variety of public health education opportunities made available by NJ and nation-wide organizations for more NJ's 110 local health departments, 3,300 governmental public health professionals and over 11,000 other workers within the statewide public health system.

1. Participate in the management of a memorandum of agreement with Rutgers University for the maintenance and further development of the NJ Learning Management Network as the premier portal to public health education and training.
2. Market the value of the NJ Learning Management Network to the local public health professional workforce and increase active membership and participation in education and training opportunities.
3. Develop and implement a Continuing Education Providership Program that assures high quality education to public health professionals and attracts new public health course sponsors.

4. Review and approve course applications submitted by course sponsors to assure that educational programs meet State standards.

National Health Objective: HO 23-11 Performance standards

State Health Objective(s):

Between 10/2008 and 12/2010, increase the proportion of local public health agencies that meet state performance standards for essential public health services through public health partnerships.

Baseline:

Increase the percentage of local health departments that perform the following core public health functions from 51.9 % (Assessment) to 75%; 55.1 % (Policy Development) to 75%; from 73.7% (Assurance) to 90%.

Data Source:

NJ Local Health Evaluation Report
NJ Performance Evaluation Reports
NJ Community Health Improvement Plans
NACCHO Profile of New Jersey Local Health Departments
Other targeted survey and data collection instruments

State Health Problem:

Health Burden:

New Jersey has 110 local health departments which provide services to more than eight million people. Inconsistencies in the capacity of the local government public health system to meet national performance standards continue to exist, although not as dramatically as in previous years. The development of partnerships between local health departments (Governmental Public Health Partnerships) and broader health partnerships (Community Public Health Partnerships) in every county for the purpose of assuring improved health outcomes, with a special emphasis on preventing chronic disease, reducing health disparities and improving access to care, are important developments in meeting national performance standards and accelerating our ability to improve population health.

Target Population:

Number: 110
Infrastructure Groups: State and Local Health Departments

Disparate Population:

Number: 1
Infrastructure Groups: State and Local Health Departments

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Model Practices Database (National Association of County and City Health Officials)

Other: NJAC 8:52, Public Health Practice Standards of Performance for Local Boards of Health in New Jersey
National Public Health Model Performance Standards (Centers for Disease Control and Prevention)

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

Total Current Year Funds Allocated to Health Objective: \$402,379
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$0
Funds to Local Entities: \$0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 4 – Mobilize Partnerships

Objective 1:

Collaborate with statewide partners to identify effective solutions to public health priorities

Between 10/2009 and 09/2010, the Office of Public Health Infrastructure will maintain 6 collaborative initiatives undertaken with statewide partners.

Annual Activities:

1. Partner with PHACE (Public Health Associations' Collaborative Effort

Between 10/2009 and 09/2010, partner and collaborate with PHACE (Public Health Associations Collaborative Effort) which is an association comprised of the leadership of the Department's public health partners in various activities which will promote and nurture the development of partnerships for the purpose of assuring improved health outcomes.

2. Partnership with NJ Health Officers Association

Between 10/2009 and 09/2010, partner and collaborate with the NJ Health Officers Association and the NJ Association of County Health Officers in various activities which will promote and nurture the development of partnerships for the purpose of assuring improved health outcomes.

Essential Service 5 – Develop policies and plans

Objective 1:

Complete the State Public Health System Assessment

Between 10/2009 and 09/2010, the Office of Public Health Infrastructure will conduct 1 National Public Health Performance Standards Program, Statewide Public Health System Performance Assessment, in partnership with public health stakeholders throughout NJ.

Annual Activities:

1. Prioritize the results of the New Jersey Statewide Public Health System Performance Assessment

Between 10/2009 and 08/2010,

1. Report the results of the New Jersey Statewide Public Health System Performance Assessment, conducted in 2009, to the public health community.
2. Examine how other states have used the results of their Statewide Assessments to promote quality improvement models for potential system improvement activities in New Jersey.
3. Prioritize those Essential Public Health Services that quality improvement activities should be focused on, through completion of the Statewide Public Health System Performance Assessment Supplemental Questionnaire – Priority of Model Standards.
4. Prepare a report to the Commissioner of the NJDHSS containing results of the Assessments and prioritized recommendations for improvement.

Essential Service 9 – Evaluate health programs

Objective 1:

Support the evaluation of county-based Public Health Partnerships

Between 01/2010 and 12/2010, the Office of Public Health Infrastructure will provide technical assistance to facilitate the evaluation of the county-wide community health improvement plans (CHIPs) to 21 community public health partnerships.

Annual Activities:

1. CHIP Evaluation Workgroup

Between 01/2010 and 12/2010, a workgroup comprised of Public Health Partnership facilitators and members will create a process with representatives of the Office of Public Health Infrastructure to identify and implement a methodology to be used by the 21 county-based Community Health Partnerships to evaluate CHIPs in NJ.

State Program Title: Quality Emergency Medical Services Care

State Program Strategy:

State Program Strategy:

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

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

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

It is estimated that New Jersey's population in 2005 was 8,703,150. It is also estimated that the state's EMS system responds to over 800,000 requests annually. In 2007, the advanced life support (ALS) component of the state's EMS system responded to over 468,510 requests for assistance and rendered care for 178,218 patients. Of these patients, over 44,689 patients were treated for heart ailments and 40,682 were treated for respiratory distress.

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

Primary Strategic Partners:

Internal

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

External

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

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

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

State Program Setting:

State health department

FTEs (Full Time Equivalent):

Full Time Equivalent positions that are funded with PHHS Block Grant funds.

Position Title: Regulatory Officer

State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Title: Public Health Representative 2

State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Title: Public Health Representative 2

State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Title: Customer Service

State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Title: Customer Service

State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 5

Total FTEs Funded: 5.00

National Health Objective: HO 1-11 Emergency Medical Services

State Health Objective(s):

Between 01/2000 and 12/2010, There are no specific EMS-related objectives in Healthy New Jersey 2010. However, the mission of the Department is to foster accessible and high-quality health for all New Jerseyans. This goal is further emphasized by the mission statements of the Office of Emergency Medical Services – to reduce mortality and morbidity associated with accident or sudden illness; and the Division of Health Infrastructure Preparedness and Emergency Response in the provision of strategic and operational leadership and direction, coordination, provision of services and assessment of activities to ensure state and local readiness for public health threats and emergencies.

Baseline:

8,703,150 state population

Data Source:

NJ Department of Health and Senior Services – Center for Health Statistics

State Health Problem:

Health Burden:

When primary and secondary prevention efforts fail, and people become victims of illness, intentional or unintentional injury, they enter the state's emergency medical services (EMS) system. EMS responds to all requests for prehospital medical assistance, including trauma, cardiac and medical emergencies,

which can affect persons of all age groups and socio-economic status. A properly organized EMS system contains many components working in a coordinated manner.

The prevalence of chronic illness in ethnic and low socioeconomic populations as well as those at either extreme of the life cycle has been well documented from a national perspective. As New Jersey's population ages, the requests for medical assistance will only increase. The Emergency Department, which serviced 3,379,968 patients in 2008, and the EMS system remain as the safety net for the entire healthcare system.

It is also estimated that the state's EMS system responds to over 800,000 requests annually. In 2007, the advanced life support (ALS) component of the state's EMS system responded to over 468,510 requests for assistance and rendered care for 178,218 patients. Of these patients, over 44,689 patients were treated for heart ailments and 40,682 were treated for respiratory distress.

Target Population:

Number: 8,703,150

Ethnicity: Hispanic, Non-Hispanic

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

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 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:

Number: 3,000,000

Ethnicity: Hispanic

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

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 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

Location: Entire state

Target and Disparate Data Sources: US Census Data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

US Department of Health and Human Services, HRSA, MCHB, Emergency Medical Services for Children Program performance measures

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

Total Current Year Funds Allocated to Health Objective: \$476,164

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

50-74% - Significant source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

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

Essential Service 3 – Inform and Educate

Objective 1:

Increase the number of qualified prehospital providers

Between 10/2009 and 09/2010, Office of Emergency Medical Services (OEMS) will increase the number of EMT-B instructors by 5% over the 2009 instructional cadre. from 483 to 507.

Annual Activities:

1. Increase the number of qualified prehospital providers

Between 10/2009 and 09/2010,

1. Between 11/2009 and 04/2010, OEMS will contract with the National Association of Emergency Medical Services Educators to conduct a multi-day instructor training institute for prospective EMT-B instructors in New Jersey.
2. Between 02/2010 and 10/2010, OEMS will conduct a series of instructor workshops for current EMT-B instructors in New Jersey to update the instructor cadre on the national scope of practice and education standards.
3. Between 12/2009 and 02/2010, OEMS will support the hybrid distance learning/traditional EMT-Basic program conducted by Camden County College, for promotion statewide
4. Between 01/2010 and 07/2010, OEMS will institute a streamlined, web-based process to facilitate the recertification of current EMT-B personnel.
5. Between 10/2009 and 12/2009, OEMS will conduct objective audits for all 42 EMT-B basic education programs.
6. Between 01/2010 and 08/2010, OEMS will conduct on-site audits of 50% of all EMT-B refresher continuing education programs.

Objective 2:

Certification and Operational Regulations

Between 10/2009 and 09/2010, OEMS will publish 1 comprehensive set of certification and operational regulations to reflect current national clinical practices for the NJ EMS system.

Annual Activities:

1. Adopt comprehensive certification and operational regulations for the EMS system

Between 10/2009 and 09/2010,

1. Between 11/2009 and 12/2009, OEMS will circulate to all statewide stakeholders updated proposed certification and recertification regulations for comment.
2. Between 01/2010 and 02/2010, OEMS to prepare the refined certification and recertification regulations for proposal.
3. Between 06/2010 and 08/2010, OEMS to review all written responses sent to the Department during the open public comment period on the proposed certification and recertification regulations.
4. Between 08/2010 and 10/2010, OEMS to propose for adoption the certification and recertification regulations.
5. Between 01/2010 and 02/2010, OEMS will circulate to all statewide stakeholders updated proposed certification and recertification regulations for comment.
6. Between 04/2010 and 05/2010, OEMS to prepare the refined certification and recertification regulations for proposal.
7. Between 06/2010 and 08/2010, OEMS to review all written responses sent to the Department during the open public comment period on the proposed certification and recertification regulations.
8. Between 08/2010 and 10/2010, OEMS to propose for adoption the certification and recertification regulations

2. Republish updated regulations for certification and operations

Between 10/2009 and 09/2010, Due to the release of the new national EMS standards, all four chapters of our regulations were adopted without change. OEMS staff is in the process of preparing an updated set of regulations for publication.

