# New Jersey

# STATE HEALTH IMPROVEMENT PLAN 2012 - 2015

HEALTHY NEW JERSEY

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***Public health has been defined as "what we, as a society, do collectively to assure the conditions for people to be healthy".[1]***

***Indicators are available for most steps in the process to health improvement—that is, indicators of resources; of capacities; of interventions, processes, and policies; of health outcomes; and performance.[2]***

***Accurate, timely, locally relevant information is crucial for the implementation of population-focused interventions of established effectiveness and for implementing and evaluating promising new strategies.[2]***

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[1] IOM (Institute of Medicine). 1988. *The Future of Public Health*. Washington, DC: National Academy Press; IOM. 2003. *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press.

[2] IOM (Institute of Medicine). 2011. *For the Public's Health: The Role of Measurement in Action and Accountability.* Washington, DC: The National Academies Press.

## CONTENTS

## ACKNOWLEDGEMENTS

This plan was developed through the efforts of New Jersey Department of Health and public health partners that participated in the development of Healthy New Jersey 2020.

***HNJ2020 Coordinating Committee***

Office of Policy and Strategic Planning
Center for Health Statistics

***HNJ2020 Action Project & Regional Meeting Steering Committee***

Office of Policy and Strategic Planning
Center for Health Statistics
Chronic Disease Program
Office of Local Public Health
Office of Minority and Multicultural Health

***HNJ2020 Workgroup***

Office of Policy and Strategic Planning
Center for Health Statistics
Family Health Services
Asthma Awareness and Education Program
Chronic Disease Program
Comprehensive Tobacco Control Program
Diabetes Prevention and Control Program
Heart Disease and Stroke Prevention Program
Office of Nutrition and Fitness
WIC Services
Office of Local Public Health
Office of Minority and Multicultural Health
Office of Health Care Quality Assessment
Communicable Disease Service
Cancer Epidemiology Services
HIV/AIDS, TB and STD Services
Emergency Preparedness
Aging and Community Services
Maternal and Child Health Epidemiology Program
Consumer, Environmental and Occupational Health Service

***Interagency Partners***

NJ Department of Education
NJ Department of Environmental Protection
NJ Department of Human Services
NJ Department of Law and Public Safety

***Non-government Partners***

Violence Institute of New Jersey at UMDNJ
New Jersey Poison Information and Education System

***Regional Meeting Participants***

See Appendix A for a list of participating organizations

## EXECUTIVE SUMMARY

The New Jersey Department of Health's (DOH) mission is

***To improve health through leadership and innovation***

Through its State Health Improvement Plan (SHIP), Healthy New Jersey 2020 (HNJ2020), the DOH works to achieve its stated mission. The SHIP is one of the instruments used to describe and promote the strategies in place to accomplish statewide health improvement goals. Using innovative strategies, best and evidence based practices, the DOH is committed to leading efficient and effective initiatives with multidisciplinary partners statewide to improve the health of all New Jerseyans.

In 2009, the DOH reinvigorated its initiative to strengthen data use to inform decision making and resource allocation, program development and implementation. The federal Healthy People framework was adopted to develop a plan designed specifically for New Jersey (HNJ2020). The DOH used a comprehensive approach that included developing specific objectives and targeted measures aligned with the needs of the state's diverse population. Only measures with valid, quality data sources were selected for inclusion.

Healthy New Jersey 2010, the State's health assessment laid the groundwork for DOH's engagement with public health system partners, provision of data and information to multidisciplinary stakeholders, and for the overall state health improvement planning process.

The development of HNJ2020 was the result of a multiyear process that reflects input from a diverse group of DOH stakeholders. Through this process, DOH provided state health assessment data, analysis, leadership and facilitated stakeholder workgroups to gain consensus on high-priority health issues. With this consensus, the State could move forward with implementation and actions to help improve health in these areas.

The SHIP includes over one hundred health improvement objectives to date. The DOH is working to achieve all the objectives simultaneously. However, the HNJ2020 leading health indicators (LHI2020) are the focus of the SHIP for 2012 to 2015. LHI2020 promotes collaboration across sectors and guides DOH investment in State initiatives. The SHIP is an actionable document that allows for surveillance, evaluation, and subsequent revisions and adjustments to plans as needed. This flexibility helps ensure that the assessment of objectives, strategies and priorities occur regularly during designated periods of time and accommodation for changes related to emerging health issues and trends. The DOH's dissemination of population health data and sharing of best practices will provide New Jerseyans with information and tools necessary to improve health statewide.

### *SHIP and Strategic Planning*

The overarching goals of the SHIP are tied to the DOH's Strategic Planning goals (See Appendix A: DOH Strategic Plan 2012-2015 Strategy Map) and the Department's central goal of *leading proactive efforts to drive measurable improvements in the health of the people of New Jersey.* The SHIP aligns directly with the related DOH Strategic Plan (SP) objective to assess and report progress on Healthy New Jersey 2020

(Objective A-3) which focuses on using evaluation to assess progress on Healthy New Jersey 2020 and using the results of that assessment as the basis for regular updates on progress.

Further, the SHIP advances the strategic planning goal to use evaluation to demonstrate the value of and guide investment in DOH programs. This objective focuses on the importance of communicating the value of Public Health Programs, evaluating outcomes to guide future investments in DOH programming; and ensuring Department program investments focus on optimizing the benefit of DOH programs at an appropriate cost.

### *Defining the SHIP Process*

A detailed review of the overall SHIP development process, which includes examination of state health assessment data, is provided. Internal activities to gather and evaluate existing data sources as well as to identify new ones were conducted. Best practices were illustrated using successful DOH interventions as an example. The promoted approach for health improvement activity statewide includes the following steps:

Step 1 – Identify, with data, the health improvement needed, establish a baseline, and set a target for improvement

Step 2 - Brainstorm innovative strategies, best practices and evidence-based approaches to address the need

Step 3 - Apply selected strategies to high risk populations

Step 4 - Measure the impact of intervention and monitor the data on a set schedule

Step 5 - Make adjustments to the prevention strategy based on findings

### *Engaging Stakeholders in the SHIP*

Stakeholder engagement was conducted through a series of meetings with multidisciplinary partners statewide. An overview of the State health assessment was provided to participants and feedback was received regarding the overall SHIP development process. Some key themes from the meeting series included:

- Conducting surveillance of outcomes data in priority health areas is essential to improving them.
- Understanding the relevance of health where we live, work and play is important in developing policies and applying strategies that facilitate making the healthy choice, the easy choice for all.
- There are numerous opportunities for collaboration in programming, delivery of interventions and services - locally, regionally, and across the state.
- Clear communication of health priorities, strategies for reducing the burden of disease, and promoting approaches to preserve health is essential to resolving specific health problems in targeted as well as general populations.

In addition, the meeting series provided a forum for receiving input regarding the leading health indicators. This activity represented a major addition to the framework historically employed by the agency. Selection of these five priority health areas was conducted through a two-part survey methodology and yielded the following:

- Access to Health Care

- Improve Birth Outcomes
- Increase Childhood Vaccination
- Reducing the Burden of Heart Disease & Stroke
- Prevent Obesity

DOH programs have used the SHIP as the foundation for the development of topic-specific health improvement plans and activities statewide. The Chronic Disease Prevention and Control Services' *Partnering for a Healthy New Jersey: Chronic Disease & Health Promotion Plan 2013 - 2018*, the *Maternal and Child Health Block Grant,* and the *New Jersey Obesity Prevention Action Plan* each:

- Communicates the public health relevance of the priority health issue;
- Identifies essential partners;
- Maps a plan for achieving the targeted health improvement goals,
- Describes implementation activities underway; and
- Defines required institutional policy changes when and where applicable

In addition the Delivery System Reform Incentive Payment (DSRIP) Program is one component of the New Jersey's Comprehensive Medicaid Waiver as approved by the Centers for Medicare & Medicaid Services (CMS). DSRIP is a demonstration program designed to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower costs by transitioning hospital funding to a model where payment is contingent on achieving health improvement goals.

Hospitals may qualify to receive incentive payments for implementing quality initiatives within their community and achieving measurable, incremental clinical outcome results demonstrating the initiatives' impact on improving the New Jersey health care system.

DOH's SHIP goals and implementation approaches are multifaceted. However, the overarching strategies employed fall into one or more of the following categories:

- Collaboration
- Education and Outreach
- Health Information Technology Advancements/ Health Information Exchange
- Institutional Policy and Best Practice Implementation
- Regional Planning Collaboratives
- Performance Measurement/Surveillance

Numerous accomplishments have resulted from the topic specific health plan activities and are summarized within. Future cyclical evaluations of ongoing SHIP activities will assess progress towards achieving objectives and allow for adjustments where indicated.

### *Monitoring SHIP Activities & Next Steps*

A regular evaluation of SHIP activities will occur through a series of meetings planned to measure progress, to assess quality improvement (QI) opportunities and implement relevant QI projects, and to make any required changes to implemented strategies.

A focus on SHIP performance measures will require a review of the most current data as well as an evaluation of progress toward achievement of set goals. Through facilitated discussions on implementation activities, results, partnerships, successes and challenges, the Department will be well-positioned to plan next steps in improving health in established priority areas.

While the infrastructure for health improvement surveillance has historically existed at the Department, the combination of surveillance and planning, with a focus on QI methodology and structure, promises to yield measurable results that will strengthen future health planning activities and foster a results-based health improvement culture throughout the agency and among its stakeholders.

### *SHIP Strategies*

Strategies for improving outcomes among the leading health indicators are outlined below. Further details regarding their implementation and progress to date are provided within the body of this report.

*Access to Health Care*

1. Emphasize stakeholder collaboration to implement the Chronic Disease and Health Promotion Plan
2. Develop the New Jersey Health Information Network (NJHIN) to facilitate health information exchange regionally and statewide
3. Promote Regional Planning Collaboratives
4. Make primary care accessible to all New Jersey residents
5. Support Medicaid Accountable Care Organizations (ACOs)

*Improving Birth Outcomes*

1. Implement the Improving Pregnancy and Birth Outcomes Initiative
2. Facilitate targeted quality improvement activities among the Maternal and Child Health Consortia
3. Support regional and cross-jurisdictional collaboration to facilitate research and best practice interventions
4. Administer the New Jersey Baby Friendly Hospital Initiative
5. Facilitate Medicaid incorporation of performance measures in its contracts with managed care organizations
6. Expand the Newborn Screening Program

*Childhood Immunization*

1. Implement targeted vaccine programs

2. Enhance the New Jersey Immunization Information System (NJIIS)

*Heart Disease and Stroke*

1. Promote collaboration between both traditional and nontraditional partners
2. Conduct surveillance and evaluation of heart disease and stroke outcomes
3. Conduct outreach and education on the best heart disease and stroke treatment practices
4. Implement targeted chronic disease management and health promotion activities

*Obesity*

1. Promote collaboration in multidisciplinary settings through ShapingNJ
2. Facilitate increased access to healthy food and physical activities statewide
3. Implementation obesity prevention strategies in multiple settings
4. Implement targeted obesity prevention and reduction in high risk communities
5. Provide essential services through the Women, Infants, and Children (WIC) program
6. Promote the Senior Farmer's Market Nutrition Initiative

Through the SHIP, DOH will continuously identify, analyze, and address health problems statewide. The SHIP strategies help to focus efforts and monitor accomplishments along the way. A structured and regular review of the agency-led activities will provide numerous opportunities for improvement.

Using quality improvement methods, DOH will monitor, evaluate and update the SHIP on a three year cycle. Emerging health issues will be evaluated regularly to ensure they are addressed with the same structure and deliberate planning as the long-standing health issues identified through Healthy New Jersey surveillance and data collection activities.

## INTRODUCTION

The New Jersey Department of Health (DOH) is committed to ensuring New Jerseyans are among the healthiest people in the nation. The New Jersey State Health Improvement Plan (SHIP) establishes how the DOH and communities will work together to improve the health of the state's population.

The Healthy New Jersey (HNJ) initiative is the state's health assessment and improvement plan. It serves as the health promotion and disease prevention planning model; providing the foundation as well as an action plan for the decade. As in past planning cycles, HNJ2020 is the result of a multiyear process that reflects input from a diverse group of individuals and organizations. Through HNJ, DOH undertakes a comprehensive statewide assessment process to inform health improvement and strategic planning. The collaboration and insight of various stakeholders, partners, and subject matter experts are crucial to moving these efforts forward.

## STATEWIDE PLANNING PROCESS

DOH initiated the HNJ2020 planning process in 2009, which set in motion the State Health Improvement Plan (Figure 1). DOH senior leadership assembled a working group as well as the HNJ Advisory Committee of senior staff members representing all areas of the Department to reaffirm and recommit to the HNJ process.

HNJ adapted the Healthy People vision, mission, and goals:

### Vision

A state in which all people live long, healthy lives.

### Mission

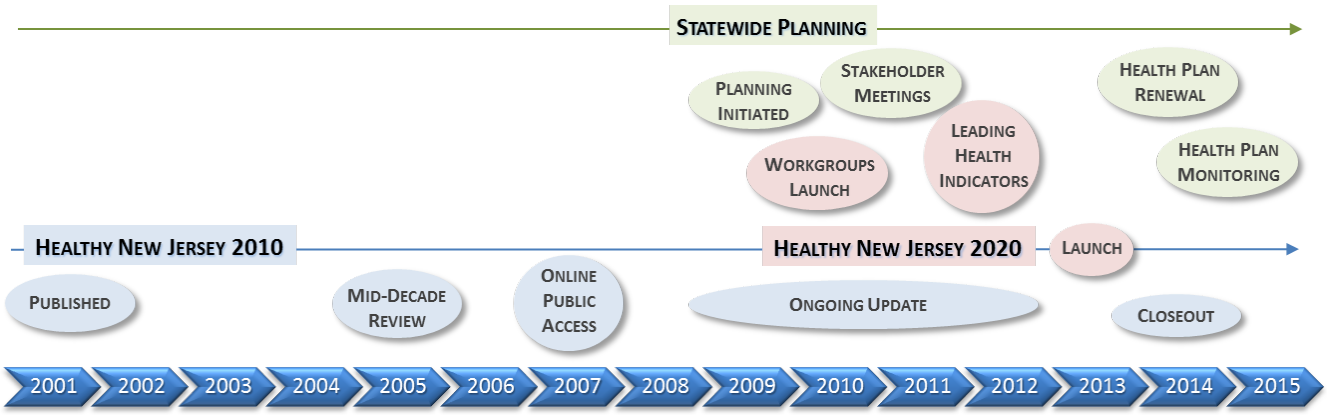
Healthy New Jersey 2020 strives to:

- Identify statewide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the State and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

### Overarching Goals

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve health for all people.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

## FIGURE 1: STATEWIDE PLANNING PROCESS




## HNJ WORKGROUP

DOH's senior leadership identified staff to represent Departmental program efforts on the Healthy New Jersey work group. The workgroup was charged with drafting state health improvement plan objectives by evaluating the state health assessment data and activities. The commitment to transform Healthy New Jersey into a tool for not only identifying priority health areas, but also for driving state actions to improve health outcomes was clearly communicated.

For over a year, the HNJ workgroup met regularly to review existing health data, evaluate trends, identify data gaps related to long-standing as well as emerging health issues, and to set priorities that would drive state health improvement planning for years to come.

The workgroup structure is shown in Figure 2 below. Specific activities of the workgroup included:

- Selecting the overall HNJ2020 objectives
- Providing baseline data for each objective
- Setting associated health improvement targets
- Providing the HNJ2020 surveillance schedule
- Describing how the data is used to drive program activities

The intention was that the collection of this information would facilitate the review of state and local level resources and assets, to inform the capacity and partnership components of the SHIP.

In parallel to the internal HNJ work group activities, sister agencies were contacted, and engaged in the SHIP planning process. In 2011, representatives from the (agencies listed in Figure 2) participated in collective interagency meetings. The culmination of that work resulted in the development of a total of over one-hundred objectives. Priority health areas (defined below, Table 1) were identified and targeted health improvement goals were set for each of the areas.

## FIGURE 2: HNJ2020 WORKGROUP STRUCTURE


## REGIONAL MEETING SERIES

The DOH successfully submitted a competitive application and received funding through a CDC Healthy People 2020 Action Project Grant to raise awareness of Healthy New Jersey, and gain public and private stakeholder feedback on HNJ initiatives. The grant funded a regional meeting series, which provided information on the process and strategies used to develop the population-level health improvement goals. The 2011 regional stakeholder meetings were held in South (Camden), Central (New Brunswick), and North Jersey (Montclair). Over 400 partners from across the state were invited to attend. The meetings were conducted to achieve increased internal and external HNJ awareness, as well as to develop new partnerships and cultivate networking among nontraditional allies. The meeting enlisted multi-sector partners to engage in priority setting for health planning initiatives statewide.

More than 130 public health professionals from around New Jersey attended the meetings. Attendees included employees of local health departments, DOH, other state agencies, community- and faith-based organizations, educational institutions, hospitals and health care providers, specific health interest groups, and private for-profit corporations and businesses (Appendix B). The attendees represented multiple

geographic regions and settings (urban, suburban and rural), specific health interest groups, various age and multicultural groups, as well as, professional groups spanning the entire state. Specific health interest groups include those that address a certain health topic, concern, issue, or condition. This includes groups like the perinatal consortia, National Kidney Foundation, American Heart Association, American Stroke Association, American Diabetes Association, lactation consultants, etc.

The meetings were planned by the HNJ2020 Regional Meeting Steering Committee at DOH and were arranged by the Center for State Health Policy (CSHP) at Rutgers University, New Brunswick, NJ. The sessions featured:

- An overview of HNJ2020
  - Development, mission, goals, and specific topic areas
- Highlight of Social, Cultural and Environmental Factors influencing health
  - Keynote Speaker Mindy Thompson Fullilove, M.D., New York State Psychiatric Institute (Montclair)
  - A screening of *UNNATURAL CAUSES: Is Inequality Making Us Sick?*[3] Video (Camden and New Brunswick)
- Unveiling of results from a regional poll on Leading Health Indicators
  - Overview of methods for selecting LHIs
  - Illustration of poll results from meeting attendees
- Facilitated discussions on local health improvement planning strategies
  - Best practices and measuring success
  - Barriers to achieving goals and opportunities for collaboration
- Training on the New Jersey State Health Assessment Data system (NJSHAD)
  - Demonstration of DOH's online data access tool
  - Review community health assessment data sources

The events presented an opportunity for the DOH to showcase the work conducted, demonstrate implementation activities, and obtain feedback regarding applicability of data and strategies regionally and locally. Some of the best feedback was obtained during the breakout sessions. Breakout groups were organized regionally to ensure that networking among participants could carry forward following the meetings. Discussions emphasized the concept of "measurable" objectives and demonstrating how attendees could align and link local initiatives to Healthy New Jersey. A structured conversation was facilitated by DOH staff and partners (See Appendix E: *A Guide for Breakout Session Facilitators*)

Emphasis was placed on answering the following questions:

- What strategies do you use now in order to reach health improvement goals?
- What strategies would you like to implement in order to reach health improvement goals?
- What barriers exist for implementing these strategies?
- What assistance could the State and other partners provide?

[3] UNNATURAL CAUSES: Is Inequality Making Us Sick? Produced by California Newsreel with Vital Pictures. Presented by the National Minority Consortia. www.unnaturalcauses.org; www.newsreel.org

## FEEDBACK FROM REGIONAL MEETINGS

Evaluation of the meeting series was conducted by the Rutgers Center for State Health Policy. Meeting attendees commented on the overarching themes listed below throughout the three regional meetings. These themes were taken into consideration, and integrated in the SHIP implementation activities.

*Overarching Themes*

- The importance of data monitoring, collection, and evaluation, as well as addressing data gap areas
- Opportunities for improvement, mainly focusing on the need for networking with other entities to develop better synergy and collaboration with partners
- Leverage existing infrastructure and programs to facilitate work
- The importance of sharing best practices and providing means by which communities can learn from one another (e.g., templates for data gathering, samples of data sharing agreements and successful strategies to address specific health problems)

Partners recommended strategies for health improvement planning statewide:

- Refine communication strategies for targeted populations.
- Guide clear and concise public health messaging on priority health areas.
- Provide language translation/multi-language education materials.
- Set priorities based on needs assessment, convene resources around priority areas.
- Identify diversified funding sources beyond the state opportunities for competitive grants.
- Provide subject matter expertise and support of health planning initiatives.
- Make state, county, and local data on the DOH website easier to access.
- Conduct staff training and regional summits for professionals and stakeholders.
- Sustain an infrastructure that addresses health issues in a comprehensive way, taking into account regional health planning needs.

Barriers that hinder SHIP implementation and pose specific challenges referenced were:

- Unfunded mandates
- Lack of communication and coordination
- Inter- and intra-departmental silos
- Lack of workforce and staff availability
- Resource limitations relative to data sharing, and
- Limited transparency regarding health system issues.

While public health issues varied from region to region, the regional meeting series created additional alignment and validated existing alignment between the state health assessment data trends, the DOH SHIP and planning activities, and regional and local health improvement agendas.

## HEALTHY NEW JERSEY 2020 OVERVIEW

Healthy New Jersey (HNJ) is composed of twenty topic areas which are consistent with the state's priority health areas (See Table 1). Each topic area outlines specific objectives with targeted measures for improving health outcomes and health behaviors among the total population, as well as in racial/ethnic, age, and gender subgroups.

HNJ2020 will be used throughout the decade to facilitate work on state health improvement priorities; and raise public awareness and understanding of the various social, political, or economic factors which influence health. HNJ2020 will also help the DOH identify critical data collection gaps and research needs.

The most current HNJ information and data were shared with meeting participants and later disseminated online. Appendix C provides links to HNJ initiative publications as well as a link to the federal Healthy People site.

### TABLE 1: HNJ 2020 TOPIC AREAS

- Access to Health Services
- Asthma
- Cancer
- Chronic Kidney Disease
- Diabetes
- Environmental Health
- Healthcare-Associated Infections
- Heart Disease and Stroke
- HIV/AIDS
- Immunization
- Injury and Violence
- Maternal and Child Health
- Nutrition and Fitness
- Occupational Safety and Health
- Older Adults
- Public Health Infrastructure
- Public Health Preparedness
- Sexually Transmitted Diseases
- Tobacco Use
- Tuberculosis

From HNJ2020 topic areas (20), more than a hundred objectives were selected (Appendix F), including the five leading health indicators (LHI2020) described below (Appendix G).

## LEADING HEALTH INDICATORS


For the first time in the history of HNJ, DOH included a selection of leading health indicators as part of the State health improvement planning activities. This strategy was used to address stakeholders' concerns communicated for years about the overwhelming volume of HNJ objectives. The Department took on the challenge to provide more meaningful direction in communicating the priorities, and developing strategies toward achieving specific health improvement goals.

The HNJ Coordinating Committee devised a poll, based on the federal leading health indicators that was distributed to the over 400 stakeholders invited to participate in the regional meeting series. Registrants for each meeting were asked to vote on the leading health issues prior to attendance. The results from the poll were analyzed and reported at each meeting. Over 200 partners participated in the poll. The sum total of the poll results were later presented to the Healthy New Jersey Advisory Committee, which approved and finalized the selections (See Appendix D: Healthy New Jersey 2020 Regional Meetings Public Health Priority Areas Poll results).

In the end, the following five were selected as New Jersey's Leading Health Indicators:

- Access to Care
- Birth Outcomes
- Childhood immunization
- Heart Disease
- Obesity

Partners are encouraged to use the LHIs to focus health promotion and disease prevention strategies, facilitate collaboration with non-traditional health partners, and motivate action to improve health across the state.

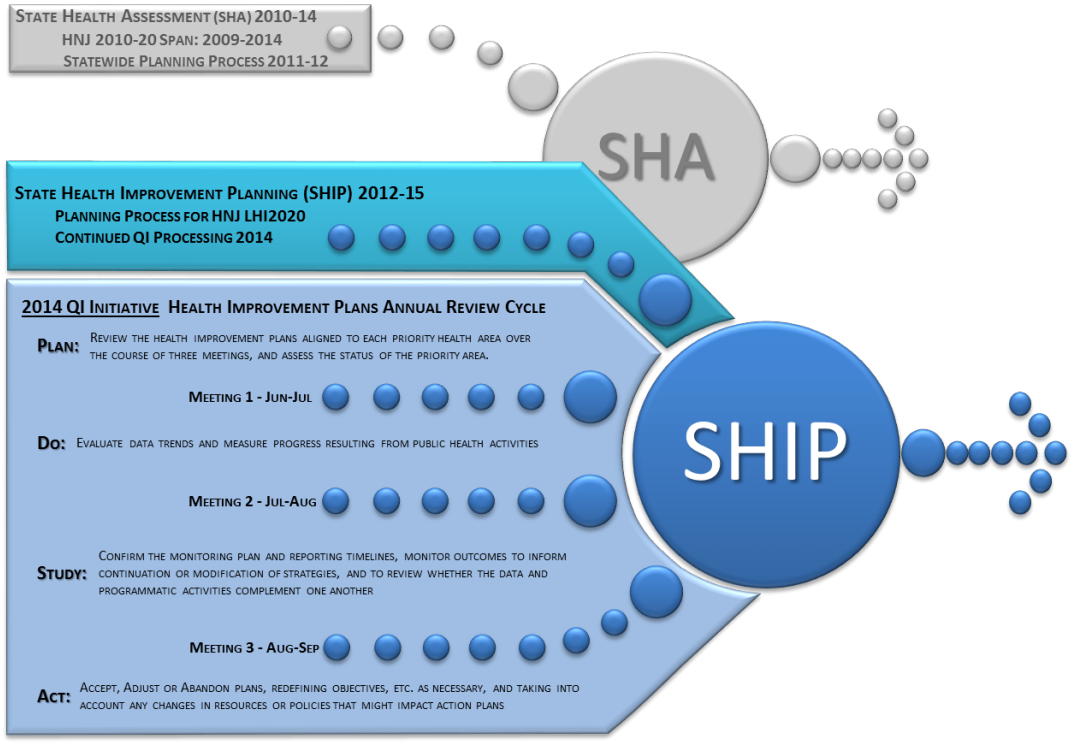
## IMPLEMENTATION STEPS

The State Health Improvement Plan (SHIP) also focuses on achieving improvements among the LHIs over the next 3 to 5 years. Figure 3 provides the overall framework for continuous health improvement planning, showing the relationship between the annual review, plan adjustments, and monitoring results.

Using a Plan-Do-Study-Act Quality Improvement methodology, DOH programs will:

- (Plan) Review the health improvement plans aligned to each priority health area and assess the status of the priority area.
- (Do) Evaluate data trends and measure progress resulting from public health activities.
- (Study) Confirm the monitoring plan and reporting timelines, monitor outcomes to inform continuation or modification of strategies, and to review whether the data and programmatic activities complement one another.
- (Act) Accept, adjust or abandon plans, redefine objectives, etc. as necessary, and take into account any changes in resources or policies that might impact action plans.

## FIGURE 3: STATE HEALTH IMPROVEMENT PLAN




## COORDINATING LOCAL HEALTH IMPROVEMENT PLANNING ACTIVITIES

New Jersey consists of twenty-one counties and 565 municipalities. There are 91 local health departments providing services to the states' nearly 9 million residents. The DOH Office of Local Public Health (OLPH), provides support to the local public health system through a legal framework for the operation of local public health agencies using the Public Health Practice Standards of Performance for Local Boards of Health in New Jersey (N.J.A.C 8:52). [4] One of the goals of public health leadership in New Jersey is to strengthen government and community partnerships to promote and facilitate healthy environments and lifestyles for all residents. To accomplish this mission, DOH:

- Evaluates the local health departments and regional systems performance to assure the provision of quality public health services and programs in accordance with the Public Health Practice Standards
- Provides support to local health departments through leadership, ongoing communications, technical liaison services, consultation, and expedition of local health department data collection
- Promotes integration of performance management practice at the local level by development of core competencies and capabilities of the public health workforce through accreditation and promotion of training and continuing education opportunities
- Promotes comprehensive public health planning at all levels of the public health system through the strengthening of collaboration and coordination among local health departments, community partners, other State departments, and non-governmental agencies

[4] Title 8, Chapter 52 (N.J.A.C 8:52), Chapter Authority: N.J.S.A. 26:1A-15 and 26:3A2-1 et seq.

- Fosters a culture of continuous quality improvement processes and use of evidence-based practices

As a result of N.J.A.C 8:52, for the past five years, local public health departments have implemented county- and municipality-based strategic planning processes statewide, engaging over 1,200 community partners. Comprehensive analyses of community assessments have been conducted leading to the development of Community Health Improvement Plans (CHIP) for each of New Jersey's 21 counties. The CHIPs identify local priority public health issues and strategies to address them using the MAPP[5] methodology.[6]

The DOH supports continuous improvement in local public health activities through the creation of a statewide Local Performance Management Initiative (LPMI). The LPMI focuses on systematically increasing and institutionalizing the performance management capacity of local public health departments in order to ensure that specific public health goals are effectively and efficiently met. The DOH partnered with Rutgers University to provide fourteen local health departments (or 15% of all health departments) in-depth training in quality improvement and performance management methods with the intent of demonstrating improvements made as a result of the training. This training builds on an earlier initiative undertaken from 2009 – 2011 where 36 health departments received in-depth training in quality improvement (QI) methods.

Since 2010, the OLPH has been working with the Rutgers School of Continuing Public Education on a new performance evaluation system for local health departments called the New Jersey Local Health Report (LHR). The system is located on the New Jersey Learning Management Network (NJLMN). NJLMN is a sophisticated web-based public health workforce tool that provides access to discipline-specific and competency-based public health education and training courses.

The previously disparate reporting methods were consolidated to this one tool which the OLPH will use to monitor performance and compliance with State regulations. Local health entities may also use the tool to provide annual updates on activities and services provided. This initiative introduced a level of transparency for local health departments that has previously not been available.

[5] Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning tool for improving community health. Facilitated by public health leaders, this tool helps communities apply strategic thinking to prioritize public health issues and identify resources to address them.

[6] New Jersey Department of Health. Improving the Health of New Jersey's Community, A Summary of the 2006-2008 County/City Community Health Improvement Plans, Final Report December 2010

## HEALTH IMPROVEMENT PLANS

Profiles of the New Jersey priority health areas and improvement plans follow. The profiles highlight the current status of each indicator. Baseline data for the LHI2020 objectives and targets for improvement are provided. Further, detailed information about plan objectives, partnerships, and plan activities are summarized in the format shown below.

### HEALTH OBJECTIVES

A summary of the relevant health objectives, baseline status and target health improvement goals are summarized.

### WHY IS THE HEALTH ISSUE IMPORTANT?

This section defines the problem, provides an overview of the importance of the health priority area as well as a summary of the significant health trends over time. In addition, environmental, behavioral, social and economic factors that impact health may be referenced. High risk groups in health areas are also identified.

### PARTNERS

The DOH works with hundreds of organizations, stakeholders, and groups to improve health. Some of the key actors are summarized herein. However, many more than listed are also engaged in related activities.

### PLAN

Several topic specific health improvement plans have been born from the SHIP. Key strategies planned to address each health priority area described. Accomplishments achieved are listed. Activities underway are described.

The overall collection of activities underway is captured in one or more of the following overarching areas:

- Collaboration
- Education and Outreach
- Health Information Technology Advancements/ Health Information Exchange
- Institutional Policy and Practice Implementation
- Medical Home Promotion
- Performance Measurement/Surveillance

Planned and practicing strategies are summarized in this section.

### POLICY

Numerous federal, state and institutional policies, practices, and initiatives impact and guide the work DOH does to achieve health improvement for New Jersey residents. When applicable, the relevant laws, regulations, or policies are described.

## ACCESS TO HEALTH CARE

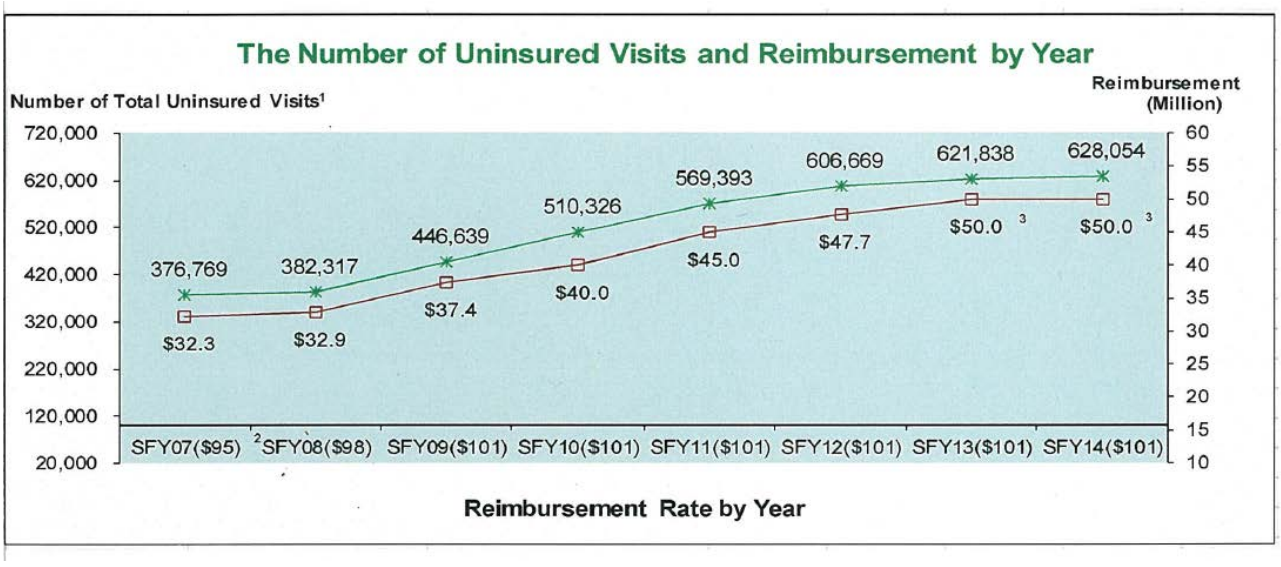
### HEALTH OBJECTIVES

| | | Baseline | Target |
|---|---|---|---|
| **INCREASE THE** | ▶Proportion of adults with a personal doctor or health care provider | 83.5% | 90.0% |
| | ▶Proportion of persons with health insurance | | |
| | Under 65 years of age | 82.6% | 93.3% |
| | Under 19 years of age | 90.5% | 95.% |

### WHY IS ACCESS TO HEALTH CARE IMPORTANT?

In 2012, New Jersey had approximately 1.11 million residents who lacked health insurance. Health insurance by itself does not ensure access. It is also necessary to have comprehensive coverage, providers that accept the individual's health insurance, close proximity of providers to patients, and primary care providers in the community. There are additional barriers to access in some populations due to lack of transportation to providers' offices, lack of knowledge about preventive care, long waits to get an appointment, low health literacy, and inability to pay the high-deductible of many insurance plans and/or co-pays for receiving treatment.[7] The major components of access to care are coverage, services, timeliness, and workforce. Access to care measures accessibility to needed primary care (Figure 4[8]), health care specialists, and emergency treatment.

Increased and sustained funding to the State's Federally Qualified Health Care Centers (FQHCs) has been essential to continue the delivery of services to New Jersey's uninsured population. The lagging economy compounded by the effects of Superstorm Sandy that displaced many residents throughout the State, make the FQHCs role all the more critical in making health care more accessible for vulnerable populations (Figure 3).




[7] Hall A, Harris Lemak C, Steingraber H, et al. Expanding the definition of access: It isn't just about health insurance. J Health Care Poor Underserved. 2008;19:625-638

[8] New Jersey Behavioral Risk Factor Survey (NJBRFS), Center for Health Statistics, New Jersey Department of Health

## PARTNERS

- Community Health Improvement Plans – Local Health agencies[9]
- Department of Children and Families (DCF)
- New Jersey Department of Human Services
- NJ Hospital Alliance
- NJ Hospital Association
- NJ Nurses Association
- NJ Primary Care Association
- Rutgers: New Jersey Medical and Rutgers School of Dental Medicine (Formerly UMDNJ)

## PLAN

### *1 – Emphasize Stakeholder Collaboration to implement the Chronic Disease and Health Promotion Plan*

The New Jersey Chronic Disease Prevention and Control Services Unit (NJCDPC) convened an internal Chronic Disease Planning Team, November 2011, which met regularly through 2012 to discuss internal opportunities for integration and to initiate planning efforts.

The Chronic Disease and Health Promotion Plan 2013 – 2018, *Partnering for a Healthy New Jersey*[10] provides a framework to focus resources and enhance future collaboration:

- Developing State, regional and local partnerships to integrate the resources of the government, private and nonprofit sectors into a seamless system of care that is easily accessible, culturally appropriate and sending a common message about wellness.
- Enhancing the collaborative use of allied health professionals and paraprofessionals in a team-based approach to care.
- Enhancing the engagement of large and small business and industry in growing worksite wellness efforts that lead to better health outcomes and healthcare cost savings

### *2 – Create the New Jersey Health Information Network (NJHIN) to facilitate Health Information Exchange regionally and statewide*

- Develop the New Jersey Health Information Network (NJHIN) to facilitate exchange of essential health information between regional health system operators.
- Promote and support implementation and expansion of health information exchanges and organizations (HIE/HIO).
- Explore opportunities to introduce Clinical Decision Systems to help enable chronic disease prevention and control.
- Promote healthcare providers' participation in HIOs.

[9] New Jersey Department of Health. Improving the Health of New Jersey's Community, A Summary of the 2006-2008 County/City Community Health Improvement Plans, Final Report December 2010

[10] New Jersey Department of Health. Chronic Disease and Health Promotion Plan 2013 – 2018, 2014

- Promote the use of health system interventions that improve the effective delivery and use of clinical and other preventive services to prevent disease, detect disease early, reduce or eliminate risk factors, and mitigate or manage complications.

### *3 – Promote implementation of Medicaid ACOs and Regional Planning Collaboratives*

- Develop and promote care coordination strategies to facilitate necessary linkages to address both clinical needs and community support for sustaining optimal health and wellness.
- Enable Community-Clinical Linkages in which communities support and clinics refer patients to programs that improve chronic condition management.
- Distinguish among the FQHC/Community Health Center/Patient Center Medical Home models and build on the strengths of each so that high-risk residents can access a full range of health and prevention services in their own community and from a variety of public and private payers
- Develop and promote care coordination across the lifespan.
- Evaluate, encourage, and expand the use of multi-disciplinary team-based approaches to care that include medical professionals, allied health professionals, and paraprofessionals.
- Identify and promote models of effective collaboration between medical, public health and community practitioners to improve coordination of services.

### *4 – Make primary care accessible to all New Jersey residents*

The DOH strives to make primary health care more accessible for all residents of New Jersey. As a result of the lagging economy in the State, compounded by the effects of Superstorm Sandy, it is anticipated that more residents will likely depend upon access to care through the States' Federally Qualified Health Centers (FQHCs). The DOH Office of Primary Care (OPC) provides financial support to 20 New Jersey FQHCS through a fee-for-service reimbursement system t in furtherance of the following objectives:

- Beginning July2014, FQHCs received an appropriation of $50 million, a 4.9% increase in funding, to expand the reach of the FQHCs to meet the demand related to the number of eligible residents who are uninsured and low income.
- Starting in July 2015 OPC will continue to focus on the needs of the uninsured and particularly those residents adversely affected by Superstorm Sandy who need access to care and who meet eligibility requirements (income at or below 250% of the federal poverty level and lacking insurance coverage for primary care).
- Fund the New Jersey's 20 FQHCs to deliver services to the most vulnerable populations of the State through the Uncompensated Care Fund, as a payor of last resort.
- Act as an access point for services to those who were displaced by Superstorm Sandy throughout the State who are eligible for services through the FQHCs.

The Department has worked with the hospital industry to secure CMS funding under a newly developed payment pool called the Delivery System Reform Incentive Payment (DSRIP) Program. The DSRIP program supports the Healthy New Jersey 2020 vision: "For New Jersey to be a state in which all people live long, healthy lives." The DSRIP Program will provide incentive based payments to hospitals centered on their population focused advances in the delivery of care resulting in better care for individuals, improved health

for community populations and overall lower costs. $166 million will be distributed annually to the 55 New Jersey hospitals approved by CMS to participate in the DSRIP Program.

- Hospitals may qualify to receive incentive payments for implementing quality initiatives within their community and achieving measurable, incremental clinical outcome results demonstrating the initiatives' impact on improving the New Jersey health care system (See Appendix H).
- The DOH financially supports hospitals through the provision of Charity Care which provides access to care for NJ's vulnerable populations.

### *Accomplishments*

- By the end of June 2013 the FQHCs served a total of 233,527 uninsured residents, who had 598,691 visits which amounts to a 1.4% decrease from the prior reporting period.

## POLICY

Restructuring Act 2012 - CHAPTER 17, 229, Section 3 of P.L.2004, c.113 (C.26:2H-18.59i). The Restructuring Act reorganized and renamed the Department of Health and Senior Services as the Department of Health, establishing a Division of Aging Services in the Department of Human Services and transferring certain services for senior citizens from the Department of Health and Senior Services to the division, revising various parts of the statutory law, and supplementing Titles 26 and 30 of the Revised Statutes.

As a result of the Restructuring Act of 2012 hospital funding programs were transferred to DOH improving the predictable and transparent funding for hospitals, the Hospital Relief Subsidy Fund and Graduate Medical Education. In addition, the Office of Health Information Technology was transferred to DOH aligning existing health information technology (HIT) commission to promote collaboration and planning across the state.

In August 2013 the DOH preserved $166.6 million in hospital funding from the Center for Medicare and Medicaid Services (CMS) for implementing the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP will reward hospitals with funding to improve quality of care in one of the following chronic disease categories: HIV/AIDS, Cardiac Care, Asthma, Diabetes, Obesity, Pneumonia, Behavioral Health and Substance Abuse

# BIRTH OUTCOMES

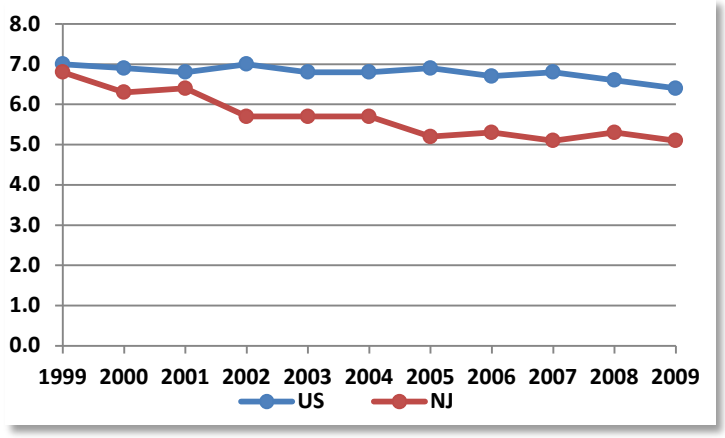
## HEALTH OBJECTIVES

| | | Baseline | Target |
|---|---|---|---|
| **REDUCE THE** | Infant death rate per 1,000 live births | 5.1 | 4.8 |
| | Low Birth Weight | 8.1% | 7.7% |
| | Percentage of breastfeeding infants who receive formula supplementation before age 2 years | 38.0% | 10.0% |
| | Percentage of premature births occurring statewide | 9.2 | |
| **INCREASE THE** | Percentage of delivery facilities that provide maternal and newborn care consistent with the WHO/UNICEF Ten Steps to Successful Breastfeeding | 0.0% | 50.0% |
| | Percentage of women who receive adequate prenatal care | | |

## WHY ARE BIRTH OUTCOMES IMPORTANT?

Infant death rate is a critical measure of a population's health and a worldwide indicator of health status and social well-being. The infant mortality rate in New Jersey is 4.8 per 1,000 live births, lower compared to the national rate of 6.1. Infant deaths have been decreasing in New Jersey since the early 1900s, while the national trend has remained the same since the mid-1990s, Figure 5[11].

**FIGURE 5: INFANT MORTALITY RATE, NEW JERSEY-UNITED STATES, 1999-2009**




Notably, the infant mortality rate varies widely across the state and by several maternal and infant characteristics. The rate among Blacks (11.6 per 1,000 live births) is significantly higher than the rate among Whites (3.2), Hispanics (4.6), and Asians (2.8). Other than Hawaii and D.C., New Jersey has the largest disparity between rates among White and Black mothers. In part, this is because the rate among Whites is relatively low compared nationally. The rate among Whites in New Jersey is the lowest in the nation and the rate among Blacks is the 11th lowest among states. [12]

[11] Birth Certificate Database, Office of Vital Statistics and Registry; Linked Infant Death-Birth Database, Center for Health Statistics, New Jersey Department of Health. National Center for Health Statistics

[12] Mathews TJ, MacDorman MF. Infant mortality statistics from the 2008 period linked birth/infant death data set. National vital statistics reports; vol 60, no 5. Hyattsville, MD: National Center for Health Statistics. 2012. http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_05.pdf

A strong predictor of infant survival and subsequent quality of life is infant birth weight. The most important risk factors for low birth weight and other poor outcomes are lack of early and adequate prenatal care, and inadequate nutrition during the prenatal period.

The low birth weight rate among New Jersey mothers is about the same as that of the nation as a whole. Low birth weight rates also vary widely across the state and by several maternal and infant characteristics. Black mothers (12.7%) are significantly more likely to deliver low birth weight infants than other racial/ethnic groups (7.3%). Low birth weight rates are lowest among mothers ages 25-29 years (7.3%). Virtually all triplet and higher order infants are born with low birth weight, as are half of twins. Low birth weight rates range from 5.7% in Warren County to 10.4% in Essex County (2010 Center for Health Statistics, Vital statistics data).

## PARTNERS

- Directors of Neonatology of the Regional Perinatal Centers (RPCs)
- March of Dimes
- Maternal and Child Health Consortia
- New Jersey Chapter, American Academy of Pediatrics
- New Jersey Department of Human Services
- Public Health Council
- Reproductive and Perinatal Health Services (RPHS)

## PLAN

### STRATEGIES

#### *1 – Implement the Improving Pregnancy and Birth outcomes Initiative*

The Division of Family Health Services in the New Jersey Department of Health administers programs to enhance the health, safety, and well-being of families and communities in New Jersey. Several programs strive to improve children's health, including reducing infant mortality, while others support pregnant women and newborns, the Supplemental Nutrition Program for Women, Infants, and Children (WIC). Ensuring that women have access to health services to maintain their overall health, and have an optimal pregnancy is a health priority for the DOH.

- Announced in 2013 and continuing for 3 years, DOH is providing $13.5 ($4.5 per year) million to community health centers, maternal and child health consortia, local health departments and social services agencies to address the issues of both preterm birth and birth outcomes. Funding focuses on hiring community health workers, who will target pregnant woman at high risk for complications and women of childbearing age and enroll these women into appropriate care. Once women are enrolled in care, they will then meet with central intake coordinators to be evaluated for eligibility for other assistance programs

### *2 – Conduct targeted quality improvement activities through New Jersey's Maternal and Child Health Consortia*

- The regional quality improvement activities within each of the 6 Maternal Child Health Consortia's (MCHC) include: regular monitoring of indicators of perinatal and pediatric statistics, fetal-infant mortality review, maternal mortality review, and maternity services reporting through the Electronic Birth Registration System.
- Central NJ MCHC will implement a Preconception, Interconception, and Prenatal Education awareness campaign targeting women of childbearing age, youth and men in the target area, and will provide a patient navigator to serve at-risk pregnant and/or interconception women within the service region.
- Hudson Perinatal Consortium will provide outreach and education, coordination of health benefits including insurance coverage, a medical home, and WIC services for program participants who are entering prenatal care. Hudson Perinatal Consortium will coordinate doula training and childbirth education sessions.
- Children's Home Society will target outreach to the Latino and African American community with emphasis on adolescents. Children's Home Society will provide access to prenatal care, interconception and preconception care and outreach and education services in the target area.
- Southern Jersey Family Medical Center will provide an integrated service delivery model for reproductive healthcare; partnering with Planned Parenthood of Southern NJ and the Southern NJ Perinatal Cooperative.
- Southern NJ Perinatal Cooperative will establish a regional practice collaborative to foster a comprehensive approach to community awareness, provider training, service integration and improved access to prenatal care, interconception and preconception care.
- Northern NJ MCHC will provide a patient navigator model of care with expansion of the Paterson Healthy Mothers Healthy Babies Coalition model.
- Gateway Northwest MCH Network will provide a technology based prenatal education/outreach model for pregnant/postpartum clients with special emphasis on adolescents through use of text messaging and email.

### *3 – Support regional and cross jurisdictional collaboration to facilitate research and best practice interventions*

- The Directors of Neonatology of the regional perinatal centers (RPCs) have initiated a NJ Vermont Oxford Network (VON) Collaborative to ensure: the development of a voluntary, collaborative NJIIS network of neonatal providers, to support a system for bench marking and continuous quality improvement activities for perinatal care; the opportunity to develop a responsive, real time, risk-adjusted, statewide perinatal data system; and the ability to integrate existing state and front-end perinatal data systems.
- All of the regional perinatal centers in the state currently participate in the NJ Neonatal Intensive Care Unit (NICU) Collaborative. The NJ NICU Collaborative plans to address infections as the common indicator in all of the RPC's site visits to include best practices will be conducted regionally. The collaborative has planned six meetings for the year, with three being conducted via the web. Education will be an ongoing goal of the collaborative.

- The NJ NICU Collaborative is participating with 7 other states in the NCABSI (catheter-associated bloodstream infection) collaborative, a multistate initiative to eliminate central-line associated blood stream infections in the NICU. The NCABSI project is part of the overall AHRQ-funded On the Cusp: Stop BSI national initiative.
- Regional Perinatal Consortium of Monmouth and Ocean Counties will provide and coordinate sub-grants for direct care including Centering Pregnancy and intensive case management services.

### *4 – Administer the New Jersey's Baby-Friendly Hospital Initiative*

- To increase breastfeeding rates, the DOH has supported maternity hospitals to implement the Baby Friendly Hospitals Initiative, a World Health Organization (WHO) and United Nations Children's Fund (UNICEF) program that encourages and recognizes hospitals that promote and promote and support breastfeeding. The DOH Baby-Friendly Hospital Initiative (BFHI) helps a small group of maternity care facilities each year to adopt the "Ten Steps to Successful Breastfeeding."
- Since 2010, the BFHI has provided funding, training and technical assistance to help New Jersey hospitals progress along the 4-D pathway toward Baby-Friendly designation. The 4-D pathway is a structured, 10 step by step process to guide hospitals through implementation.
- The DOH Division of Family Health Services will prepare an annual report card, Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report to present breastfeeding initiation as a quality of care issue, and to promote self-assessment tools and model hospital policy recommendations as references for hospitals to improve their breastfeeding policies and practices.
- ShapingNJ partners are developing a pilot program for breastfeeding support in the community.

### *Accomplishments*

- Ten hospitals received a $10,000 mini-grant (DOH/CDC) to help them on 4D Pathway to Baby-Friendly designation.
- Four hospitals as of April 2013[13] achieved a "Baby-Friendly" designation. (Two among grantees)
- Over a dozen NJ hospitals are on the 4D Pathway to Baby-Friendly designation. Efforts are underway to replicate the Initiative in the remaining NJ delivery hospitals and 26 more hospitals are actively working towards this certification.
- FHS's report card, Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report is endorsed by the State chapter of the American Academy of Pediatrics (NJ-AAP) and the NJ Breastfeeding Task Force.

**Hospitals participating in the BFHI:**

**Receive free comprehensive training.**

**Apply a quality improvement method (Plan-Do-Study-Act cycles) to implement at least two steps that are most important to each individual hospital.**

**Receive free technical assistance monthly.**

**Participate in a Baby Friendly Hospital collaborative.**

**Receive tailored onsite education and guidance about breastfeeding and the Ten Steps.**

[13] New Jersey Department of Health. Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report, August 8, 2013

### *5. - Facilitate Medicaid incorporation of performance measures in its contracts with managed care organizations*

- There has been an increase in preterm births among the Medicaid population, while the rate for non-Medicaid population is declining. The DOH has partnered with the Department of Human Services on Medicaid Performance Based Contracting in an effort to engage and motivate health care payers to demonstrate quality improvement in areas such as preterm birth.

### *6. - Expand the Newborn Screening Program*

- There has been an increase in preterm births among the Medicaid population, while the rate for non-Medicaid population is declining. The DOH has partnered with the Department of Human Services on Medicaid Performance Based Contracting in an effort to engage and motivate health care payers to demonstrate quality improvement in areas such as preterm birth.

### *Accomplishments*

- Participation in National Governor's Association (NGA) Learning Collaborative designed to assist states in improving pregnancy outcomes. New Jersey attended DC meeting with other states and held in state meeting with key stakeholders.

## POLICY

- NJ was the first state to implement pulse oximetry screening to improve early detection of critical congenital heart defects. Newborn testing was expanded from 54 to 60 genetic and metabolic disorders. Legislation mandating newborn pulse oximetry screening to detect Critical Congenital Heart Disease took effect on August 31, 2011. Since then, DOH has developed a mechanism to collect data on all infants screened by having birthing facilities submit quarterly aggregate data reports. In addition, information on all infants with failed screens is reported by each birthing facility to the Birth Defects Registry. As of October 31, 2012, DOH had received reports of infants with previously unsuspected critical congenital heart disease detected through the screening program.
- In 2013, additional funding (1.6 million dollars) was budgeted for expansion of NJ's newborn screening panel to include the 5 lysosomal storage disorders and severe combined immunodeficiency (SCID).
- DOH released its first ever Policy on Breastfeeding in the workplace on September 17, 2012. The policy enables an employee or a visitor to the Department who is a nursing mother, at her discretion, to breastfeed or express breast milk onsite at the workplace.
- The Autumn Joy Stillbirth Research and Dignity Act () was introduced to the New Jersey legislature and signed into law in January 2013 by Governor Chris Christie. The bill requires the state to establish policies and procedures for the dignified and sensitive management of each stillbirth, in consultation with nursing, psychology and social work professionals. The State will also be required to establish protocols for evaluating fetal death to ensure doctors and hospitals report accurate and complete data to the state. With that information, state health officials can create a database to increase our knowledge of stillbirth.

## CHILDHOOD IMMUNIZATIONS

### HEALTH OBJECTIVES

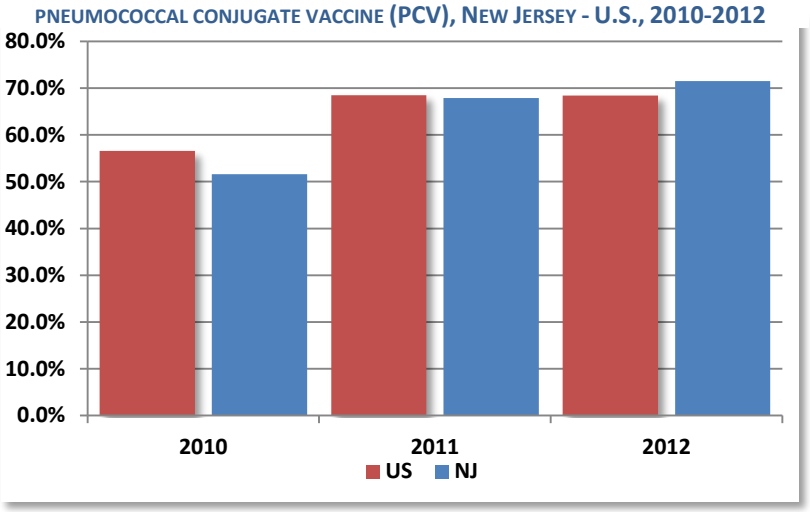
| | | Baseline | Target |
|---|---|---|---|
| **INCREASE THE** | ▸ Percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV) | 74.0% | 80.0% |
| | ▸ Effective vaccination coverage levels for universally recommended vaccines among young children | | |
| | 4 doses diphtheria-tetanus-acellular pertussis (DTaP) vaccine by age 19 to 35 months | 87.0% | 95.0% |
| | Birth dose of hepatitis B vaccine (0 to 3 days between birth date and date of vaccination, reported by annual birth cohort) | 47.0% | 75.0% |
| | 4 doses of pneumococcal conjugate vaccine (PCV) among children by age 19 to 35 months | 84.0% | 90.0% |

### WHY IS CHILDHOOD IMMUNIZATION IMPORTANT?

Vaccines play an essential role in reducing and eliminating disease and are among the most cost-effective health prevention measures. Development of vaccinations has been cited by the U.S. Public Health Service as one of the ten great public health achievements of the 20th Century.

The proportion of children who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV) is increasing every year. If the current trend continues, the HN2020 goal (Figure 6[14]) will be met. New Jersey's coverage rate (71.5%) is about the same compared to the nation (68.4%).

**Figure 6: PERCENTAGE OF CHILDREN AGED 19 TO 35 MONTHS WHO RECEIVE THE RECOMMENDED DOSES OF DTAP, POLIO, MMR, HIB, HEPATITIS B, VARICELLA AND PNEUMOCOCCAL CONJUGATE VACCINE (PCV), NEW JERSEY - U.S., 2010-2012**




[14] National Immunization Survey, National Center for Health Statistics, U.S. Centers for Disease Control and Prevention

## PARTNERS

- Federally Qualified Health Centers
- NJ Vaccines for Children Program
- Partnership to Immunize Newark Kids
- Vaccine Preventable Disease Program
- Women Infants and Children Program

## PLAN

### STRATEGIES

#### *1 – Implement Targeted Vaccine Programs*

New Jersey Vaccines for Children (NJVFC) is a federally-funded, state-operated vaccine supply program that provides pediatric vaccines at no cost to doctors who serve children who might not otherwise be vaccinated because of inability to pay. The Division of Epidemiology, Environmental and Occupational Health works collaboratively with partners through the Vaccine Preventable Disease Program to promote age appropriate immunizations. Key strategies:

- The DOH will implement its plan to assure that all immunization rates are at or above national averages. Objectives of the initiative are to identify specific barriers to immunization rates which fall below national averages and to develop strategies to improve sub-standard rates.
- Review trends in immunization coverage rates and identify areas with low rates, to target for improvements.
- Improve and/or sustain adolescent vaccination rates through promotion of statewide Adolescent Vaccination Campaign.
- Promote the administration of a birth dose of Hepatitis B vaccine through collaboration with the NJ Immunization Network and the Perinatal Hepatitis B Birth dose.
- Develop and promote an on-line vaccine promotion tool kit for parents, physicians, teachers and childcare directors.

#### *2 – Enhance the New Jersey Immunization Information System (NJIIS)*

- The DOH will enhance the New Jersey Immunization Information System (NJIIS). All newborn infants in NJ are automatically entered into the system at birth to permit tracking of population-based immunization rates and to promote the completion of immunization schedules through compilation of all immunization data relevant to the specific patient.
- DOH will enhance NJIIS to include web services to reduce burden and cost to private insurance carriers, medical technology vendors and physician offices, as well as hospitals, local health departments and clinics contribute to populating the registry.
- Advance NJIIS Search Patient functionality, continued implementation of web services with electronic medical record systems and the development of multistate data exchange documents to expand data sharing are a few of the many enhancements underway in the NJIIS. All are designed

to improve the patient flow of immunization information to providers for sustaining continuity of patient care and increasing immunization coverage rates statewide.

- Align DOH's Vaccines for Children Program activities with the Immunization Information System
- Deduplicate approximately 500 NJIIS records.

### *Accomplishments*

Over 600 providers report electronically to the New Jersey Immunization Information System (NJIIS) statewide and increase the number of vaccine doses recorded in the system to 28,484,866 the number of administrated shots in NJ, since the statewide immunization act was implemented into law.

### POLICY

- In 2004, the Statewide Immunization Registry Act (NJIIS) was signed into law requiring all providers who administer immunizations to children under 7 years of age to input the data into the NJIIS within 30 days of administration. The full implementation of the law and the corresponding rules became effective December 31, 2011.
- DOH revised the administrative rules (N.J.A.C. 8:57-4) with substantive changes to include the requirement of four new vaccines (Diphtheria and tetanus toxoids and pertussis vaccine, Pneumococcal conjugate vaccine, Influenza vaccine, and Meningococcal vaccine) for school, preschool and licensed child-care center attendance beginning in September 2008.

## HEART DISEASE AND STROKE

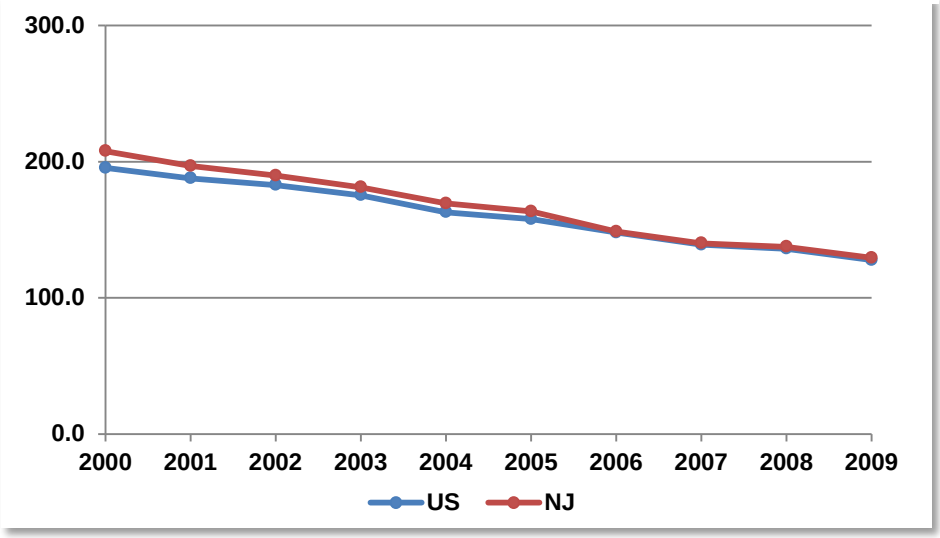
### HEALTH OBJECTIVES

| | | Baseline | Target |
|---|---|---|---|
| REDUCE THE | Death rate due to coronary heart disease per 100,000 population | 140.1 | 112.1 |
| | Death rate due to stroke | 35.8 | 28.6 |
| INCREASE THE | Proportion of adults who have had their blood cholesterol checked within the preceding 5 years | 78.8% | 86.7% |

### WHY IS HEART DISEASE IMPORTANT?

Heart disease is the leading cause of death of men and women in New Jersey and the United States. Coronary heart disease (CHD) is the most common type of heart disease and can cause heart attack, angina, heart failure, and arrhythmias. It is a condition in which blood flow to the heart is reduced. When the coronary arteries become narrowed or clogged, the heart tissue is deprived of an adequate amount of blood oxygen. The part of the heart not receiving oxygen begins to die, and some of the heart muscle may be permanently damaged. The age-adjusted death rate due to coronary heart disease (Figure 7[15]) has declined since 2000; decreasing between 4% to 5% each year similar to the national trend.

**FIGURE 7: DEATH RATE DUE TO CORONARY HEART DISEASE, AGE-ADJUSTED, NEW JERSEY - UNITED STATES, 2000-2009**




[15] Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File. CDC WONDER On-line Database accessed at http://wonder.cdc.gov/cmf-icd10.html Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health Population Estimates, State Data Center, New Jersey Department of Labor and Workforce Development

## PARTNERS

- American Heart Association
- American Stroke Association
- Inner City Demonstration Project
- NJ Prevention Network
- Rutgers: New Jersey Medical and Rutgers School of Dental Medicine (Formerly UMDNJ)
- Robert Wood Johnson Medical School

## PLANS

### STRATEGIES

The DOH Heart Disease and Stroke Prevention (HDSP) Program works in partnership with public and private sector groups and organizations from health care, work site, and community settings to affect policy and systems level change. The HDSP Program strives to address all points of opportunity, from prevention of heart disease and stroke in healthy persons to controlling risk factors, treatment of illness and prevention of recurrence in those who have had an event, as well as issues related to rehabilitation, long-term, and end-of-life care.

#### *1 – Conduct surveillance and evaluation of heart disease and stroke outcomes*

- The DOH will gather, analyze and disseminate data and information relevant to improving heart disease outcomes.
    - Collect and report data from New Jersey's cardiac surgery hospitals. Use the data to create risk-adjusted mortality rates for each hospital and surgeon performing one common type of open heart surgery -- coronary artery bypass graft surgery (CABG). Publish findings
    - Establish the Children's Sudden Cardiac Events Registry to track cardiac arrests in children. The data will provide valuable information to help improve the diagnosis, prevention, and treatment of sudden cardiac events and learn how outcomes can be improved.
- Evaluation of data will be conducted routinely to inform, prioritize, and administer targeted programming to improve outcomes.
- Administer the Cardiovascular Health Advisory Panel (CHAP) which is charged to assist with the development of cardiovascular health policies and advise the Commissioner of Health.
- Promote environmental strategies that support and reinforce healthful behaviors statewide in schools, worksites, and communities.
- The DOH Healthcare Quality Assessment Office maintains the New Jersey Stroke Registry (NJASR) as required by the 2004 Stroke Act (P.L. 2004, C.136) on Primary and Comprehensive Stroke Center Hospitals. The intent is to promote a higher standard of stroke treatment through designation of primary or comprehensive stroke centers to improve the quality of stroke care services in New Jersey and to track stroke care services using a standardized data collection tool. The HCQA:
    - Collects patient-level stroke data from all designated Stroke Center hospitals.
    - Generates NJASR quarterly reports and share with hospital CEOs and data abstractors to provide hospitals with feedback on their performance on selected measures.

- Evaluates the performances of hospitals based on outcomes and deliver critical information lacking in the State to support policy as required by the Stroke Act.
- The NJDSP program partnered with the office of healthcare quality Assessment and Rutgers University to develop scientific capacity to define and monitor cardiovascular disease burden in New Jersey.

*2- Provide education and conduct outreach on the best heart disease and stroke treatment practices*

- In 2011, DOH implemented guidelines developed for pre-hospital providers including Basic Life Support and Advanced Life Support providers and apply to the care of all patients with possible stroke and TIA (Transient Ischemic Attack) symptoms. Plastic pocket cards of the guideline basics were distributed to New Jersey EMS providers and to promote better understanding of these guidelines, DOH developed educational materials utilized by the NJ Stroke Consortium to educate area EMS providers
- In 2013, DOH hosted the first statewide stroke conference which drew over 450 participants from throughout the state, April 13, 2013. Again, in 2014, DOH served as the host for the second statewide stroke conference, April 3, 2014.

*3- Implement targeted chronic disease management and health promotion activities*

- In 2013, the DOH Office of Minority and Multicultural Health released its 2014 Community Health Disparity Prevention Programs (CHDPP) funding opportunities to reduce health disparities. The CHDPP Mini Grants RFA resulted in 22 grants of $36,000 each to nonprofit community based organizations in 17 counties. The focus of the grants is implementation of evidence based or innovative health prevention initiatives to target NJ health priority area disparities : diabetes, asthma, cancer, cardiac illnesses, violence, and infant mortality, hepatitis B/C, HIV AIDS, immunization, obesity, or unintentional violence.
- OMMH launched the Chronic Disease Self-Management Program (CDSMP) for Languages Other than English grants in 2014. The CDSMP format is a six week workshop with each session occurring once a week for two and a half hours in a community setting such as a church, hospital, senior center, clinic, community college, etc . The CDSMP workshops are designed to help the caregiver of an individual or individuals with a chronic condition to improve his/her overall quality of life. Workshop participants learn strategies that specifically target emotional distress, relaxation techniques, interactions with health care professionals, the importance of well-balanced nutritional meals, and ways in which to exercise in a safe and easy manner, and other relevant topics.
- The DOH Heart Disease and Stroke Program worked with Rutgers University to develop and pilot a worksite wellness toolkit for employers to promote and support heart health in the work place.

*Accomplishments*

Stroke Centers

- As of 2013, New Jersey has 13 hospitals designated as comprehensive stroke centers and 52 as primary stroke centers.

Stroke Registry

- In 2010, the DOH launched the New Jersey Acute Stroke Registry (NJASR). The NJASR collects data on patients served at designated stoke centers in NJ.
- Analyzed stroke treatment methods and have found improvements in stroke treatment for both Primary and Comprehensive Stroke Center hospitals.
- In 2011, the NJSAR data and collection system was revised to align with national registries such as Get with the Guidelines-Stroke (GWTG-Stroke), CDC's Paul Coverdell and the Joint Commission data elements and definitions.[16]

## POLICY

New Jersey enacted the "Stroke Center Act" (P.L. 2004, c. 136, codified at N.J.S.A. 26:2H-12.27 through 26:2H12.32) which requires the Department of Health to designate licensed general hospitals that meet certain standards as either Primary or Comprehensive Stroke Centers. L.2004, c.136, s.3; amended 2007, c.270.[17]

In 2006, DOH proposed new rules (N.J.A.C. 8:43G-7A, effective August 17, 2009) that applied to all designated Stroke Centers to maintain a database that supports evaluation of outcomes and continuous quality improvements.

In 2008 DOH convened a 15-member Stroke Advisory Panel (SAP) that represents all regions of the state and includes neurologists, emergency physicians, nurses and the hospital industry; experts to advance stroke care in New Jersey.

[16] The New Jersey Acute Stroke Registry, (NJASR), Version 1.0. Data Collection Manual, Effective Date: January 1, 2010, Revised: May 2, 2011

[17] Title 8 Chapter 43G, Hospital Licensing Standards, Subchapter 7a. Stroke Centers, N.J.A.C. 8:43G-7a.3 (2014), Amended by R.2011 d.055, effective February 22, 2011. See: 42 N.J.R. 1774(a), 42 N.J.R. 2561(a), 43 N.J.R. 401(b). This subchapter sets forth the standards for designation as a primary or comprehensive stroke center.

# OBESITY

## HEALTH OBJECTIVES

| | | Baseline | Target |
|---|---|---|---|
| **PREVENT AN** | Increase in the proportion of the population that is obese | | |
| | Adults 20 years+ | 23.8% | 23.8% |
| | High school students | 10.3% | 10.3% |
| **INCREASE THE** | Proportion of the population consuming five or more servings of fruits and vegetables per day | | |
| | Adults 18 years and older | 26.1% | 28.7% |
| | High School students | 20.1% | 22.1% |
| | Proportion of NJ adults who meet current Federal physical activity guidelines for moderate or vigorous physical activity | 53.1% | 58.2% |
| | Proportion of NJ high school students that meet current physical activity guidelines for aerobic physical activity (data shown are 60+ min, 5+ days/week) | 21.3% | 23.4% |
| **REDUCE THE** | Screen time among high school students | | |
| | Increase the proportion who watch TV for no more than 2 hours a day | 67.4% | 74.1% |
| | Increase the proportion who use the computer for no more than 2 hours a day | 71.1% | 78.3% |
| | Proportion of high school students (grades 9-12) who drank soda one or more times per day in the past 7 days | 19.9% | 13.9% |

## WHY IS OBESITY IMPORTANT?

Obesity often results in an increased risk of morbidity from hypertension, high LDL cholesterol, type 2 diabetes, coronary heart disease, stroke, and osteoarthritis.

In just ten years, the age-adjusted proportion of obese New Jersey adults increased from 18.5% in 2000 to 24% in 2010. The age-adjusted prevalence of obesity among New Jersey adults is slightly lower than compared to the U.S. prevalence (27.6%). Obesity prevalence varies by race/ethnicity statewide. Black (32.5%) and Hispanic (28.0%) obesity rates are higher compared to those of Whites (22.4%) and Asians (11.0%). (Figure 8[18])

The proportion of New Jersey high school students who are obese is consistently lower than that of the nation as a whole (Figure 9[19]). The obesity rate among high school students has remained constant at about 10% to 11% since data became available in 2001. In contrast, the obesity rate among New Jersey's low-income toddlers ages 2 to 5 is 17.9% which is among the top three highest in the nation. Notably, New Jersey was cited as one of the states that have had an absolute decrease in the prevalence of obesity between 2008 and 2011 by the Centers for Disease Control and Prevention (CDC). NJ 2010 data reveals that:

Among New Jersey's adolescents in grades 9 through 12[18]

- 14.2% were overweight ($\geq$85th and < 95th percentiles for BMI by age and sex)
- 10.3% were obese ($\geq$95th percentile for BMI by age and sex)

[18] Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
[19].Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
[18] CDC, Division of Adolescent and School Health. The 2009 Youth Risk Behavior Survey
[19] CDC, Division of Nutrition, Physical Activity, and Obesity. 2010 Pediatric Nutrition Surveillance System.

Among New Jersey's children aged 2 years to less than 5 years[19]

- 17.0% were overweight (85th to <95th percentile BMI-for-Age)
- 17.3% were obese (≥95th percentile BMI-for-Age)

**FIGURE 8: PERCENTAGE OF PERSONS AGED 20+ YEARS WHO ARE OBESE, BY RACE/ETHNICITY, NEW JERSEY, 2011**

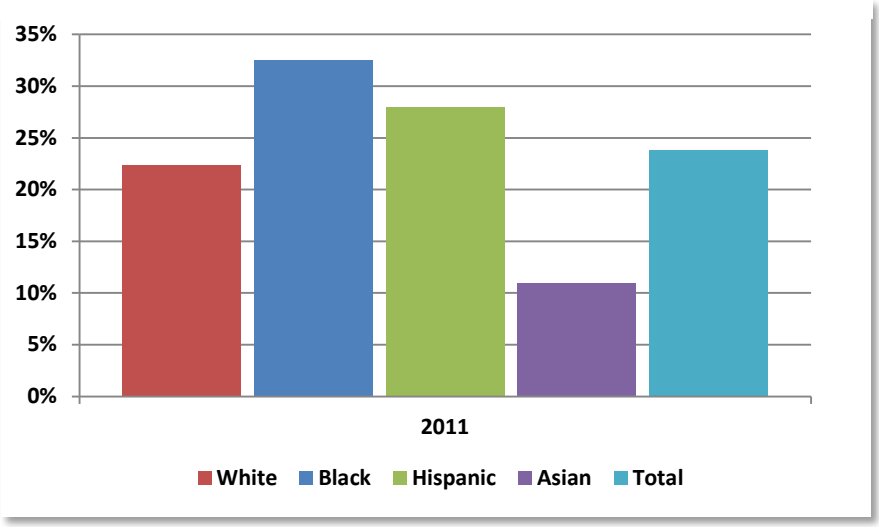
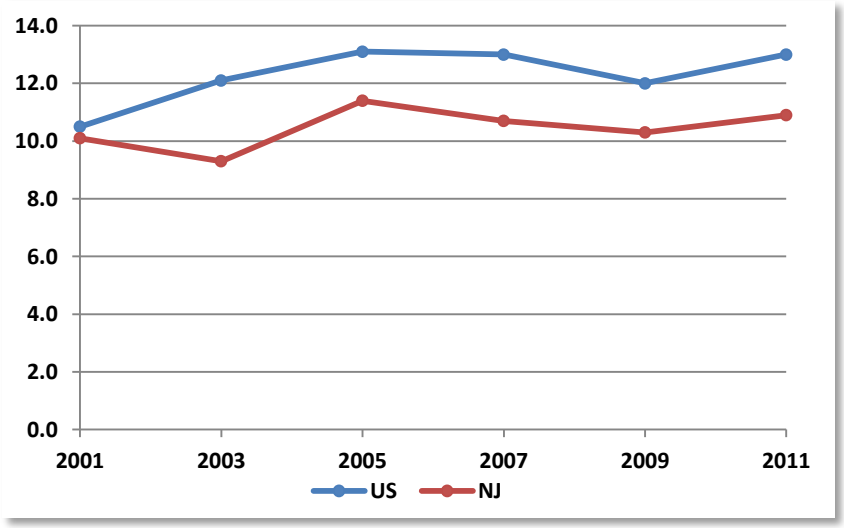



**FIGURE 9: OBESITY PREVALENCE AMONG HIGH SCHOOL STUDENTS - GRADES 9 TO 12, NEW JERSEY-UNITED STATES, 2001-2011**




PARTNERS

- Emergency Care Research Institute
- Departments of Transportation
- Mayors Wellness Campaign
- New Jersey Health Care Quality Institute
- New Jersey Obesity Group
- New Jersey League of Municipalities
- Obesity Prevention Task Force
- ShapingNJ Partnership for Nutrition, Physical Activity and Obesity Prevention
- The Alan M. Voorhees Transportation Center at Rutgers University Bloustein School of Public Policy
- The Regional Planning Association
- Rutgers: New Jersey Medical and Rutgers School of Dental Medicine (Formerly UMDNJ)

## PLANS

### STRATEGIES

#### *1 – Promote Collaboration*

- **ShapingNJ** is a public-private partnership for nutrition, physical activity and obesity prevention. The partnership is with over 200 organizations across New Jersey working to "make the healthy choice, the easy choice" for all residents. The 10-year vision is a New Jersey where regular physical activity, good nutrition, and healthy weight are part of everyone's life. The goal of this partnership is to prevent obesity and improve the health of populations that are at risk for poor health outcomes. The Office of Nutrition & Fitness (ONF) at the Department of Health (DOH) coordinates ShapingNJ.
- **ShapingNJ** organizations and community systems, such as workplaces, faith-based groups, senior and community centers, park and recreation agencies, and schools will continue to collaborate to serve the target populations, to provide support for nutrition and physical activity interventions tailored to the needs and preferences of these groups.
- Promote the translation of research into practice regarding the effectiveness of programs promoting healthy eating and physical activity, with emphasis on programs tailored for high-risk populations, by partnering with organizations such as Rutgers Cooperative Research and Extension, the University of Medicine and Dentistry of New Jersey, and the Rutgers Center for State Health Policy.

#### *2 – Facilitate increased access to healthy food and physical activity opportunities statewide*

NJ is one of six states included in a 5-year, CDC-funded initiative led by the Delaware-based Nemours Foundation, building on ShapingNJ's work to improve child care policy and practice.
Eighteen communities are funded under ShapingNJ community grants, increasing access to healthy food and physical activity through initiatives such as planning a pedestrian-friendly downtown, placing bike racks along community trails, piloting a farmers market, working with faith congregations to adopt healthy policies, promoting school breakfast programs and designing safer parks. Some of the strategies to increase access to healthy food and physical activity opportunities include the following:

- Assessing Camden's parks for safety and developing recommendations to improve their safety;
- Installing bike racks along a new trail in Red Bank,

- Creating healthy vending machine policies for East Orange municipality and school district,
- Implementing healthy policies in faith congregations in Newark, Vineland and Trenton; and
- Opening up *play streets*, closed to traffic and open to communities to create an area where kids can play and be active, in Irvington and Perth Amboy.

### *3 - Promote Implementation of Obesity Prevention Strategies in multiple settings – workplace, community, school, childcare, and healthcare*

Workplace

- Encourage New Jersey businesses to accommodate breastfeeding women.
- Encourage the food and beverage industry to engage in advertising that promotes healthy eating for children.
- Disseminate model worksite wellness policies and programs internally, and externally to the business community.

Communities

- Put fruits, vegetables and other healthy foods and beverages within easy reach for all residents in all neighborhoods.
- Provide safe and convenient opportunities for daily physical activity in all neighborhoods.

Schools

- Support the efforts of schools to serve healthy and child-friendly meals and snacks.
- Strengthen state and local school wellness policies and facilitate policy implementation and monitoring in every school through strong school wellness councils.
- Involve all students in high-quality physical education programs and additional physical activity throughout the school day.

Childcare

- Require childcare centers and after-school programs to offer healthy food and beverages, provide opportunities for physical activity, limit television viewing and support breastfeeding for children in their care.

Healthcare

- Promote exclusive breastfeeding at hospitals through proven policies and practices.

### *4-Implement targeted obesity prevention and reduction in high risk communities*

- Through the OMMH Community Health Disparities grant program direct funds to community and faith based organizations to implement evidence based intervention communities at high risk for obesity. 1. The Community Health Disparity Prevention Program focus is the implementation of evidence based or innovative health prevention initiatives to reduce disparities in diabetes, asthma, cancer, cardiac illnesses, violence, and infant mortality, hepatitis B/C, HIV AIDS, immunization, obesity, or unintentional violence.

- Implement the Faithful Families Eating Smarter Moving More (FFESMM) Grant program through the OMMH to promote and improve nutrition and increase physical activity by implementing policy and environmental changes using evidence-based strategies for at-risk racial/ethnic minority populations
- ShapingNJ also provided 17 small community grants designed to implement policy and environmental policies to promote physical activity and healthy eating. Funds support small projects and build infrastructure in communities by fostering partnerships.

### *5. - Provide essential services through the Women, Infants, and Children (WIC) program*

- New Jersey WIC Services provides supplemental nutritious foods to pregnant, breastfeeding and postpartum women, infants and children up to the age of five. WIC services include nutrition education and counseling, breastfeeding promotion and support, immunization screening and health care referrals.
- Through WIC, serve New Jersey's youngest residents and their families at risk for poor nutrition and medically related health problems. Services are available to low and no income families as well as families experiencing unemployment, military deployment and other interim family financial hardships.
- Issue WIC checks for nutritious foods that can be cashed at grocery stores
- Provide nutrition education and counseling, breastfeeding education and support, Immunization screening and referrals, referrals for free or reduced cost health care, and referrals to health or social services including Medicaid, Food stamps/Supplemental Nutrition Assistance Program (SNEP); Family care (health care); and TANF (Temporary Assistance for Needy Families).

### *6. Promote the Senior Farmer's Market Nutrition Initiative*

The purpose of the Senior Farmers' Market Nutrition Program (SFMNP) is to provide unprepared, locally grown fresh fruits, vegetables, and herbs for the nutritional health of New Jersey's senior citizens, and to expand the awareness and use of the local farmers' markets. To be eligible to receive SFMNP benefits, a senior citizen must be at least sixty years old, and be at or below the Federal Income guidelines. The program is administered through the County Offices on Aging, City of Paterson, and Jersey City. Each County or City agency screens senior citizens for eligibility and determines the number of seniors that would receive SFMNP benefits each year based on available funding.

- Provide eligible senior participant a total of $20.00 for the season to purchase fresh fruits, vegetables, and herbs from authorized farmers to be used one time for the entire season, from June 1 to September 30 each year.
- Recruit additional authorized farmer vendors to participate in SFMNP

## POLICY

P.L. 2011 c.10 (A2854 1R)

- The Department of Agriculture, in cooperation with the Department of Education, coordinates with farmers in the State, the New Jersey Farm to School Network to establish an annual week of promotional events to be known as "Jersey Fresh Farm to School Week." The week is celebrated each year throughout the State with the holding of relevant promotional events during the last week of September, effective June 1, 2011. "Jersey Fresh Farm to School Week" promotes the value and importance of New Jersey agriculture and fresh foods produced in New Jersey, and the value in consuming fresh farm foods for children, their general health, and their success in school. The promotional events shall be provided to: (1) children through school breakfast, lunch, and snack programs and in the classroom; (2) community groups, churches, and service organizations; (3) the public at large at farms and community farmers markets; and (4) other organizations or groups or at other locations in the State determined by the Department of Agriculture to be beneficial for the success of promoting the value and importance of New Jersey agriculture and fresh foods produced in New Jersey.

Complete Streets in New Jersey, December 3, 2009 - A Compilation of State, County and Municipal Policies, August, 2012.

- The New Jersey Department of Transportation shall implement a Complete Streets policy through the planning, design, construction, maintenance and operation of new and retrofit transportation facilities, enabling safe access and mobility of pedestrians, bicyclists, transit users of all ages and abilities. This includes all projects funded through the Department's Capital Program. The Department strongly encourages the adoption of similar policies by regional and local jurisdictions who apply for funding through local aid programs.
- In 2013, the DOH collaborated with the Department of Transportation to expand the Complete Streets initiative from five counties to all 21 counties in New Jersey.

## CONCLUSION AND NEXT STEPS

Hundreds of DOH staff work collaboratively with internal and external partners to implement the State Health Improvement Plan strategies described within. Throughout the decade, DOH will continuously identify, analyze and address health problems in the state. The SHIP helps to focus the strategies, and monitor accomplishments along the way. A structured and regular review of the agency led activities will provide numerous opportunities for improvement.

Using quality improvement methods, DOH will monitor, evaluate and update the SHIP on a three year cycle. Emerging health issues will be evaluated regularly to ensure they are addressed with the same structure and deliberate planning as those long standing health issues identified through Healthy New Jersey surveillance and data collection activities.

# APPENDIX

A: NEW JERSEY DOH STRATEGIC PLAN 2012-2015 STRATEGY MAP

B: REGIONAL MEETING PARTICIPATING ORGANIZATIONS NOVEMBER 2011

C: HNJ INITIATIVE RESOURCE LINKS

D: HNJ2020 REGIONAL MEETINGS PUBLIC HEALTH PRIORITY AREAS POLL

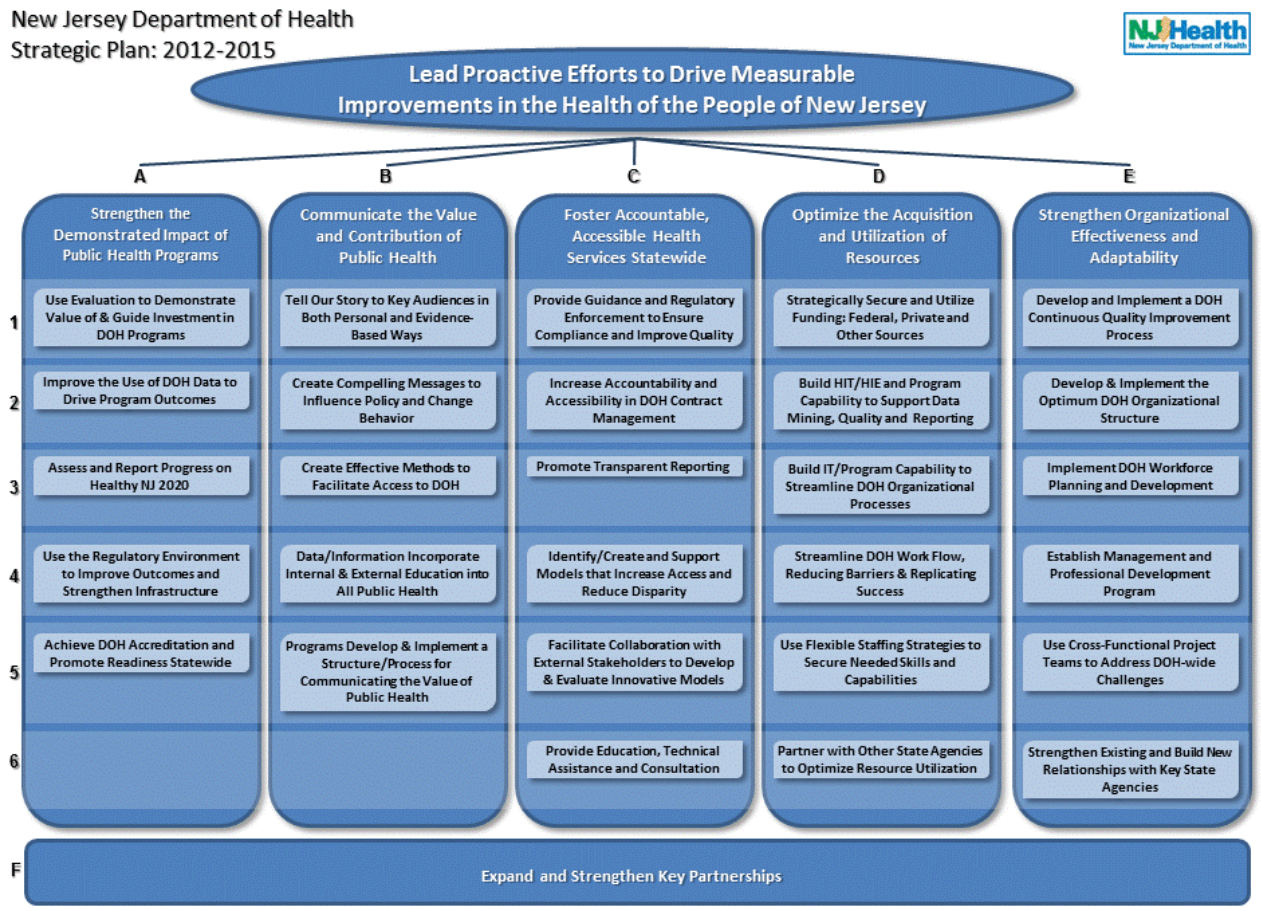
E: GUIDE FOR BREAKOUT SESSION FACILITATORS

F: HEALTHY NEW JERSEY 2020 OBJECTIVES, BASELINES, AND TARGETS

G: HEALTHY NEW JERSEY 2020 LEADING HEALTH INDICATORS

H: SHIP STRATEGIES 2012-2015

## APPENDIX A: NEW JERSEY DOH STRATEGIC PLAN 2012-2015 STRATEGY MAP



## APPENDIX B: REGIONAL MEETING PARTICIPATING ORGANIZATIONS NOVEMBER 2011

American Dairy Association and Dairy Council
American Diabetes Association
American Heart Association
Amerigroup
Barnabas Health, Institute for Prevention
Boston Medical Center
CAMcare Health Corporation
Camden County
City of Englewood
County Sussex Department of Environmental & Public Health
Department of Veterans Affairs
DHS Division of Medical Assistance & Health Services
Edison Department of Health & Human Services
George Street Playhouse
HiTOPS Adolescent Health & Education Center
Horizon NJ Health
Juvenile Justice Commission
Komen North Jersey Affiliate
Latino Health Institute
Leche de Mama
Madison Health Department
Middlesex County
Monmouth County Regional Health Commission
Montville Health Department
Morris County Office of Health Management
Morris County Park Commission
National Kidney Foundation
NJ Department of Education
NJ Prevention Network
NJ Association of Mental Health & Addiction Agencies
NJ Poison Information Education System
NJ Society for Public Health Education
Medical School
New Jersey School-Age Care Coalition
Ocean County Health Department
Passaic County
Programs for Parents
Robin Fein, LCSW
Rutgers University - School of Nursing
Rutgers University – Camden
Saint Peter's University Hospital
Senior Citizens United Community Services
Sisters Network Newark
Southern NJ Perinatal Cooperative
The Family Resource Network
The Valley Hospital
Township of South Orange
Rutgers School of Dental Medicine
Eric B. Chandler Health Center
Violence Institute of New Jersey
American Cancer Society
American Stroke Association
American Lung Association in New Jersey
Atlanticare
Bergen County Department of Health Services
Borough of Paramus
Camden Area Health Education Center (AHEC)
Center for Independent Living of South Jersey
City of Hackensack
Creighton University

E Morristown Medical Center
Friends of Grace Seniors Korean Community Center
Hispanic Family Center
Holy Redeemer Homecare
Hudson Perinatal Consortium
Kennedy Health System
Lactation Education of Princeton
Latino Information Network at Rutgers
Linden Health Department
Middle-Brook Regional Health Commission
Middlesex County College
Montclair State University
Morris County
Morristown Medical Center
Morris Regional Public Health Partnership, Inc.
NJ Catholic Conference
NJ Health Literacy Coalition
Newark Beth Israel Medical Center
NJ Global Advisors on Smokefree Policy
NJ Partnership for Healthy Kids-Camden
NJDHS, Diabetic Eye Disease Detection ProgramNew Jersey
Woodbridge Township Board of Education
North West Bergen Regional Health Commission
Our Wellness Group
Passaic County Department of Health
Rescue Mission of Trenton
Rose Health Coaching
Rutgers University
Saint Peter's Healthcare System
Sanofi, Inc.
Shri Krishna Nidhi (SKN) Foundation
SNJ Perinatal Cooperative
Sussex County
The Healthcare Foundation of New Jersey
Township of Edison
Rutgers New Jersey Medical
Rutgers- School of Public Health
United Way
Vineland City Department of Health

## APPENDIX C: HNJ INITIATIVE RESOURCE LINKS

### Healthy New Jersey 2020

[Healthy New Jersey Website]


[Healthy New Jersey 2020: Leading Health Indicators]

### New Jersey State Health Assessment Data (NJSHAD) System

[Tracking Healthy New Jersey Progress]
Baseline and trend data and graphs for Healthy New Jersey and Healthy People objectives

### Healthy New Jersey 2010

[Healthy New Jersey 2010: Update 2005]
Progress assessment and trend data and graphs
[Healthy New Jersey 2010: Volume I (6/2001)]
[Healthy New Jersey 2010: Volume II (6/2001)]
Baseline data and targets

### Federal Initiatives - Healthy People


[Healthy People 2020]

[Healthy People 2010]
Federal comprehensive health promotion and disease prevention agenda

[Data 2010]
Interactive database used to track Healthy People 2010 objectives

## APPENDIX D: HNJ2020 REGIONAL MEETINGS PUBLIC HEALTH PRIORITY AREAS POLL

### Healthy New Jersey 2020 Regional Meetings Public Health Priority Areas Poll

**Please select five (5) topics/indicators below that you feel should be the State's priorities for 2011-2020. All responses will be aggregated and the ten (10) with the most votes will become the new Leading Health Indicators for New Jersey.**
**Note: Select no more than 5 topics (indicators in parentheses).**

| Answer Options | Response Percent | Response Count |
|---|---|---|
| **Childhood obesity** (Reduce the proportion of children and adolescents who are considered obese) | 57.2% | 91 |
| **Youth smoking** (Reduce the initiation of tobacco use among children, adolescents, and young adults) | 49.7% | 79 |
| **Health insurance coverage** (Increase the proportion of persons with health insurance) | 44.7% | 71 |
| **Adult smoking** (Reduce tobacco use by adults) | 40.3% | 64 |
| **Access to primary care** (Increase proportion of persons with a usual primary care provider) | 34.6% | 55 |
| **Adult physical activity** (Increase the proportion of adults who meet current federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity) | 31.4% | 50 |
| **Cancer** (Reduce the overall cancer death rate) | 28.9% | 46 |
| **Educational achievement** (Increase educational achievement of adolescents and young adults) | 27.0% | 43 |
| **Heart disease** (Reduce coronary heart disease deaths) | 22.6% | 36 |
| **Substance abuse** (Reduce past-month use of illicit substances) | 20.8% | 33 |
| **Hypertension** (Reduce the proportion of persons in the population with hypertension) | 15.1% | 24 |
| **Safe sex** (Increase the proportion of sexually active persons who use condoms) | 14.5% | 23 |
| **Other** (specify) | 14.5% | 23 |
| **Depression** (Reduce the proportion of persons who experience major depressive episodes) | 13.2% | 21 |
| **Teen births** (Reduce birth rates among adolescent females) | 12.6% | 20 |
| **Air quality** (Reduce the number of days the Air Quality Index (AQI) exceeds 100) | 11.3% | 18 |
| **Binge drinking** (Reduce the proportion of persons engaging in binge drinking of alcoholic beverages) | 8.8% | 14 |
| **Low birth weight** (Reduce low birth weight) | 6.3% | 10 |
| **Healthcare-associated infections** (Reduce central line-associated bloodstream infections) | 6.3% | 10 |
| **Injury** (Reduce fatal injuries) | 2.5% | 4 |

**Healthy New Jersey 2020 Regional Meetings Public Health Priority Areas Poll**

| Number | Response Date | Other (specify) |
|---|---|---|
| 1 | Nov 4, 2011 2:34 PM | Improve education about the effects of overall lifestyle choices,on all of the above motioned topics, with action steps and follow up to help make the improvements in lifestyle become habit. |
| 2 | Nov 4, 2011 11:20 AM | Chronic Kidney Disease |
| 3 | Nov 3, 2011 5:58 PM | focus on prevention and wellness |
| 4 | Nov 3, 2011 2:55 PM | adult obesity and nutrition |
| 5 | Nov 3, 2011 12:54 PM | Smoke-free outdoor air |
| 6 | Nov 2, 2011 6:52 PM | Prevention/reduction of obesity in adults as well as children |
| 7 | Nov 2, 2011 6:48 PM | Lead Poisoning Prevention |
| 8 | Nov 2, 2011 4:47 PM | Reduce Eliminate Health Disparities |
| 9 | Oct 29, 2011 7:40 AM | Military and their families. (Assistance in readjustment to the community, support the spouse and children during deployment. |
| 10 | Oct 27, 2011 2:16 PM | reduce diabetes |
| 11 | Oct 27, 2011 11:55 AM | Diabetes prevention, control, & education |
| 12 | Oct 26, 2011 8:44 PM | Built environment and access to daily physical activity |
| 13 | Oct 26, 2011 5:15 PM | Diabetes Prevention |
| 14 | Oct 25, 2011 10:19 PM | reduce the incidence of type 2 Diabetes, |
| 15 | Oct 24, 2011 5:40 PM | Reduce poverty |
| 16 | Oct 23, 2011 1:29 PM | Increase access to dental care to the uninsured and underinsured adult/child |
| 17 | Oct 21, 2011 11:48 PM | supporting financing medical home |
| 18 | Oct 20, 2011 3:30 PM | Access to preventive care services for individuals with intellectual and developmental disabilities |
| 19 | Oct 19, 2011 5:50 PM | disability |
| 20 | Oct 18, 2011 7:28 PM | Harmful public policies towards substance use disorders |
| 21 | Oct 18, 2011 6:21 PM | Health insurance should emphasize wellness and prevention - not just treatment |
| 22 | Oct 18, 2011 4:26 PM | Diabetes, and I think you should use the National Prevention Strategy categories Active Living Healthy Eating etc |
| 23 | Oct 18, 2011 4:22 PM | teen abstinence/chastity |

## Healthy New Jersey 2020 Regional Meetings

## Guide for Breakout Session Facilitators

Facilitators will lead one-hour, small-group discussions with approx. 15-20 attendees (smaller groups at the Camden meeting) around the four primary questions outlined below. The first two questions are actually 3-part questions. To give you an idea of the kinds of responses to illicit from participants for each question, we have included a mock dialogue below. Facilitator questions appear in black text, and "good example" responses appear in blue text. General advice and guidelines for facilitators appear at the end.

1. What strategies do you use now in order to reach health improvement goals? (**Example #1: reducing pediatric asthma hospitalizations**)

   - In Camden, we are implementing an intervention to reduce pediatric asthma hospitalizations and in-school absences, and to improve overall self-management techniques.

     a. Name the one thing that makes this strategy successful?

        - We assign a case manager to each family, and they complete an in-take form, which includes questions about the number of asthma hospitalizations and number of school days missed due to asthma for each child in the household.

     b. How are you measuring the success of these strategies?

        - The questions are repeated during sessions with the families every three months. The case manager enters this information into a database over the course of a year. Additionally, an Asthma Action Plan, which identifies the asthma triggers specific to the child(ren), is developed for each family in consultation with a health care provider. Access to health care services for participating children is coordinated with the local FQHC.

**2.** What strategies would you like to implement in order to reach health improvement goals?

(**Example #2: Expanding a smoking cessation program)**

- The County Health Department currently offers counseling for smoking cessation through a telephone hotline. We would like to develop an online version of this service. However, no one in our organization knows how to set up the web resource, and we do not have any funds to pay for a consultant to help us.

  a. Why do you think this strategy would be successful?

     - Based on what we know about the local community, we think we can assist more people in their smoking cessation efforts if we allow them the opportunity to seek this help on line at any time of day or night. Also, some people would rather not speak to a live person.

  b. How would you measure the success of these strategies?

- We can keep track of the number of hits on the web page or number of registrants to the site to see if it is having the impact we'd like it to.

3. What barriers exist for implementing these existing or new strategies?

- Staff turnover is too quick.
- We do not have staff members who have the appropriate skill set to accomplish the goals we set.
- There is a language issue which we have not yet determined how to address. We are not able to effectively communicate with some of our non-English speaking community members.

4. What assistance could the State and other partners provide? (besides money!)

- Technical assistance to assess the health status at the local level.
- Guidance on developing health improvement initiatives, and instructions for setting goals and targets for achievement.

---

**General Guidelines:**

- Prior to the breakout sessions, the Regional Meeting speaker presentations will provide definitions to common HNJ terms (i.e., objectives, targets, topic areas, etc.), and will explain how local activities can be tied to HNJ and how baselines can be established.

- CAMDEN FACILITATORS ONLY: Before starting the breakout session, ask for a volunteer to summarize the session's primary discussion points and report to the full group at the Breakout Session Recap. (The Recap portion will NOT be included in New Brunswick).

- Please remind participants that they can MODIFY existing HNJ objectives to meet locally-based objectives that have corresponding data sources, or they can develop NEW objectives that are measurable using local resources.

- Facilitators can encourage discussions about strategies that have not been successful; if the participant was able to quantify the (lack of) success; what barriers impeded their success, etc.

- If a participant is dominating the conversation:
    - Identify that their response has already been captured on the flip chart
    - Walk towards the person and express agreement with them
    - Be direct. "Thank you, but this has already been said." Ask for comments from others.

---

# Healthy New Jersey 2020 Objectives, Baselines, and Targets

*Footnotes and acronym key are below the table.*

| | | | Baseline | Total | | White | | Black | | Hispanic | | Asian | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Data Year | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target |
| **AHS** | **Access to Health Services** | | | | | | | | | | | | |
| | 1 | Increase the proportion of persons with health insurance | | | | | | | | | | | |
| | a | under 65 years of age | 2010 | 82.6% | 93.3% | 90.4% | 93.3% | 72.8% | 93.0% | 66.6% | 75.5% | 87.2% | 95.0% |
| | b | under 19 years of age | 2010 | 90.5% | 95.0% | 94.2% | 95.0% | 80.1% | 93.0% | 87.5% | 90.0% | 93.0% | 95.0% |
| | 2 | Increase the proportion of persons with a personal doctor or health care provider | 2011 | 83.5% | 90.0% | 88.8% | 90.0% | 81.8% | 90.0% | 65.4% | 80.0% | 84.1% | 90.0% |
| **AS** | **Asthma** | | | | | | | | | | | | |
| | 1 | Reduce the death rate due to asthma | | | | | | | | | | | |
| | a | aged 35 to 64 years old | 2005-07 | 1.3 | 0.8 | 0.9 | 0.8 | 4.5 | 0.8 | DSU | DSU | DSU | DSU |
| | b | aged 65 years and older | 2005-07 | 3.7 | 2.0 | 3.2 | 2.0 | 6.6 | 6.0 | DSU | DSU | DSU | DSU |
| | 2 | Reduce the hospitalization rate due to asthma | | | | | | | | | | | |
| | a | aged under 5 years | 2009 | 469 | 328 | 264 | 211 | 928 | 463 | 492 | 295 | 177 | 159 |
| | b | aged 5 to 64 years | 2009 | 140 | 112 | 91 | 77 | 355 | 249 | 162 | 122 | 26 | 23 |
| | c | aged 65 years and older | 2009 | 325 | 260 | 238 | 202 | 661 | 463 | 639 | 479 | 188 | 169 |
| | 3 | Reduce the rate of ED visits due to asthma | | | | | | | | | | | |
| | a | aged under 5 years | 2009 | 1,525 | 1,220 | 780 | 663 | 3731 | 2612 | 1704 | 1278 | 327 | 294 |
| | b | aged 5 to 64 years | 2009 | 626 | 501 | 357 | 303 | 1735 | 1215 | 735 | 551 | 97 | 87 |
| | c | aged 65 years and older | 2009 | 160 | 128 | 90 | 77 | 458 | 321 | 416 | 312 | 65 | 59 |
| | 4 | Reduce the proportion of persons with asthma who miss school or work days | | | | | | | | | | | |
| | a | Children attending school or preschool with asthma who miss days because of asthma | 2013 | NYA | NYA | | | | | | | | |
| | b | Adults aged 18 years and older with asthma who miss work days or limit usual activities because of asthma | 2013 | NYA | NYA | | | | | | | | |
| | 5 | Increase the proportion of persons with asthma who have ever received an asthma action. management, or treatment plan from a health professional | | | | | | | | | | | |
| | a | Children aged 0 to 17 years | 2013 | NYA | NYA | | | | | | | | |
| | b | Adults aged 18 years and older | 2013 | NYA | NYA | | | | | | | | |
| | 6 | Increase the proportion of persons with asthma who have ever been advised by a health professional to change things in the home, school, or work to improve their asthma | | | | | | | | | | | |
| | a | Children aged 0 to 17 years | 2013 | NYA | NYA | | | | | | | | |
| | b | Adults aged 18 years and older | 2013 | NYA | NYA | | | | | | | | |
| **CA** | **Cancer** | | | | | | | | | | | | |
| | 1 | Reduce the death rate due to all cancers (age-adjusted) | 2007 | 179.4 | 161.5 | 189.1 | 170.2 | 207.6 | 186.8 | 102.1 | 91.9 | 72.5 | 65.3 |
| | 2 | Reduce the death rate due to lung cancer (age-adjusted) | 2007 | 46.7 | 42.0 | 52.0 | 46.8 | 46.3 | 41.7 | 17.0 | 15.3 | 14.5 | 13.1 |
| | 3 | Reduce the death rate due to female breast cancer (a-a) | 2007 | 26.1 | 23.5 | 27.4 | 24.7 | 31.8 | 28.6 | 12.4 | 11.2 | 12.1 | 10.9 |
| | 4 | Reduce the death rate due to uterine cervix cancer (a-a) | 2007 | 2.1 | 1.9 | 1.8 | 1.6 | 4.0 | 3.6 | DSU | DSU | DSU | DSU |
| | 5 | Reduce the death rate due to colorectal cancer (age-adj.) | 2007 | 18.6 | 15.8 | 19.1 | 16.2 | 23.7 | 20.1 | 11.2 | 9.5 | 6.3 | 5.4 |
| | 6 | Reduce the death rate due to oropharyngeal cancer (a-a) | 2005-07 | 2.2 | 2.0 | 2.0 | 1.8 | 4.0 | 3.6 | 1.1 | 1.0 | 1.7 | 1.5 |
| | 7 | Reduce the death rate due to prostate cancer (age-adj.) | 2007 | 23.6 | 21.2 | 21.8 | 19.6 | 53.4 | 48.1 | 19.5 | 17.6 | DSU | DSU |
| | 8 | Reduce the death rate due to melanoma cancer (age-adj.) | 2007 | 2.7 | 2.4 | 3.3 | 3.0 | DSU | DSU | DSU | DSU | DSU | DSU |
| | 9 | Reduce the incidence rate of invasive colorectal cancer (a-a) | 2009 preliminary | 44.7 | 39.7 | 46.9 | 39.8 | 48.5 | 41.2 | 36.7 | 31.2 | 29.5 | 25.1 |
| | 10 | Reduce the incidence rate of invasive uterine cervical cancer (age-adjusted) | 2009 preliminary | 8.5 | 7.2 | 7.9 | 7.1 | 10.0 | 9.0 | 12.9 | 11.6 | 7.0 | 6.3 |

# Healthy New Jersey 2020 Objectives, Baselines, and Targets

*Footnotes and acronym key are below the table.*

| | | Baseline | Total | | White | | Black | | Hispanic | | Asian | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Data Year | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target |
| 11 | Reduce the incidence rate of late-stage female breast cancer (age-adjusted) | 2009 preliminary | 46.9 | 43.7 | 45.6 | 43.3 | 51.5 | 48.9 | 37.6 | 35.7 | 35.0 | 33.2 |
| 12 | Increase the proportion of oral and pharyngeal cancers detected at the earliest stage | 2009 preliminary diagnosed 2003-07 and followed thru 2010 | 31.5% | 36.9% | 34.6% | 38.1% | DSU | DSU | DSU | DSU | DSU | DSU |
| 13 | Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis | | 66.6% | 74.6% | 66.8% | 75.0% | 58.7% | 65.7% | 67.3% | 74.6% | 69.0% | 75.2% |
| 14 | Increase the proportion of women aged 21 to 65 years who receive a cervical cancer screening based on the most recent guidelines (Pap smear within past 3 years) | 2011 | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| 15 | Increase the proportion of adults aged 50 to 75 years who receive a colorectal cancer screening based on the most recent guidelines | 2011 | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| 16 | Increase the proportion of women aged 50 to 74 years who receive a breast cancer screening based on the most recent guidelines (mammogram in past 2 years) | 2011 | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| 17 | Increase the proportion of men aged 40 and over whose doctor, nurse or other health professional have ever talked to them about the advantages and disadvantages of the prostate-specific antigen (PSA) test to screen for prostate cancer | 2011 | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| 18 | Reduce the proportion of adults aged 18 years and older who report sunburn | 2011 | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| **CKD** | **Chronic Kidney Disease** | | | | | | | | | | | |
| 1 | Reduce the death rate due to kidney disease (age-adjusted) | 2007 | 17.4 | | 16.2 | | 31.6 | | 11.5 | | 11.6 | |
| 2 | Reduce the incidence of end-stage renal disease (ESRD) | 2009 | 39.8 | 35.8 | 33.9 | 30.5 | 93.6 | 74.9 | 27.1 | 24.4 | 19.7 | 17.7 |
| 3 | Reduce the incidence of ESRD due to diabetes among adults aged 18 years and older with diagnosed diabetes | 2009 | 22.4 | 20.2 | 17.0 | 15.3 | 57.6 | 51.8 | 21.3 | 19.2 | 10.0 | 9.0 |
| 4 | Reduce the death rate due to end-stage renal disease (ESRD) (age-adjusted) | 2005-2007 | 4.4 | 4.0 | 3.6 | 3.2 | 12.1 | 10.9 | 4.0 | 3.6 | 2.2 | 2.0 |
| **DM** | **Diabetes** | | | | | | | | | | | |
| 1 | Reduce the death rate due to diabetes (age-adjusted) | 2007 | 24.4 | 15.8 | 21.4 | 16.0 | 47.9 | 38.5 | 29.2 | 24.5 | 18.0 | 12.0 |
| 2 | Reduce the rate of lower extremity amputations in persons with diagnosed diabetes | 2009 | 31.8 | 28.6 | 26.9 | 24.2 | 76.6 | 68.9 | 26.4 | 23.8 | 7.0 | 6.3 |
| 3 | Increase the proportion of adults with diabetes who have an annual dilated eye examination (age-adjusted) | 2009-2011 | 65.6% | 72.2% | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| 4 | Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement (A1C) at least twice a year (age-adjusted) | 2009-2011 | 54.0% | 59.4% | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| **EH** | **Environmental Health** | | | | | | | | | | | |
| 1 | Reduce the number of unhealthful days throughout the state, as determined by the Air Quality Index | 2010 | 5 | 0 | | | | | | | | |
| 2 | Increase the percentage of homes in New Jersey that have ever been tested for radon | 2010 | 25.3% | 35.0% | | | | | | | | |

# Healthy New Jersey 2020 Objectives, Baselines, and Targets

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| | | | Baseline | Total | | White | | Black | | Hispanic | | Asian | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Data Year | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target |
| | 3 | Increase the percentage of homes testing equal to or greater than 4 picocuries per liter of air that have been mitigated | 2010 | 43.6% | 50.0% | | | | | | | | |
| | 4 | Maintain or increase the percentage of community water systems in compliance with all current state and federal drinking water requirements for water quality | | | | | | | | | | | |
| | a | Chemical standard | 2010 | 97% | 97% | | | | | | | | |
| | b | Radiological standard | 2010 | 98% | 98% | | | | | | | | |
| | c | Microbiological standard | 2010 | 97% | 97% | | | | | | | | |
| | 5 | Reduce the number of beach closings due to elevated bacteriological levels | 2000-2010 annual average | 48.3 | 30 | | | | | | | | |
| **HAI** | | **Healthcare-Associated Infections** | | | | | | | | | | | |
| | 1 | Reduce central line blood related infections (CLASBI) | 2006-2008 | 0.73 | 0.50 | | | | | | | | |
| | 2 | Reduce catheter associated urinary tract infections (CAUTI) | 2010 | 1.00 | 0.75 | | | | | | | | |
| | 3 | Reduce Clostridium difficile/Multidrug-Resistant Organism (CDIFF/MDRO) infections | TBD | NYA | 0.90 | | | | | | | | |
| | 4 | Reduce surgical site infections (SSI) in coronary artery bypass grafts (CABGs) in hospitals | 2009 | 0.80 | 0.70 | | | | | | | | |
| | 5 | Reduce surgical site infections (SSI) in abdominal hysterectomies in hospitals | 2009 | 0.97 | 0.80 | | | | | | | | |
| | 6 | Reduce surgical site infections (SSI) in knee arthroplasties in hospitals | 2010 | 0.80 | 0.70 | | | | | | | | |
| | 7 | Reduce surgical site infections (SSI) in knee arthroplasties in ambulatory surgery centers (ASCs) | 2012 | NYA | 0.70 | | | | | | | | |
| | 8 | Reduce surgical site infections (SSI) in laminectomies in ambulatory surgery centers (ASCs) | 2012 | NYA | 0.80 | | | | | | | | |
| | 9 | Reduce surgical site infections (SSI) in breast surgery in ambulatory surgery centers (ASCs) | 2012 | NYA | 0.90 | | | | | | | | |
| **HDS** | | **Heart Disease and Stroke** | | | | | | | | | | | |
| | 1 | Reduce the death rate due to coronary heart disease (age-adjusted) | 2007 | 140.1 | 112.1 | 144.6 | 115.7 | 167.3 | 133.8 | 78.2 | 62.6 | 66.1 | 52.9 |
| | 2 | Reduce the death rate due to stroke (age-adjusted) | 2007 | 35.8 | 28.6 | 35.0 | 28.0 | 51.8 | 41.4 | 21.4 | 17.1 | 21.7 | 17.4 |
| | 3 | Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years (age-adjusted) | 2011 | 78.8% | 86.7% | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| **HIV** | | **HIV/AIDS** | | | | | | | | | | | |
| | 1 | Reduce the rate of HIV transmission among adolescents and adults | 2008 | 15.6 | 12.5 | 4.5 | 3.6 | 65.3 | 52.2 | 23.2 | 18.6 | DSU | DSU |
| | 2 | Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards | 2008 | 54% | 65% | 56% | 67% | 55% | 67% | 49% | 60% | DSU | DSU |
| | 3 | Reduce the death rate due to HIV infection | 2007 | 5.3 | 4.2 | 1.7 | 1.4 | 27.3 | 21.8 | 5.9 | 4.7 | DSU | DSU |
| | 4 | Increase the proportion of adults aged 18 to 64 years who have been tested for HIV in the past 12 months | 2010 | 13.3% | 16.0% | 9.8% | 11.8% | 35.4% | 42.5% | 19.3% | 23.2% | DSU | DSU |
| | 5 | Reduce the proportion of cases simultaneously diagnosed with HIV and AIDS | 2008 | 26.6% | 21.3% | 22.9% | 18.3% | 26.7% | 21.3% | 30.0% | 24.0% | DSU | DSU |

# Healthy New Jersey 2020 Objectives, Baselines, and Targets

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| | | Baseline | Total | | White | | Black | | Hispanic | | Asian | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Data Year | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target |
| **IMM** | **Immunization** | | | | | | | | | | | |
| 1 | Increase effective vaccination coverage levels for universally recommended vaccines among young children | | | | | | | | | | | |
| a | 4 doses diphtheria-tetanus-acellular pertussis (DTaP) vaccine by age 19 to 35 months | 2011 | 87% | 95% | | | | | | | | |
| b | birth dose of hepatitis B vaccine (0 to 3 days between birth date and date of vaccination, reported by annual birth cohort) | 2011 | 47% | 75% | | | | | | | | |
| c | 4 doses of pneumococcal conjugate vaccine (PCV) among children by age 19 to 35 months | 2011 | 84% | 90% | | | | | | | | |
| 2 | Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV) | 2011 | 74% | 80% | | | | | | | | |
| 3 | Increase the percentage of noninstitutionalized adults aged 65 years and older who have ever been vaccinated against pneumococcal infections | 2011 | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| 4 | Increase the percentage of noninstitutionalized adults aged 65 years and older who are vaccinated annually against seasonal influenza | 2011 | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| **IVP** | **Injury and Violence Prevention** | | | | | | | | | | | |
| 1 | Reduce the death rate due to homicide | | | | | | | | | | | |
| a | age-adjusted | 2007 | 4.8 | 4.3 | 1.2 | 1.1 | 20.7 | 18.6 | 5.1 | 4.6 | DSU | DSU |
| b | 15-19 year old males | 2005-07 | 16.2 | 14.6 | DSU | DSU | 78.4 | 70.6 | 15.4 | 13.9 | DSU | DSU |
| c | 20-34 years old - both genders | 2005-07 | 13.4 | 12.1 | 2.6 | 2.3 | 63.3 | 57.0 | 9.5 | 8.6 | DSU | DSU |
| 2 | Reduce the death rates due to firearm-related injuries | | | | | | | | | | | |
| a | age-adjusted | 2007 | 5.2 | 4.7 | 2.7 | 2.4 | 17.5 | 15.8 | 4.0 | 3.6 | DSU | DSU |
| b | 15-19 year old males | 2005-07 | 15.2 | 13.7 | DSU | DSU | 75.6 | 68.0 | DSU | DSU | DSU | DSU |
| 3 | Reduce the age-adjusted suicide rate | 2007 | 6.6 | 5.9 | 7.8 | 7.0 | 2.8 | 2.5 | 6.1 | 5.5 | 5.1 | 4.6 |
| 4 | Reduce suicide attempts by adolescents (grades 9 through 12) | 2007 | 7.2% | 6.5% | 4.8% | 4.3% | 9.1% | 8.2% | 11.7% | 10.5% | DSU | DSU |
| 5 | Reduce the death rate due to motor vehicle-related injuries | 2007 | 7.8 | 7.1 | 7.5 | 6.8 | 10.4 | 9.6 | 8.8 | 8.2 | 4.3 | 3.6 |
| 6 | Reduce the death rate due to unintentional poisonings | 2007 | 7.5 | 6.8 | 9.5 | 8.6 | 9.5 | 8.6 | 3.4 | 3.1 | DSU | DSU |
| 7 | Increase seat belt use "most of the time" or "always" | | | | | | | | | | | |
| a | adults aged 18 years and older | 2010 | 90.3% | 99.3% | 89.3% | 98.2% | 89.5% | 98.5% | 93.1% | 100.0% | 95.7% | 100.0% |
| b | high school students (grades 9-12) | 2009 | 78.0% | 85.8% | 83.0% | 91.3% | 69.5% | 76.5% | 71.2% | 78.3% | | |
| c | observational | 2010 | 93.7% | 100.0% | | | | | | | | |
| **MCH** | **Maternal and Child Health** | | | | | | | | | | | |
| 1 | Reduce the rate of all infant deaths | 2007 | 5.1 | 4.8 | 3.1 | 1.9 | 10.9 | 6.0 | 5.4 | 4.5 | 2.3 | 2.2 |
| 2 | Reduce low birth weight (LBW) and very low birth weight (VLBW) * | | | | | | | | | | | |
| a | low birth weight (LBW) | 2008 | 8.1% | 7.7% | 7.3% | 6.9% | 13.0% | 12.4% | 7.5% | 7.1% | 8.3% | 7.9% |
| b | very low birth weight (VLBW) | 2008 | 1.5% | 1.4% | 1.3% | 1.2% | 3.1% | 2.9% | 1.5% | 1.4% | 1.0% | 1.0% |
| 3 | Increase the proportion of pregnant women who receive prenatal care beginning in first trimester * | 2008 | 75.6% | 79.4% | 86.4% | 90.7% | 64.2% | 67.4% | 68.7% | 72.1% | 86.5% | 90.8% |
| 4 | Increase abstinence from alcohol among pregnant women * | 2008 | 94.2% | 99.5% | 96.0% | 99.4% | 97.9% | 98.8% | 99.0% | 99.6% | 98.6% | 99.8% |

# Healthy New Jersey 2020 Objectives, Baselines, and Targets

*Footnotes and acronym key are below the table.*

| | | Baseline | Total | | White | | Black | | Hispanic | | Asian | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Data Year | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target |
| 5 | Increase abstinence from cigarette smoking among pregnant women * | 2008 | 88.9% | 94.8% | 88.9% | 94.8% | 89.9% | 92.1% | 96.1% | 96.8% | 97.9% | 99.3% |
| 6 | Increase the proportion of infants who are put to sleep on their backs | 2006-2008 | 69.0% | 80.0% | | | | | | | | |
| 7 | Increase the proportion of infants who are breastfed | | | | | | | | | | | |
| a | Ever | 2007 | 72.1% | 85.0% | | | | | | | | |
| b | At 6 months | 2007 | 42.3% | 60.0% | | | | | | | | |
| c | Exclusively through 3 months | 2007 | 29.8% | 45.0% | | | | | | | | |
| 8 | Reduce the proportion of breastfeeding infants who receive formula supplementation before two days of age | 2009 | 38.0% | 10.0% | | | | | | | | |
| 9 | Increase the percentage of New Jersey delivery facilities that provide maternal and newborn care consistent with the WHO/UNICEF Ten Steps to Successful Breastfeeding | 2007 | 0% | 50.0% | | | | | | | | |
| 10 | Reduce the birth rate among females aged 15-17 | 2008 | 12.0 | 11.4 | 2.6 | 2.5 | 26.9 | 25.6 | 33.0 | 31.4 | DSU | DSU |
| 11 | Reduce the proportion of children aged 1-5 years who have an initial blood lead level >= 10ug/dL | 2005-08 | 1.3% | 0.9% | | | | | | | | |
| 12 | Reduce mean blood lead levels in children aged 1 to 5 years to an average blood lead level of <=2.9 µg/dL | 2005-08 | 3.2 µg/dL | 2.9 µg/dL | | | | | | | | |
| 13 | Increase the percentage of infants receiving diagnostic follow-up after a positive screen for hearing loss by 3 months of age | 2009 | 60.7% | 80.0% | 69.3% | 80.0% | 54.9% | 80.0% | 76.1% | 80.0% | 55.3% | 80.0% |
| **NF** | **Nutrition and Fitness** | | | | | | | | | | | |
| 1 | Prevent an increase in the proportion of the population that is obese | | | | | | | | | | | |
| a | adults 20 years and older (age-adjusted) | 2011 2009 total | 23.8% | 23.8% | 22.4% | 22.4% | 32.5% | 32.5% | 28.0% | 28.0% | 11.0% | 11.0% |
| b | high school students | 2007 r/e | 10.3% | 10.3% | 8.2% | 8.2% | 16.5% | 16.5% | 14.4% | 14.4% | n/a | n/a |
| 2 | Increase the proportion of the population consuming five or more servings of fruits and vegetables per day | | | | | | | | | | | |
| a | adults 18 years and older | 2011 2009 total | 26.1% | 28.7% | 26.1% | 22.1% | 26.6% | 19.9% | 23.9% | 30.8% | 24.8% | 18.6% |
| b | high school students | 2007 r/e | 20.1% | 22.1% | 17.9% | 19.7% | 21.5% | 23.7% | 19.0% | 20.9% | n/a | n/a |
| 3 | Increase aerobic physical activity | | | | | | | | | | | |
| a | proportion of NJ adults who meet current Federal physical activity guidelines for moderate or vigorous physical activity (age-adjusted) | 2011 | 53.2% | 58.5% | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| b | proportion of NJ high school students that meet current physical activity guidelines for aerobic physical activity *(data shown are 60+ min, 5+ days/wk)* | 2009 | 21.3% | 23.4% | 23.1% | 25.4% | 18.6% | 20.5% | 18.7% | 20.6% | n/a | n/a |
| 4 | Reduce screen time among high school students | | | | | | | | | | | |
| a | Increase the proportion who watch TV for no more than 2 hours a day | 2009 | 67.4% | 74.1% | 75.1% | 82.6% | 45.6% | 50.2% | 58.1% | 63.9% | n/a | n/a |
| b | Increase the proportion who use the computer for no more than 2 hours a day | 2009 | 71.1% | 78.2% | 74.7% | 82.2% | 63.9% | 70.3% | 69.6% | 76.6% | n/a | n/a |
| 5 | Reduce the proportion of high school students (grades 9-12) who drank soda one or more times per day in the past 7 days | 2009 | 19.9% | 13.9% | 18.6% | 13.0% | 22.7% | 15.9% | 21.3% | 14.9% | | |
| **OSH** | **Occupational Safety & Health** | | | | | | | | | | | |

# Healthy New Jersey 2020 Objectives, Baselines, and Targets

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Data Year | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target |
| | Reduce the mortality rate due to work-related fatal injuries | | | | | | | | | | | |
| 1 | (unintentional and homicide) | | | | | | | | | | | |
| a | all industry | 2008 | 2.1 | 1.7 | | | | | | | | |
| b | construction | 2008 | 11.0 | 8.8 | | | | | | | | |
| | Reduce deaths from pneumoconiosis among persons aged 15 | | | | | | | | | | | |
| 2 | years and older (per 1,000,000) | 2007 | 6.9 | 6.0 | | | | | | | | |
| | Reduce the proportion of persons who have elevated (>=25 | | | | | | | | | | | |
| 3 | µg/dL) blood lead concentrations from work exposures | 2007 | 1.8 | 1.6 | | | | | | | | |
| **OA** | **Older Adults** | | | | | | | | | | | |
| 1 | Reduce the rate of hip fractures among older adults | | | | | | | | | | | |
| a | females aged 65 years and older | 2010 | 802.0 | 681.7 | 926.8 | 787.8 | 256.1 | 217.7 | 382.4 | 325.0 | 318.4 | 270.6 |
| b | males aged 65 years and older | 2010 | 413.0 | 351.1 | 458.8 | 390.0 | 232.4 | 197.5 | 249.0 | 211.7 | 124.8 | 106.1 |
| | Reduce the rate of fall-related deaths among persons aged 65 | | | | | | | | | | | |
| 2 | years and older | 2006-08 | 24.8 | 24.8 | 28.2 | 28.2 | 12.8 | 12.8 | 12.4 | 12.4 | DSU | DSU |
| | Reduce the proportion of older adults who engage in no | | | | | | | | | | | |
| 3 | leisure-time physical activity | | | | | | | | | | | |
| a | aged 65-74 years | 2011 | 33.7% | 30.3% | 31.9% | 28.7% | 43.2% | 38.9% | 38.2% | 34.4% | DSU | DSU |
| b | aged 75+ years | 2011 | 43.1% | 38.8% | 41.6% | 37.4% | 49.9% | 44.9% | 55.1% | 49.6% | DSU | DSU |
| | Reduce the percentage of funds allocated to nursing homes | | | | | | | | | | | |
| | as compared to funds allocated to Home and Community | | | | | | | | | | | |
| 4 | Based Programs (HCBP) | SFY 2010 | 71.3% | 59.2% | | | | | | | | |
| | Reduce the percentage of non-institutionalized persons aged | | | | | | | | | | | |
| 5 | 65 years and older reporting fair or poor health status | 2011 | 26.3% | 25.0% | 23.9% | 22.7% | 30.8% | 29.3% | 47.0% | 44.7% | DSU | DSU |
| **PHI** | **Public Health Infrastructure** | | | | | | | | | | | |
| | Increase the proportion of NJ community colleges that offer | | | | | | | | | | | |
| | public health or related associates degrees and/or certificate | | | | | | | | | | | |
| 1 | programs | 2012 | 0.0% | 20.0% | | | | | | | | |
| | Increase the percentage of local public health agencies | | | | | | | | | | | |
| | actively participating in county-wide community public health | | | | | | | | | | | |
| 2 | partnerships | 2013 | 95.0% | 100.0% | | | | | | | | |
| | On a scale of 1 (nonexistent) to 5 (ideal), increase the median | | | | | | | | | | | |
| | level of collaboration of local public health agencies in county- | | | | | | | | | | | |
| 3 | wide community public health partnerships | 2013 | 3 | 5 | | | | | | | | |
| | Increase the proportion of local health departments that | | | | | | | | | | | |
| 4 | achieve voluntary national accreditation | 2012 | 0.0% | 75.0% | | | | | | | | |
| **PHP** | **Public Health Preparedness** | | | | | | | | | | | |
| | Reduce the time necessary to issue official information to the | | | | | | | | | | | |
| 1 | public about a public health emergency | 2009 | 6 hours | 5 hours | | | | | | | | |
| | Reduce the time necessary to activate designated personnel | | | | | | | | | | | |
| 2 | in response to a public health emergency | 2011 | 120 min | 100 min | | | | | | | | |
| | Reduce the time for State public health agencies to establish | | | | | | | | | | | |
| | after action reports and improvement plans following | | 160 | | | | | | | | | |
| 3 | responses to public health emergencies and exercises | 2010 | days | 120 days | | | | | | | | |
| **STD** | **Sexually Transmitted Diseases** | | | | | | | | | | | |
| | Reduce the proportion of females 15-24 years-old with | | | | | | | | | | | |
| 1 | Chlamydia trachomatis infections ("tested anywhere") ** | 2010 | 3,029 | 2,726 | | | | | | | | |

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| | | Baseline | Total | | White | | Black | | Hispanic | | Asian | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Baseline Data Year | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target | Baseline | Target |
| | Reduce the proportion of persons 15-24 with Chlamydia trachomatis infections (family planning patients and STD clinic | | | | | | | | | | | |
| 2 | patients) | 2010 | 9.8% | 8.8% | 4.4% | 3.9% | 15.2% | 13.7% | 7.9% | 7.1% | 7.8% | 7.0% |
| 3 | Reduce the incidence rate of gonorrhea ** | | | | | | | | | | | |
| a | males aged 15 to 44 years | 2010 | 147.0 | 132.0 | | | | | | | | |
| b | females aged 15 to 44 years | 2010 | 165.0 | 149.0 | | | | | | | | |
| | Reduce the sustained domestic transmission of primary and | | | | | | | | | | | |
| 4 | secondary syphilis | 2010 | 2.8 | 2.5 | 1.3 | 1.2 | 8.2 | 7.0 | 6.0 | 5.0 | 0.4 | 0.4 |
| 5 | Reduce the congenital syphilis incidence rate | 2010 | 4.4 | 4.0 | 0.0 | 0.0 | 12.1 | 11.0 | 3.7 | 3.2 | 0.0 | 0.0 |
| **TU** | **Tobacco Use** | | | | | | | | | | | |
| | Reduce the proportion of the population who are current | | | | | | | | | | | |
| 1 | smokers (any use in past 30 days) | | | | | | | | | | | |
| a | adults aged 18 years and older (age-adjusted) | 2011 | 17.0% | 13.6% | NYA | NYA | NYA | NYA | NYA | NYA | NYA | NYA |
| b | high school students (grades 9-12) | 2010 | 14.3% | 12.8% | 15.4% | 13.8% | 11.1% | 9.9% | 14.6% | 13.1% | | |
| c | middle school students (grades 7-8) | 2010 | 4.4% | 3.9% | 4.6% | 4.2% | 3.1% | 2.8% | 6.6% | 5.9% | 1.2% | 1.1% |
| | Reduce current tobacco use (cigarettes, cigars, smokeless | | | | | | | | | | | |
| 2 | tobacco, bidis) by high school students (grades 9-12) | 2008 | 23.3% | 20.0% | 24.4% | 21.5% | 20.8% | 19.5% | 24.5% | 22.6% | | |
| | Reduce the proportion of high school student (grades 9-12) | | | | | | | | | | | |
| 3 | nonsmokers exposed to secondhand smoke | 2010 | 48.1% | 43.3% | 52.1% | 46.9% | 46.4% | 41.8% | 43.0% | 38.7% | 30.9% | 27.9% |
| **TB** | **Tuberculosis** | | | | | | | | | | | |
| 1 | Reduce the incidence rate of tuberculosis (TB) (all ages) *** | 2010 | 4.6 | 3.5 | 0.8 | | 7.6 | | 8 | | 21.5 | |
| | Increase the treatment completion rate within 12 months for all TB cases which can be adequately treated in that time frame | | | | | | | | | | | |
| 2 | *** | 2008 | 87.6% | 93.0% | 86.0% | | 90.3% | | 90.8% | | 84.5% | |
| | Increase the treatment completion rate of contacts to sputum smear-positive cases who are diagnosed with latent | | | | | | | | | | | |
| 3 | tuberculosis infection (LTBI) and started LTBI treatment *** | 2008 | 69.9% | 79.0% | | | | | | | | |
| | Increase the proportion of TB cases alive at diagnosis for | | | | | | | | | | | |
| 4 | which an HIV status is known *** | 2010 | 79.7% | 90.0% | 75.0% | | 88.0% | | 93.7% | | 72.7% | |

**Notes**

All data are per 100,000 unless otherwise noted.

Cells with a gray pattern are meant to be blank.

DSU = Data are statistically unreliable. The numerator is too small (<20) to calculate a reliable rate.

NYA = Data are not yet available. Data have not yet been collected or have been collected but are not yet ready for analysis.

r/e = Race/ethnicity

SFY = State fiscal year

TBD = To be determined.

* Data in the Asian columns for MCH-2 through MCH-5 are for Asians & Pacific Islanders combined, not Asians alone.

** The Sexually Transmitted Disease Program (STDP) collects and compiles over 30,000 positive STD laboratory tests per year. The STDP has neither the authority nor the manpower to compel laboratories to report race and ethnicity. It is hoped the utilization by the laboratories of the electronic laboratory reporting component of CDRSS will decrease the amount of records with unknown race and ethnicity.

*** The TB Program does not have funding or personnel for targeted interventions. Because the effectiveness of non-existent interventions can not be determined, there are no targets by race/ethnicity.

# What Are the Leading Health Indicators?

*March 2013*

Leading Health Indicators are a small set of Healthy New Jersey 2020 (HNJ2020) objectives selected to communicate high-priority health issues and actions that can be taken to address them. New Jersey's Leading Health Indicators are considered to be a reflection of the state's major public health concerns. The HNJ2020 initiative is a comprehensive set of disease prevention and health promotion objectives for the state to achieve over the next decade.

## Identifying the Leading Health Indicators

New Jersey's Leading Health Indicators are the product of an extensive external and internal feedback process. In order to first identify local public health priorities, the New Jersey Department of Health administered the HNJ2020 Leading Health Indicator Poll to stakeholders throughout the State who were invited to attend one of three Healthy New Jersey 2020 Regional Meetings. Over 200 partners participated in the Poll. A refined list of indicators based on the results of the HNJ2020 Leading Health Indicators Poll was presented to the Department's HNJ2020 Advisory Committee in the form of a survey for final determination.

The New Jersey Department of Health considers the following five health indicators to be the leading health issues facing New Jerseyans today. The Leading Health Indicators will be used to facilitate collaboration with public health partners and motivate action to improve health across the state for the remainder of the decade.

## The Leading Health Indicators

1. **Access to Primary Care**
   **Measurement:** Increase the proportion of adults with a personal doctor or health care provider
   **Baseline (2011):** 83.5%
   **Target (2020):** 90.0%

2. **Birth Outcomes**
   **Measurement:** Reduce the infant death rate
   **Baseline (2007):** 5.1 per 1,000 live births
   **Target (2020):** 4.8 per 1,000 live births

3. **Childhood Immunization**
   **Measurement:** Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV)
   **Baseline (2010):** 74%
   **Target (2020):** 80%

4. **Heart Disease**
   **Measurement:** Reduce the death rate due to coronary heart disease
   **Baseline (2007):** 140.1 per 100,000 population (age-adjusted)
   **Target (2020):** 112.1 per 100,000 population (age-adjusted)

5. **Obesity**
   **Measurement:** Prevent an increase in the proportion of the population that is obese
   **Baseline:**
   - Adults (2011; 20 years+): 23.8%
   - High school students (2009): 10.3%

   **Targets:**
   - Adults (2020): 23.8%
   - High school students (2020): 10.3%

## 1. Access to Primary Care

**Measurement:** Increase the proportion of adults with a personal doctor or health care provider

| | Total Population | Race/Ethnicity | | | |
|---|---|---|---|---|---|
| | | White | Black | Hispanic | Asian |
| Baseline (2011) | 83.5% | 88.8% | 81.8% | 65.4% | 84.1% |
| Target (2020) | 90.0% | 90.0% | 90.0% | 80.0% | 90.0% |

*Baseline data source: New Jersey Behavioral Risk Factor Survey (NJBRFS), Center for Health Statistics, New Jersey Department of Health*

## 2. Birth Outcomes

**Measurement:** Reduce the infant death rate (per 1,000 live births)

| | Total Population | Race/Ethnicity | | | |
|---|---|---|---|---|---|
| | | White | Black | Hispanic | Asian |
| Baseline (2007) | 5.1 | 3.1 | 10.9 | 5.4 | 2.3 |
| Target (2020) | 4.8 | 1.9 | 6.0 | 4.5 | 2.2 |

*Baseline data source: Matched Infant Death-Birth Certificate Database, Center for Health Statistics, New Jersey Department of Health*

## 3. Childhood Immunization

**Measurement:** Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV)
**Baseline (2010):** 74%
**Target (2020):** 80%
Data by race/ethnicity are not available.

*Baseline data source: National Immunization Survey, U.S. Centers for Disease Control and Prevention*

## 4. Heart Disease

**Measurement:** Reduce the death rate due to coronary heart disease (age-adjusted per 100,000 population)

| | Total Population | Race/Ethnicity | | | |
|---|---|---|---|---|---|
| | | White | Black | Hispanic | Asian |
| Baseline (2007) | 140.1 | 144.0 | 167.3 | 78.2 | 66.1 |
| Target (2020) | 112.1 | 115.7 | 133.8 | 62.6 | 52.9 |

*Baseline data source: Death certificate database, Center for Health Statistics, New Jersey Department of Health*

## 5. Obesity

**Measurement:** Prevent an increase in the proportion of the population that is obese

| | Total Population | Race/Ethnicity | | | |
|---|---|---|---|---|---|
| | | White | Black | Hispanic | Asian |
| Adult aged 20+: Baseline (2011) & Target (2020) | 23.8% | 22.4% | 32.5% | 28.0% | 11.0% |
| HS Student: Baseline (2009*) & Target (2020) | 10.3% | 8.2% | 16.5% | 14.4% | N/A |

*High School (HS) Student Baseline data by race/ethnicity are from 2007. The number of Asians in the student sample is too small to compute reliable statistics.

*Baseline data source (adults): New Jersey Behavioral Risk Factor Survey (NJBRFS), Center for Health Statistics, New Jersey Department of Health. Baseline data source (high school): New Jersey Student Health Survey of High School Students, New Jersey Department of Education.*

## APPENDIX H: DSRIP HOSPITALS

| Hospitals Approved to implement the Delivery System Reform Incentive Payment Pool (DSRIP) Program | | | |
|---|---|---|---|
| **HOSPITAL** | **FOCUS** | **PROJECT** | **COUNTY** |
| ATLANTICARE REG'L MEDICAL CENTER | Diabetes | Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension | Atlantic |
| BAYONNE HOSPITAL | Cardiac Care | Extensive Patient CHF-Focused Multi-Therapeutic Model | Hudson |
| BAYSHORE COMMUNITY HOSPITAL | Diabetes | Diabetes Group Visits for Patients and Community Education | Monmouth |
| BERGEN REG'L MEDICAL CENTER | Behavioral Health | Electronic Self-Assessment Decision Support Tool | Bergen |
| CAPE REGIONAL MEDICAL CENTER | Diabetes | Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension | Cape May |
| CAPITAL HEALTH SYSTEM - FULD CAMPUS | Chemical Addiction / Substance Abuse | Hospital-Wide Screening for Substance Use Disorder | Mercer |
| CAPITAL HEALTH SYSTEM - HOPEWELL | Obesity | After School Obesity Program | Mercer |
| CENTRASTATE MEDICAL CENTER | Diabetes | Diabetes Group Visits for Patients and Community Education | Monmouth |
| CHILTON MEMORIAL HOSPITAL | Cardiac Care | The Congestive Heart Failure Transition Program (CHF-TP) | Morris |
| CHRIST HOSPITAL | Cardiac Care | Extensive Patient CHF-Focused Multi-Therapeutic Model | Hudson |
| CLARA MAASS MEDICAL CENTER | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Essex |
| COMMUNITY MEDICAL CENTER | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Ocean |
| COOPER UNIVERSITY MEDICAL CTR | Diabetes | Diabetes Group Visits for Patients and Community Education | Camden |
| DEBORAH HEART & LUNG CENTER | Non-Participating | Non-Participating | Burlington |
| EAST ORANGE GENERAL HOSPITAL | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Essex |
| ENGLEWOOD HOSPITAL ASSOCIATION | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Bergen |
| HACKENSACK UNIVERSITY MEDICAL CENTER | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Bergen |
| HOBOKEN HOSPITAL CENTER | Cardiac Care | Extensive Patient CHF-Focused Multi-Therapeutic Model | Hudson |

| Hospitals Approved to implement the Delivery System Reform Incentive Payment Pool (DSRIP) Program | | | |
|---|---|---|---|
| **HOSPITAL** | **FOCUS** | **PROJECT** | **COUNTY** |
| JERSEY CITY MEDICAL CENTER | Asthma | Pediatric Asthma Case Management and Home Evaluations | Hudson |
| JERSEY SHORE MEDICAL CENTER | Asthma | Pediatric Asthma Case Management and Home Evaluations | Monmouth |
| JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencsics | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Middlesex |
| KENNEDY UNIVERSITY HOSPITAL | Diabetes | Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension | Camden |
| KIMBALL MEDICAL CENTER | Behavioral Health | Integrated Health Home for the Seriously Mentally Ill (SMI) | Ocean |
| LOURDES MED CTR OF BURLINGTON CNTY | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Burlington |
| MEADOWLANDS HOSPITAL MEDICAL CENTER | Cardiac Care | The Congestive Heart Failure Transition Program (CHF-TP) | Hudson |
| MEDICAL CENTER OF OCEAN COUNTY | Diabetes | Diabetes Group Visits for Patients and Community Education | Ocean |
| MEMORIAL HOSP OF BURLINGTON CTY (Virtua) | Diabetes | Diabetes Group Visits for Patients and Community Education | Burlington |
| MONMOUTH MEDICAL CENTER | Behavioral Health | Integrated Health Home for the Seriously Mentally Ill (SMI) | Monmouth |
| MORRISTOWN MEMORIAL HOSPITAL | Cardiac Care | The Congestive Heart Failure Transition Program (CHF-TP) | Morris |
| MOUNTAINSIDE HOSPITAL | Diabetes | Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension | Essex |
| NEWARK BETH ISRAEL MEDICAL CENTER | Cardiac Care | The Congestive Heart Failure Transition Program (CHF-TP) | Essex |
| NEWTON MEMORIAL HOSPITAL | Cardiac Care | The Congestive Heart Failure Transition Program (CHF-TP) | Sussex |
| OUR LADY OF LOURDES MEDICAL CENTER | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Camden |
| OVERLOOK HOSPITAL | Cardiac Care | The Congestive Heart Failure Transition Program (CHF-TP) | Union |
| PALISADES GENERAL HOSPITAL | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Hudson |
| R. W. JOHNSON UNIVERSITY HOSPITAL | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Middlesex |
| RARITAN BAY MEDICAL CENTER | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Middlesex |
| RIVERVIEW MEDICAL CENTER | Diabetes | Diabetes Group Visits for Patients and Community Education | Monmouth |

| Hospitals Approved to implement the Delivery System Reform Incentive Payment Pool (DSRIP) Program | | | |
|---|---|---|---|
| **HOSPITAL** | **FOCUS** | **PROJECT** | **COUNTY** |
| RWJ UNIVERSITY MEDICAL CTR AT HAMILTON | Pneumonia | Patients Receive Recommended Care for Community-Acquired Pneumonia | Mercer |
| SOMERSET MEDICAL CENTER | Diabetes | Diabetes Group Visits for Patients and Community Education | Somerset |
| SOUTH JERSEY HEALTH SYSTEM | Chemical Addiction / Substance Abuse | Hospital-Wide Screening for Substance Use Disorder | Cumberland |
| SOUTH JERSEY HEALTH SYSTEM - ELMER | Chemical Addiction / Substance Abuse | Hospital-Wide Screening for Substance Use Disorder | Salem |
| SOUTHERN OCEAN COUNTY HOSPITAL | Cardiac Care | Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions | Ocean |
| ST. BARNABAS MEDICAL CENTER | Asthma | Hospital-Based Educators Teach Optimal Asthma Care | Essex |
| ST. CLARE'S-RIVERSIDE MED CTR DENVILLE | Behavioral Health | Electronic Self-Assessment Decision Support Tool | Morris |
| ST. FRANCIS MEDICAL CENTER (TRENTON) | Diabetes | Diabetes Group Visits for Patients and Community Education | Mercer |
| ST. JOSEPH'S HOSPITAL MEDICAL CENTER | Asthma | Hospital-Based Educators Teach Optimal Asthma Care | Passaic |
| ST. LUKE'S HOSPITAL (formerly Warren Hospital) | Diabetes | Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension | Warren |
| ST. MARY'S HOSPITAL (PASSAIC) | Cardiac Care | Extensive Patient CHF-Focused Multi-Therapeutic Model | Passaic |
| ST. MICHAEL'S MEDICAL CENTER | Diabetes | Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension | Essex |
| ST. PETER'S MEDICAL CENTER | Diabetes | Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension | Middlesex |
| TRINITAS - ELIZABETH GENERAL | Chemical Addiction / Substance Abuse | Hospital-Wide Screening for Substance Use Disorder | Union |
| UNDERWOOD MEMORIAL HOSPITAL (Inspira Med Ctr – Woodbury) | Chemical Addiction / Substance Abuse | Hospital-Wide Screening for Substance Use Disorder | Gloucester |
| UNIVERSITY HOSPITAL | Cardiac Care | The Congestive Heart Failure Transition Program (CHF-TP) | Essex |
| UNIVERSITY MED CTR PRINCETON @ PLAINSBORO | Diabetes | Diabetes Group Visits for Patients and Community Education | Middlesex |
| VIRTUA - WEST JERSEY HEALTH SYSTEM | Diabetes | Diabetes Group Visits for Patients and Community Education | Camden |