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PUBLIC HEARING

before

JOINT BUDGET OVERSIGHT COMMITTEE

Testimony on the Federal Block Grants administered by the Departments of Community Affairs, Health, and Human Services

September 29, 1988
Room 424
State House Annex
Trenton, New Jersey

SENATE MEMBERS OF COMMITTEE PRESENT:

Senator Laurence S. Weiss, Co-Chairman
Senator Walter Rand
Senator John H. Ewing

ASSEMBLY MEMBERS OF COMMITTEE PRESENT:

Assemblyman Rodney P. Frelinghuysen, Co-Chairman
Assemblyman John S. Watson

ALSO PRESENT:

Peter R. Lawrance
Ernest T. Hagans
Office of Legislative Services
Aides, Joint Budget Oversight Committee

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Hearing Recorded and Transcribed by
Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
Trenton, New Jersey 08625

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September 21, 1988

NOTICE OF PUBLIC HEARING

SEPTEMBER 29, 1988

The Joint Budget Oversight Committee will hold a public hearing Thursday, September 29, 1988, beginning at 9:00 a.m. in Room 424 in the State House Annex, Trenton, New Jersey.

The purpose of the public hearing is to hear testimony on the Federal Block Grants administered by the Departments of Community Affairs, Health and Human Services.

The following grant programs are:

- Community Services Block Grant - Administered by the Department of Community Affairs.
- Preventive Health and Health Services Block Grant - Administered by the Department of Health.
- Maternal and Child Health Block Grant - Administered by the Department of Health.
- Alcohol, Drug Abuse, and Mental Health Block Grant - Administered by the Department of Health.
- Low Income Home Energy Assistance Block Grant - Administered by the Department of Human Services.

Anyone wishing to testify at the hearing should contact Ernest T. Hagans, at (609) 292-8030.

GDS:ac

TABLE OF CONTENTS

	Page
Richard Knight Supervisor, Office of Community Services New Jersey Department of Community Affairs	2
Bernice Shepard Director, Division of Community Resources New Jersey Department of Community Affairs	2
Dr. William Parkin Assistant Commissioner Division of Epidemiology and Disease Control New Jersey Department of Health	4
Diane Telencio Field Service Supervisor Home Energy Assistance Unit Division of Public Welfare New Jersey Department of Human Services	5
Flora E. Loder Haddon Heights, New Jersey	6
Edward P. O'Connor Legislative Chairman New Jersey Association of Mental Health Agencies	8
APPENDIX:	
Statement submitted by Bernice Shepard	1x
Statement submitted by Diane Telencio	4x
Statement submitted by Edward P. O'Connor	6x
Statement submitted by Clinton C. Barlow Trenton, New Jersey	7x
Memorandum addressed to the Joint Budget Oversight Committee, plus attachments, from Gerald D. Silliphant, Secretary to the Joint Budget Oversight Committee	14x

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mjz: 1-9

SENATOR LAURENCE S. WEISS (Cochairman): Good morning. The first hearing before the Joint Budget Oversight Committee is now open. We do have a quorum. I would like to introduce the members who are here: Assemblyman Rod Frelinghuysen and myself, and I think Assemblyman Watson was here. He has left the room, but he will be back in a minute.

At the outset, I would like to congratulate Assemblyman Frelinghuysen on his appointment as Chairman of the Assembly Revenue, Finance and Appropriations Committee. I know he is going to do a great job, and I look forward to working with him.

ASSEMBLYMAN RODNEY P. FRELINGHUYSEN (Cochairman): Thank you very much, Senator. I look forward to working with you, too. Shall we begin?

SENATOR WEISS: We will begin, right. The purpose of this morning's meeting is to hold a public hearing on Federal funds -- the Community Services Block Grant, the Preventive Health and Health Services Block Grant, the Maternal and Child Health Block Grant, the Alcohol, Drug Abuse and Mental Health Block Grant, and the Low Income Home Energy Assistance Block Grant. We are going to take them in that order. I would ask those who are going to testify this morning to keep their testimony as short as possible. If you have, in fact, a written statement, we will entertain that statement. If you will give it to Mr. Ernest Hagans, our Committee aide, or Mr. Peter Lawrance, also a Committee aide, we can go from there.

The Community Services Block Grant-- I do have a list. If, in fact, there are people who are in agreement -- two, three, four, whatever -- we would appreciate your testimony becoming as one. Okay? We will listen very intently.

ASSEMBLYMAN FRELINGHUYSEN: Let me tell you, the tall microphones are for recording purposes, to the best of my knowledge, and the smaller microphone with the button-- You push the button, and once it is on red it functions for this room, so that everyone can hear you.

R I C H A R D K N I G H T: Mr. Chairman, we have written testimony that we could submit to you from our Director for the Community Services Block Grant Program. Okay?

SENATOR WEISS: Yes. You're from DCA?

B E R N I C E S H E P A R D: Yes. I am Bernice Shepard. Good timing. (referring to the fact that she just arrived)

SENATOR WEISS: Okay, Ms. Shepard. Were you in the room before when we started the hearing?

MS. SHEPARD: No, I wasn't.

SENATOR WEISS: Okay. If you have written testimony, please submit it, and we will entertain that testimony. If you care to make a short statement for or against -- I doubt it is going to be against, but for -- we will listen. If you will make it short, the Committee would appreciate it.

MS. SHEPARD: Okay, thank you very much.

To the members of the Committee: Thank you very much for the opportunity to report to you on our Community Services Block Grant State Plan for the 1989 Federal fiscal year, and on the conduct of our current program.

The purpose of the CSBG Program is the amelioration of the conditions of poverty. This is to be accomplished through the support of locally developed employment, health, education, day care, homeless, nutrition, housing, and other related programs. A central focus of the Act is the enlistment of public and private support to maximize available resources.

The CSBG Program had its origin in the Economic Opportunity Act of 1964, which created, among other anti-poverty projects, community action agencies, Head Start, and legal services. Prior to the passage of the CSBG Program, community action agencies were funded directly by the Federal government, with minimal involvement by the states, outside of a matching fund requirement. Under the Block Grant Program, practically all funds are channeled through the states to eligible entities as defined by the Omnibus Budget Reconciliation Act of 1981.

ASSEMBLYMAN FRELINGHUYSEN: Ms. Shepard, Senator Weiss and the members of the Committee agreed prior to the start of the public hearing, that we would really like it if you could paraphrase your statement. Actually, the best course of action for representatives of the different State departments-- We would like to make your testimony a matter of public record from this point on, in the sense that there is no need for you to read it. It will be part of the public record, as recorded by the Office of Legislative Services. This is in the interest of recognizing the Committee members' and your busy schedules. So, I would ask you to maybe just sum up in a minute, your thoughts relative to the Community Services Block Grant.

MS. SHEPARD: Okay. I think that would be fairly easy to do. I would like to personally thank Assemblyman Watson and the Legislature for the $50,000 that you did give to the Community Services Block Grant. It shows us that you have a real understanding of what the community action agencies are attempting to do, and the strain that they are really under, in terms of providing that service.

I would also like to indicate that last year we told you that we were going to change the formula. The Department made a real attempt at that. We just felt that what we had was not good enough for this year. We are going to keep working on that, and hopefully by this time next year we will have a mechanism in place, and if it is feasible, then we will change the formula.

That is basically what I would like to say to you.

ASSEMBLYMAN FRELINGHUYSEN: Great, thank you.

SENATOR WEISS: Thank you very much, Ms. Shepard. We appreciate your coming down this morning.

MS. SHEPARD: Thank you.

SENATOR WEISS: Is there anyone else from the Department? (no response) Apparently not. Well, we thank you very much again for your appearance.

Are there others here who would like to speak on the Community Block Grants? (no response) Apparently there are none.

MS. SHEPARD: If I may, I would just like to introduce the members of the staff.

SENATOR WEISS: Oh, by all means, go right ahead.

MS. SHEPARD: This is Richard Knight, who is the Supervisor of the Community Services Block Grant Program, and this is Patricia Burvachiello, who is the Fiscal Officer in that office.

SENATOR WEISS: Oh, she is the one we ought to know.

MS. SHEPARD: Yes. Thank you very much.

MR. KNIGHT: Thank you.

SENATOR WEISS: The second block grant for this morning is the Preventive Health and Health Services Block Grant, administered by the Department of Health. Is there anyone here from the Department of Health?

A S S I S T A N T C O M M. W I L L I A M P A R K I N: Sort of. (laughter)

SENATOR WEISS: Okay. We won't keep you too long.

ASSISTENT COMMISSIONER PARKIN: I am in a little bit of an embarrassing position. Dr. Leah Ziskin is the individual who was to make the presentation. I am Dr. William Parkin, Assistant Commissioner for Epidemiology and Disease Control. I was asked to be present to answer any questions on our portion of the Preventive Block Grant, but I don't know where Dr. Ziskin is.

SENATOR WEISS: Doctor, we will accept Dr. Ziskin's testimony when it comes in. You don't have it with you, do you?

ASSISTANT COMMISSIONER PARKIN: No, I don't. I haven't seen it.

SENATOR WEISS: Okay. We will accept her testimony and make it part of the record.

ASSISTANT COMMISSIONER PARKIN: Okay. I will go find a telephone and find out where she is.

SENATOR WEISS: Don't worry about that. Don't be concerned. Just tell her to stay wherever she is.

ASSISTANT COMMISSIONER PARKIN: Okay, fine. Thank you.

SENATOR WEISS: The Maternal and Child Health Block Grant?

ASSISTANT COMMISSIONER PARKIN: That is Dr. Ziskin once again.

SENATOR WEISS: All right.

ASSEMBLYMAN FRELINGHUYSEN: Good, two birds with one stone.

SENATOR WEISS: The same goes for that. Alcohol, Drug Abuse and Mental Health Block Grant?

ASSISTANT COMMISSIONER PARKIN: That would be Mr. Russo. Once again, I am the only one here.

SENATOR WEISS: Okay. If there is written testimony on it--

ASSISTANT COMMISSIONER PARKIN: I would assume there is.

SENATOR WEISS: Would you have them send it over, please?

ASSISTANT COMMISSIONER PARKIN: Yes, sir.

SENATOR WEISS: The Low Income Home Energy Assistance Block Grant, Department of Human Services?

D I A N E T E L E N C I O: We have a written fact sheet here.

SENATOR WEISS: Why don't you use the other microphone, and pull it a little bit closer? I see the light on, so the microphone is hot.

MS. TELENCIO: We have a written fact sheet about the program, but I don't think it is necessary to read it. There is only one paragraph here that is fairly important. Do you need the fact sheet up there perhaps, or--

ASSEMBLYMAN FRELINGHUYSEN: I think we will make the fact sheet a matter of the public record. If you just want to read that paragraph--

MS. TELENCIO: Okay. In Fiscal Year 1989, this upcoming heating season, New Jersey is expecting approximately $53.8 million in Low Income Home Energy Assistance Block Grant funds. This figure represents a $5.8 million reduction from the Fiscal Year 1988 allocation. So, this is about a 9.7% reduction.

It appears that this block grant amount, when combined with the additional $20 million in Oil Overcharge Funds -- which we expect to receive -- will be sufficient to administer the Home Energy Program at current benefit levels and income guidelines, that is for this upcoming heating season.

ASSEMBLYMAN FRELINGHUYSEN: Thank you very much for your testimony, written as well as oral. Thank you very much for coming.

SENATOR WEISS: Thank you, Ms. Telencio. Are there any members of the public who would like to testify? (affirmative response from audience) Madam?

F L O R A E. L O D E R: (speaking from audience at first) I wish to express my feelings and my opinions. My name is Flora E. Loder, 21 Seventh Avenue, Haddon Heights, New Jersey.

Although of local origin, it is a national problem and nonpartisan. All elected officials have sworn to uphold the Constitution of New Jersey and the Constitution of the United States of America. In my opinion, too long and too often, moneys allocated for the improvement of the quality of life of senior citizens, and disabled and handicapped citizens, have been used for political reasons, and do not benefit the ones for whom they were intended, such as the expenditures for community development, many times, and I wonder if this is fraud.

I urge you to reject all applications for community development that do not allow, where applicable, access into and within all municipal buildings such as in Haddon Heights. Government buildings are supposed to be accessible to the handicapped and disabled, and many are not.

I urge you to reject all applications for curb cuts that are at or near the tip of the corner. It goes against all safety rules ever taught. They put those at risk at further risk by going into two lanes of traffic at one time. It makes pedestrian lights obsolete. It makes no sense whatsoever. Curb cuts done in the name of the disabled and handicapped need to follow the lines of the sidewalk. There needs to be a smooth transition from the roadway to the sidewalk to prevent swivel wheels on wheelchairs, baby strollers, baby coaches, and also skateboards and bicycles, from throwing the person into the street.

The Haddon Heights Municipal Building is on three levels, with meetings on all levels. The police station, court, etc., and the men's room, are on the first level. The auditorium and kitchen are on the street or accessible level -- the second level. The municipal offices, the mayor's office, and the women's room are on the third level. What is needed is to have that building and all of the rooms accessible to the residents.

We need a two-door elevator, so that we can get in and out of that building with ease and safety.

The last Community Development Block Grant was made for the auditorium to be remodeled, and the kitchen, and a small bathroom put in. That is not the answer, and is not for the benefit of the senior citizens and the disabled. The majority of the time, that room is not used for senior citizens and the disabled. I urge you to stop the moneys for that renovation.

This morning, on my way in here, I saw that the curbs at the White Horse Pike and Kings Highway were-- It looked to me as if they were getting ready to put curb cuts in. What sense does it make to make people with disabilities and/or other needs go into the Kings Highway and White Horse Pike lanes of traffic?

Please, won't you help us? Won't you do something for us? Thank you.

SENATOR WEISS: Ms. Loder, we thank you very much for your testimony. We will consider everything you indicated. I am not really sure that we can stop it, but we will look into it. We thank you very much for coming this morning.

Is there anyone else from the public?

ASSEMBLYMAN FRELINGHUYSEN: Edward O'Connor.

SENATOR WEISS: Mr. O'Connor?

ASSEMBLYMAN FRELINGHUYSEN: Good morning, Mr. O'Connor.

E D W A R D P. O ' C O N N O R: Mr. Chairmen: I am the Legislative Chairman for the New Jersey Association of Mental Health Agencies. We just wanted to go on the record with respect to the block grant and the changes that have been proposed in the Alcohol, Drug Abuse and Mental Health Block Grant, which we see as being deleterious to New Jersey's interests.

One, because it simply represents a diminution in funds because of a reallocation formula. We have worked with our legislators, and with as many others as we could, to try to turn that around and to get a hold harmless clause for New Jersey. We have done well in the past, and we don't feel that money can be taken away from a program that is already stretched to the limit in terms of its funding.

The other piece of it is, we are concerned about the tendency to go toward the seed money concept, which can be attractive and which answers a lot of needs, because there are all these -- so many unmet needs that people are clamoring to have met.

Our concern, because we do run these agencies that provide the services, is that you can't just keep putting services on top of services, and not give a firm funding base that will continue on through the years. To simply do something new every time new money comes out is self-defeating

because there is no way that those programs can sustain themselves once the seed, as it is, withers and fails to come to fruition.

Thank you very much.

SENATOR WEISS: Thank you very much, Mr. O'Connor.

Is there anyone else? (no response) Apparently there is no one else. Mr. Barlow is not here. (referring to a gentleman on the witness list)

Oh, I had planned to introduce some of the members who arrived. To my left, Senator Ewing and Senator Rand. I mentioned Assemblyman Watson before.

That closes out the folks who attended this morning, and who got up real early to get here. I thank everyone for their participation.

(HEARING CONCLUDED)

APPENDIX

Mrs. Bernice Shepard, Director
Division of Community Resources
Testimony Before The Joint Budget Oversight
Committee On FY'89
Community Services Block Grant State Plan
September 29, 1988

TO: Members of the Committee:

Thank you for the opportunity to report to you on our Community Services Block Grant (CSBG) State Plan for the 1989 federal fiscal year, and on the conduct of our current program.

The purpose of the CSBG program is the amelioration of the conditions of poverty. This is to be accomplished through the support of locally developed employment, health, education, day care, homeless, nutrition, housing, and other related programs. A central focus of the Act is the enlistment of public and private support to maximize available resources.

The CSBG Program had its origin in the Economic Opportunity Act of 1964, which created among other anti-poverty projects, Community Action Agencies, Head Start and Legal Services. Prior to the passage of the CSBG program, Community Action Agencies were funded directly by the federal government with minimal involvement by the states, outside of a matching fund requirement. Under the Block Grant Program practically all funds are channeled through the states to eligible entities as defined by the Omnibus Budget Reconciliation Act of 1981.

Beginning in 1982 the Department of Community Affairs was designated as the administering agency for the Community Services Block Grant. That role requires that a State Plan be developed indicating how New Jersey intends to comply with the Statutory requirements of the Act. Along with the State Plan, the Governor is also required to certify to the United States Department of Health and Human Services that certain enumerated assurances will be met.

In Federal, FY'88 the Department received $9,271,112. Due to Gramm/Rudman cutbacks, this amount constitutes $271,421 less than originally expected. Thanks to Assemblyman Watson and the Legislature a $50,000 grant was passed, thereby softening the effect of the above reduction. As the Act requires, 90% of New Jersey's allocation was passed through to the designated entities, which are primarily Commmunity Action Agencies.

Consistent with the law, the Department retained 5% of its CSBG award for administrative expenses, with the remaining 5% of the allocation designated for state priorities and initiatives. CSBG funds will be expended in the same proportions in FY'89.

This year's plan has been developed in concert with the CSBG Task Force that comprises representatives from public and private service agencies. The Plan differs from past years with the inclusion of the Office of Administrative Law (OAL) in the hearing process and our decision to raise client eligibility for CSBG funded services to 125% of the poverty line as defined by the Office of Management and Budget.

This year the Department gave serious consideration to revising the CSBG funding formula to more accurately reflect changes in the poverty population. We elected, though, to retain the current method of distribution given the cutbacks imposed by Gramm/Rudman, the relatively early stage of our new evaluation format and the adverse impact that would result from a redistribution of CSBG monies.

On the latter issue, if one uses only poverty census data to determine allocation levels, Counties such as Atlantic, would see significant reductions in their grant awards. Nevertheless, Atlantic City still has critical social problems: an unemployment rate of over 7%, compared to the state average of 4%, along with the fact that two out of every three babies are born of teenage mothers. Additionally, experience has demonstrated that CSBG funded support of day care, education and other projects is more effective when coupled with decent entry level employment opportunities as are currently present in Atlantic City.

It is our intent this year to ask for state funding in support of the CSBG program. We will, at that time, attempt to give greater assistance to those locations where the poverty population has significantly increased over the last decade.

As we had outlined in last years plan, the Department is making funds available for the upgrading and training of personnel in the twenty-six (26) designated agencies throughout New Jersey. We are optimistic that the results will not only improve the level of competence at the agencies, but will lead to an even greater capacity on their part to serve the interests of New Jersey's disadvantaged population.

In conclusion, I am pleased to report that when the final program results are tabulated at the end of the fiscal year, our agencies will have reached over a quarter of a million of New Jersey's most needy citizens; and the 8.5 million dollars they receive under CSBG will have effectively generated over 50 million dollars of local, state and other federal support.

I thank you for having had the opportunity to present testimony on this important program.

BS/RWK/djt

HOME ENERGY ASSISTANCE

. BACKGROUND

The New Jersey Home Energy Assistance (HEA) program is one of the seven block grants established by the Omnibus Budget Reconciliation Act of 1981. The program is administered in New Jersey by the Department of Human Services, Division of Public Welfare. The twenty-one county welfare agencies serve as local administrative units, and are responsible for accepting applications and verifying program eligibility factors. The purpose of the program is to assist low income families and individuals meet home heating and medically necessary cooling costs.

. FISCAL YEAR 1988 HEA PROGRAM

Applications have been accepted by the county welfare agencies from November 1, 1987 through April 30, 1988.

In fiscal year 1988, New Jersey received $59.5 million. The HEA program issued $54,356,192 in heating assistance benefits to 139,872 households of which 98,354 were AFDC or Food Stamp eligible. The average heating assistance benefit is $389. We also issued 14,825 heating related emergencies. The average emergency heating benefit is $165. During the summer months 16,475 families received medically necessary cooling assistance with an expenditure of $2,059,432.

Emergency assistance was issued to 14,825 households with an expenditure of $2,449,405.

. FISCAL YEAR 1989 HEA PROGRAM

In FFY 1989, New Jersey is expecting approximately $53.8 million in Low Income Home Energy Assistance Block Grant funds. This figure represents a $5.8 million reduction from the FFY 1988 allocation. (9.7% reduction)

It appears that this block grant amount, when combined with $20 million in Oil Overcharge Funds will be sufficient to administer the HEA program at current benefit levels and income guidelines.

. ELIGIBILITY CRITERIA

To be eligible, the household must be a resident of the State of New Jersey, and pay for its own heating and/or cooling costs directly to the fuel supplier, pay its landlord according to usage, or pay a rental charge which includes such costs. The household's income must be less than or equal to the allowable gross monthly limits set at 150% of Federal Poverty Level for the applicable household size. Under the New Jersey guidelines, a single person must have a gross monthly income at or below $721; $966 for a family of two; $1,211 for a family of three; $1,456 for a family of four; for each additional member add $245.

. TYPES OF HEA PAYMENTS

There are four types of HEA payments:

(1) Automatic payments to eligible Public Assistance (PA) and non-Public Assistance (NPA) Food Stamp (FS) recipients;

(2) Special Energy Assistance to all other eligible households who apply for assistance;

(3) Emergency Assistance for those households without heat or in danger of being without heat and lack sufficient financial resources to purchase fuel; and,

(4) Medically necessary Cooling Assistance.

. HOW HEA PAYMENTS ARE ISSUED

The heating assistance payments vary by household size, income, fuel type, living arrangement, and heating region. It has been determined that Sussex and Warren counties are the coldest counties in the State. Benefits for eligible residents of those counties are approximately 15% higher than the rest of the State.

The maximum total HEA heating benefit any household may receive is $900. This includes automatic or special payments and those emergency energy assistance benefits issued for the purpose of purchasing home heating fuel.

We also provide emergency assistance up to the $900 benefit limit to households which have heating costs included in their monthly rental charge and are faced with eviction for nonpayment of rent. Also, the maximum for emergency furnace repairs is $1,000 for homeowners. These two initiatives were implemented for FY 87-88 to help prevent homelessness.

All HEA payments are made as one party checks to the clients with the exception of eligible households which are directly responsible to a fuel supplier to heat their home. In those cases, the Division will issue a two party HEA check in the name of the eligible household and their fuel supplier as long as the fuel supplier has signed an agreement with this Department to participate in the program.

Eligible households for which there is medical evidence that the health of at least one household member will be seriously endangered unless the living quarters are cooled may receive a one-time benefit of $125. This benefit is in addition to other program benefits received by the household.

. HOW TO APPLY FOR HEA BENEFITS

Applications will be available through the local county welfare agencies, offices on aging and other outreach sites utilized by the county welfare agencies. Special arrangements have been made to allow senior and disabled families to receive and return the applications by mail.

. HOTLINE

The Hotline number is 1-800-792-9773.

5X

The New Jersey Association of Mental Health Agencies represents over eighty community based mental health programs in every county of the State. Member agencies deliver over 90% of state funded non-institutional services to the mentally ill.

I address you today on behalf of our Association on the matter of the Alcohol, Drug Abuse and Mental Health Block Grant.

As you know, under the current version of the reauthorization bill, New Jersey would lose three to four million of the ten million dollars currently going for mental health services.

We oppose any reduction in the already meager federal share of the mental health program. Any cutback affects our ability to serve the seriously mentally ill who are the exclusive target group for this funding.

We are also concerned about the philosophy behind this restructuring. The Congress appears to want to use the Block Grant money as seed money for new programs rather than to sustain existing programs. This is a seductive but dangerous path. You will recall the parable of the seed which falls on shallow soil, sprouts quickly, but withers in the noonday sun because it has no roots. Too often funding seeks to address the many unmet needs at the expense of a strong foundation for the existing programs.

Thank you for the opportunity to speak to you today. I urge you to vigorously oppose any cut in the Alcohol, Drug Abuse and Mental Health Block Grant.

Respectfully submitted
Edward P. O'Connor
Chairman, Legislative Action Committee
New Jersey Association of Mental Health Agencies
609-795-5218

Testimony before Legislative Services Commission September 29, 1988

part ONE

TESTIMONY GIVEN FROM : ME;
CLINTON C. BARLOW JR. III
C/O MRS. MAY G. BARLOW, JR
AND MS FELICIA A. BARLOW
WITH THEIR INFANT BABY CHILDREN,
RE: 214 SPRING STREET, HUD APT. BLDG.
AFFR. HOUSING DWELLING TRENTON, N.J. 08618,

EXHIBITS CONTENTS:
EXHIBIT ONE: GIVEN OPEN TESTIMONY TO COMMITTEE OF COMPLAINT.
EXHIBIT TWO: EXPLAINTING HOW FEDERAL BLOCK DEPRIVED TWO MOTHERS,
EXHIBIT THREE: HOW MOTHERS WERE MISTREATED IN LOCAL GOVERNME
EXHIBIT FOUR: COMMUNITY AFFAIRS WRONGFULLY MAKING THEM HOMELES
EXHIBIT FIVE: COMMUNITY AFFAIRS OVERLOOKING HOUSING VIOLATIONS;

STATE COMMITTEE MEMBERS THIS FEDERAL, STATE HOUSING ACT COMPLAINT FALLS UNDER THE STEWART B. MCKINNEY AC HOMELESS ASSISTANCE AMENDMENTS OF 1988, REPORTED FROM: COMMITTEE ON BANKING, HOUSING AND URBAN AFFAIRS, OF UNITED STATES SENATE;

PLEASE UNDERSTAND THAT COMMUNITY AFFAIRS DEPT. AND THE CITY OF TRENTON HOUSING ADMINISTRATION NEEDS TO BE CLOSELY INVESTIGATED PROPER BY THE STATE SENATE AND BY THE STATE GENERAL ASSEMBLY; TO ENSURE THE CITIZENS FAIR HOUSING BILL OF RIGHTS! BECAUSE TO MY KNOWLEDGE THERE ARE TO MANY CITIZEN GETTING VIOLATED BY HOUSING SLUM LAND LORDS.

Testimony Complaint EXHIBIT'S MEMORANDUM;
To: Joint Budget OVERSight Committee
HONORABLE LAURENCE S. WEISS, CO-Chairman
HONORABLE Rodney P. FRELINGHUYSEN, CO-Chairman
AND to: HON. WALTER RAND
HON. JOHN H. EWING,
HON. C. RICHARD KAMIN,
HON. JOHN S. WATSON,
MR. GERALD D. SILLIPHANT, SECRETary to
THE JOINT Budget OVERSight Committee,
DATE September 29, 1988,
SUBJECT: SPEAK to Joint Committee CONCERNING
Community SERVICES Federal BLOCK GRANT,
that's ADMINISTERED by N.J. Community AFFAIRS
CONCERNING two deprived mothers by BLOCK GRANT progra

GOOD MORNING, MR. CO-Chairman LAURENCE S. WEISS,
CO-Chairman Rodney P. FRELINGHUYSEN AND to the-
Following Joint Committee members; I am VERY..
happy to be here, to SPEAK to you HONORABLE MEN AND GIVE
my testimony CONCERNING THE U.S. Federal BLOCK GRANT,
that IS ADMINISTERED BY THE Dept. OF Community AFFAIRS
AND IS OFFICIALLY FUNDED BY U.S. CONGRESS House-
Committee ON BANKING, FINANCE AND URBAN AFFAIRS
OF WASHington, D.C., THEN GIVEN through, WASHington
D.C. HUD Dept., where MR. Samuel R. PIERCE, JR. IS
THE SECRETary OF THE U.S. HUD Department!

This - Testimony ON HUD Community Affairs Block Grant that FALLS UNDER HUD Federal Block Rental ASS't, Sect 8 AND this Legislation CONCERNS the MCKINNEY Act ALSO it MOSTLY CONCERNS the DR. KING-BILL that WAS Just Signed BY MR. PRESIDENT REAGAN, EVEN though it Should OF been passed 20 YEARS AGO, when DR. MARTIN L. KING, JR. WAS taKing All KINDS OF bad PUNISHMENT FROM people, who were AGAINST the black IN 1968, but with our Lord Jesus blessings - times are Slowly but Surely Changing; thANK God for that !

THEREFORE; I am Respectfully Requesting that the State Joint Budget OVERSight Committee will Start AN INVESTIGATION CONCERNING Community AFFAIRS Neglient REGARDING ONE OF THEIR HUD Fed. BLOCK Dwelling Apt. Bldgs That is NOW Still being Repeatedly FRAUD CONSTRUCTIVELY BY A HUD Fed., STATE Housing LAND Lord - HUD OWNER", MR. MRS. Rudolph FRAZIER RESIDING AT 204 Spring Street, In trenton, Mercer, New Jersey, 08618, that IS Still NOW Stealing FRAUDING, depriving, VIOLating AND WRONGFULLY Connecting their ELECTRICAL 1st FLR. power Lights, Outlets to the 2nd FLR. OF A LOW INCOME TENANT that WRONGFULLY doesn't Recieve Rental ASST., AT ALL AND MRS may GLORIA Barlow JR IS WRONGFULLY paying FOR HER SLUM LAND LORDS PUBLIC P.S.E. ELECTRIC AND GAS bill, that ALSO WAS OVERLOOKED BY N.J. STATE COMMUNITY AFFAIRS Dept. Housing DIVISION O Mercer State-County Rental ASSISTANCE Section "8" program

And Also State Committee member's

This Housing testimony is Concerning Community Affair Federal Block Grants on Low Income Housing - State County Rental Asst. Section "8" of HUD - Urban Affairs - Concerning when Hon. Gov. Kean Gave his Speech Housing Testimony to the U.S. House of Congress Sub Committee on Housing And Community Develop - ment, on April 25, 1988, at the Trenton City Hall Annex bldg, which I Clinton Barlow thought Hon. Kean, was gaven untrue facts by N.J. State Community Affairs Commissioner Leonard Coleman who now is Replaced By Ex Assemblyman A Villane, J

The reason for that Statement was that, since the year of 1983 through 1986 up until this year of 1988, Various Low Income Citizens have been Violated depuved, Harrassed, Ripped off, By their Housing Land Lords (HUD) Rental Asst. drug Saling tenant that been Saling All Kinds of drugs daily in their HU Rental Asst Apts - Grossing ten thousands dollars a day with State Housing Division, Trenton police, And the Slum Landlord married Couple over Looking the bad.. drug HUD - Housing Apt bldg. drug Saling, And been.. Repeatedly wrongfully Over Looked By Several State Community Affairs Dept. Housing Division workers, that Now Caused Housing Hardship for two mothers, And they were wrongfully forced to became unlawful Evicted!

10X

And you Joint Budget Oversight Committee Membus;

Now At this proper time; I, Mr. Barlow, am now presenting you with my testimony Letters And papers that concerns; these four grant programs, that had depived two Low Income Mothers along with me Clenton Barlow;

1st. Community Services Block Grant, Administered By the Department of Community Affairs-Rental Asst. wrongfully threw Mrs. May G. Barlow Jr. with her infant grand Babies off of mer. State Rental Asst Section 8 Then wrongfully State mercer Rental Asst. Housing Division had wrongfully Renewed A Rental Contract to An bad drug Saling Nuisance 1st flr. tenant that was grossing untax-ten thousand dollars a day in her 1st flr. HUD Apt. drug Saling while Also Recieving Mercer Welfare Benfits, Food Stumps, Energy Asst. Checks, drug Moneys As well; wrongfully Leaving three weeks before her 214 Spring Stt A 1st flr. drug Raid had happened on May 25, 1987, At 2:29 p. then as I clenton Barlow was visiting my Mother on the 2nd flr. of 214 Spring Stt 5 flr. Apt Bldg Dwelling there was A drug Raid on 1st flr. with Ms. Vanessa V. Blunt Apt. 1st flr. then I was Falsely Arrested And threw into police wagon. In front of 400 people; then Later it was A black pt. Mer Raymond young had Criminally Slander that A Barlow "of 214 Spring Stt was Arrested in a drug" that Slander Statement

This HUD-Community Affairs Block Grant Complaint; Now Concerns; House Committee on Banking, Finance, and Urban Affairs, Committee on Gas, Public Works U.S. Senate, U.S. Attorney General Office, Hon. Gov. Keans Office; U.S. Congress Chris Smith; Trenton May or Arthur Holland Trenton Mercer Freeholder President Douglas Palmer, U.S. Housing Sub Committee Staff Dir. Gerald McMurray; N.J. Attorney General W. Cary Edwards; U.S. HUD Dep And Hon. Mercer County Superior Judge Coleman Brennan Trenton City Housing Dept. on Eletrical wire inspection Several Wash. D.C., N.Y., Newark HUD Workers and also Several of N.J. Community Affairs Housing Workers, Mercer prosecutor office, Trenton public Safty Dir. R. Luchenin that whom Mrs. May G. Barlow Jr. And Clenton-Barlow, my mother been Repeatedly Contacting yes Since 1984 up until this year of 1988, to get this Housing Neglicent Harassment problem Workout!

Pursuit to this Federal Housing Block Grant; this matter Concerns Bad problems with New Jersey; Trenton Board of Public utilities Trenton N.J. Bell-Atlantic phone Company (609)-989-9627- that Mrs May G. Barlow Jr. and myself-Clinton Barlow had Losted and paid out Mounts of Dollars tring to Stop this Bad HUD Housing Criminal Act problem that Mostly is the Wrongfully fault of Mercer, Trento And Slum Landlord - Mr. Mrs Rudolph Frazier, of 204 Spring Strt, Trenton, N.J. 08618, who also owns 25 Apa Houses in the State of N.J. in Atlantic City and Trenton N.J.:

PART B

To: N. J. STATE JOINT Budget OVERSight STAFF:

MEMbers: ON the 25th day OF May 1987, Monday 2:29p.m
ON the 1st. FLR 214 Spring Stat, IN Trenton, Where MS.
VANNESSA Y. BLUNT, Where wrongFully Saling drugs
GROSSing TEN Thousand a day with Community Affair
Rental ASSt., AND her AUNT, UNCle M, MRS. Rudolph FRAZIER
LANDLord HUD OWNERS. permission to "my KNOWNLedge,"
because we been Complaunting About MS. BLUNT
drug Saling Since NOV. 1986, AND NOthing was
being done NOT at All, So my Mother MRS. Barlow
and I Clinton Barlow then went Complaunting
to N.J. Community AFFAIRS Commissioner Coleman,
Then we Started Complaunting to U.S. HUD Depts;
AND NOthing was being done, So weie NOW...
Advising you Committee members OF this bad
HARASSment, Homeless, Hardship-drug Saling Act!
P.S. here are Several Letters Documents FROM
VARIOUS public SERVANTS, Stating OF this drug matter!

LEGISLATIVE SERVICES COMMISSION
SENATOR
JOHN F. RUSSO
Chairman
ASSEMBLYMAN
ROBERT E. LITTELL
Vice-Chairman
SENATE
LEONARD T. CONNORS, JR.
JOHN H. DORSEY
MATTHEW FELDMAN
S. THOMAS GAGLIANO
JAMES R. HURLEY
CARMEN A. ORECHIO
LAURENCE S. WEISS
GENERAL ASSEMBLY
BYRON M. BAER
JOHN O. BENNETT
WILLIE B. BROWN
JOHN PAUL DOYLE
CHUCK HARDWICK
WALTER J. KAVANAUGH
DENNIS L. RILEY

New Jersey State Legislature
OFFICE OF LEGISLATIVE SERVICES
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625

ALBERT PORRONI
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Legislative Budget and Finance Officer
(609) 292-1170

PETER R. LAWRANCE
Assistant Legislative Budget and Finance Officer
(609) 292-8030

MEMORANDUM

TO: Joint Budget Oversight Committee
Honorable Laurence S. Weiss, Co-Chairman
Honorable Rodney P. Frelinghuysen,

Honorable Walter Rand
Honorable John H. Ewing
Honorable C. Richard Kamin
Honorable John S. Watson

FROM: Gerald D. Silliphant, Secretary to the Joint Budget Oversight Committee

DATE: September 29, 1988

SUBJECT: BLOCK GRANT SUMMARY SHEETS

The Joint Budget Oversight Committee will hold a public hearing on the following block grants:

- Community Services Block Grant - Administered by the Department of Community Affairs.
- Preventive Health and Health Services Block Grant - Administered by the Department of Health.
- Maternal and Child Health Block Grant - Administered by the Department of Health.
- Alcohol, Drug Abuse, and Mental Health Block Grant - Administered by the Department of Health.
- Low Income Home Energy Assistance Block Grant - Administered by the Department of Human Services.

Attached are copies of the block grants to be considered by the Committee. This office has also prepared a brief summary sheet which includes possible areas for discussion.

GDS:ac
Attachments

14X

MODEL PLAN

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

PUBLIC LAW 97-35, AS AMENDED

FFY 89

Department of Health and Human Services
Family Support Administration
Office of Community Services
Washington, D.C. 20201

August 1988
OMB Approval No. 0970-0075

15X

GRANTEE State of New Jersey

statutory references

2605(a)(1) The State of New Jersey agrees to:

2605(b)(1)-(b)(14) (1) use the funds available under this title for the purpose described in section 2602(a) and otherwise in accordance with the requirements of this title, and agrees not to use such funds for any payments other than payments specified in this section;

(2) make payments under this title only with respect to--

(A) households in which 1 or more individuals are receiving--

(i) aid to families with dependent children under the State's plan approved under part A of title IV of the Social Security Act (other than such aid in the form of foster care in accordance with section 408 of such Act);

(ii) supplemental security income payment under title XVI of the Social Security Act;

(iii) food stamps under the Food Stamp Act of 1977; or

(iv) Payments under section 415, 521, 541, or 542 of title 38, United States Code, or under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978; or

statutory references 2605(b)(1)-(b)(14)

(B) households with incomes which do not exceed the greater of--

(i) an amount equal to 150 percent poverty level for such State; or

(ii) an amount equal to 60 percent of the State median income;

except that no household may be excluded from eligibility under this subclause for payments under this title for fiscal year 1986 and thereafter if the household has an income which is less than 110 percent of the poverty level for such State for such fiscal year;

(3) conduct outreach activities designed to assure that eligible households, especially households with elderly individuals or handicapped individuals, or both, are made aware of the assistance available under this title, and any similar energy-related assistance available under subtitle B of title VI (relating to community services block grant program) or under any other provision of law which carries out programs which were administered under the Economic Opportunity Act of 1964 before the date of the enactment of this Act;

statutory references 2605(b)(1)-(b)(14)

(4) coordinate its activities under this title with similar and related programs administered by the Federal Government and such State, particularly low-income energy-related programs under subtitle B of title VI (relating to community services block grant program), under the supplemental security income program, under part A of title IV of the Social Security Act, under title XX of the Social Security Act, under the low-income weatherization assistance program under title IV of the Energy Conservation and Production Act, or under any other provision of law which carries out programs which were administered under the Economic Opportunity Act of 1964 before the date of the enactment of this Act;

(5) provide, in a timely manner, that the highest level of assistance will be furnished to those households which have the lowest incomes and the highest energy costs in relation to income, taking into account family size, except that the State may not differentiate in implementing this section between the households described in clauses 2(A) and 2(B) of this subsection;

(6) to the extent it is necessary to designate local administrative agencies in order to carry out the purposes of this title; give special consideration,

statutory references 2605(b)(1)-(b)(14)

in the designation of such agencies, to any local public or private nonprofit agency which was receiving Federal funds under any low-income energy assistance program or weatherization program under the Economic Opportunity Act Of 1964 or any other provision of law on the day before the date of the enactment of this Act, except that--

(A) the State shall, before giving such special consideration, determine that the agency involved meets program and fiscal requirements established by the State; and

(B) if there is no such agency because of any change in the assistance furnished to programs for economically disadvantaged persons, then the State shall give special consideration in the designation of local administrative agencies to any successor agency which is operated in substantially the same manner as the predecessor agency which did receive funds for the fiscal year preceding the fiscal year for which the determination is made;

(7) if the State chooses to pay home energy suppliers directly, establish procedures to--

(A) notify each participating household of the amount of assistance paid on its behalf;

statutory references 2605(b)(1)-(b)(14)

(B) assure that the home energy supplier will charge the eligible household, in the normal billing process, the difference between the actual cost of the home energy and the amount of the payment made by the State under this title;

(C) assure that the home energy supplier will provide assurances that any agreement entered into with a home energy supplier under this paragraph will contain provisions to assure that no household receiving assistance under this title will be treated adversely because of such assistance under applicable provisions of State law or public regulatory requirements; and

(D) assure that any home energy supplier receiving direct payments agrees not to discriminate, either in the cost of the goods supplied or the services provided, against the eligible household on whose behalf payments are made;

(8) provide assurances that--

(A) the State will not exclude households described in clause (2)(B) of this subsection from receiving home energy assistance benefits under clause (2), and

(B) the State will treat owners and renters equitably under the program assisted under this title;

statutory references 2605(b)(1)-(b)(14)

(9) provide that--:

(A) the State may use for planning and administering the use of funds under this title an amount not to exceed 10 percent of the funds payable to such State under this title for a fiscal year and not transferred pursuant to section 2604(f) for use under another block grant; and

(B) the State will pay from non-Federal sources the remaining costs of planning and administering the program assisted under this title and will not use Federal funds for such remaining costs;

(10) provide that such fiscal control and fund accounting procedures will be established as may be necessary to assure the proper disbursal of and accounting for Federal funds paid to the State under this title, including procedures for monitoring the assistance provided under this title, and provide that at least every two years the State shall prepare an audit of its expenditures of amounts received under this title and amounts transferred to carry out the purposes of this title;

(11) permit and cooperate with Federal investigations undertaken in accordance with section 2608;

(12) provide for public participation in the development of the plan described in subsection (c);

GRANTEE State of New Jersey

statutory references 2605(b)(1)-(b)(14)

(13) provide an opportunity for a fair administrative hearing to individuals whose claims for assistance under the plan described in subsection (c) are denied or are not acted upon with reasonable promptness; and

(14) cooperate with the Secretary with respect to data collecting and reporting under section 2610.

Certification to the Assurances

Signature of Tribal Chairperson or Chief Executive Officer of the State**

Signature: _____

Title: Governor, State of New Jersey

Date: _____

EIN*: 1-216000928-C3

*HHS needs the EIN (Employer Identification Number) of the tribal agency or State agency that is to receive the grant funds before it can issue the grant.

**If a person other than the Tribal Chairman or Chief Executive Officer of the State is signing the certification to the assurances, a letter must be submitted delegating such authority.

In the above assurances which are quoted from the law, State means Tribe or Tribal Organization and "title" and "section" of the Act refer to Title XXVI of the Omnibus Budget Reconciliation Act of 1981, as amended, the Low Income Home Energy Assistance Act.

GRANTEE State of New Jersey

statutory references	
2605(b)(4), (5), (6), (8)(A), (9), (10), (11), (12), (13), and (14) and 2605(c)(1)(A)	Please describe how the grantee will carry out the assurances cited in the statutory reference column. (Grantee may attach pages that are applicable.) See attachments
2605(a)(2)	The grantee held public hearings on the following date(s): The New Jersey State Legislature will conduct public hearings on the FFY 1989 Home Energy Assistance program. Program changes will also be published in the New Jersey Register for public comment.

FFY 89

GRANTEE State of New Jersey

statutory references

2605(a)
2605(b)(1) The grantee will operate the following components under its LIHEA Program:

(purpose of funds)

X heating assistance
X cooling assistance
X crisis assistance (specify type(s)e.g., heating, cooling or area-wide emergency declared by Governor
winter crisis assistance

X weatherization assistance

The projected dates for accepting applications and closing the programs are as follows:

heating 11-1-88/4-28-89 cooling 11-1-88/6-30-89
crisis 12-1-88/5-31-89 wx 1/ 10-1-88/9-30-89

2605(c)(1)(c) 2605(c)(1)(F) The grantee estimates the amount of available * LIHEAP funds will be expended as follows:

___% heating assistance or $50.6
___% cooling assistance or $ 1.5
___% crisis assistance or $ 3.0
___% weatherization assistance or $ 3.6
___% block grant transfer(s) or $ 5.9
___% carryover or $ 0
___% administrative costs or $ 6.4

1/ Weatherization.

* These figures include FY 88 carryover of $1.5 million and $10.0 million in Oil Overcharge Funds for FFY 89. The estimates also presume a LIHEAP allocation of $59.5 million to New Jersey for FFY 1989.

FFY 89

GRANTEE State of New Jersey

statutory references

2605(c)(1)(C) The funds reserved for crisis assistance which have not been expended by March 15 will be reprogrammed to:

X heating assistance
X cooling assistance
___ weatherization assistance
Other(specify): _____
_____

2605(b)(2)
2605(c)(1)(A)
(eligibility) The grantee's maximum eligibility limits are:

X 150% of the FFY 88 OMB poverty guidelines for each of the components under the grantee's LIHEA Program.
Specify component(s) heating assistance, winter crisis assistance, weatherization assistance

___ 125% of the FFY___ OMB poverty guidelines for each of the components under the grantee's LIHEA Program.
Specify component(s)_____

___ 110% of the FFY___ OMB poverty guidelines for each of the components under the grantee's LIHEA Program.
Specify component(s)_____

___ 60% of the State's FFY___ median income for each of the components under the grantee's LIHEA Program.
Specify component(s)_____

___ Other (specify for each component and include any categorically eligible households) _____
_____

FFY 89

GRANTEE State of New Jersey

statutory references

2605(c)(1)(A) The grantee has set the following additional eligibility requirements for each LIHEAP component (checks yes or no)

Heating	Yes	No
Assets Test	___	X
Subsidized housing tenants eligible:		
If heat is included in rent	___	X
If heat is paid directly	X	___
Restricted eligibility for group living arrangements	___	X
Restricted eligibility for non-subsidized renters	___	X
Higher eligibility maximum for elderly/handicapped	___	X
Other: (Specify below)	___	X

GRANTEE State of New Jersey

statutory references

2605(c)(1)(A) Cooling (additional eligibility requirements - continued)

	Yes	No
Assets Test	___	X
Subsidized housing tenants eligible:		
If cooling is included in rent	___	X
If cooling is paid directly	X	___
Restricted eligibility for group living arrangements	___	X
Restricted eligibility for non-subsidized renters	___	X
Higher eligibility maximum for elderly/handicapped	___	X
Other: (Specify below)	X	___

Medical evidence indicating a need for cooling assistance is required when applying for The New Jersey Home Energy Assistance (HEA) cooling program.

GRANTEE State of New Jersey

statutory references			
2605(c)(1)(A)	Crisis (additional eligibility requirements - continued)	Yes	No
	Assets Test	___	X
	* Subsidized housing tenants eligible: If heat/cooling is in rent	___	X
	If heat/cooling is paid directly	X	___
	Household must have received a shut-off notice or have an empty tank	X	___
	Household must have exhausted regular benefit	X	___
	Household must have received a rent eviction notice	X	___
	Higher eligibility maximum for elderly/handicapped	___	X
	*Heating/cooling must be medically necessary	___	X
	Other: (Specify)	___	___

* The State of New Jersey does not operate a cooling crisis program.

GRANTEE State of New Jersey

statutory references			
2605(c)(1)(A)	Weatherization: (additional eligibility requirements - continued)	Yes	No
	Assets Test	___	X
	Subsidized housing: tenants eligible:		
	If heat is included in rent	X	___
	If heat is paid directly	X	___
	Restricted eligibility for group living arrangements	___	X
	Restricted eligibility for non-subsidized renters	___	X
	Household must have received LIHEAP benefits	___	X
	Household must fail infiltration standards	X	___
	Other: (Specify below)	___	X

GRANTEE State of New Jersey

statutory references

2605(b)(3) (outreach)

The grantee conducts the following outreach activities designed to assure that eligible households are made aware of all LIHEAP assistance available:

Yes provide intake service through home visits or by telephone for the physically infirm (i.e. elderly or handicapped).

Yes place posters/flyers in local and county social service agencies, offices of aging, social security offices, VA, etc.

Yes publish articles in local newspapers or media announcements are aired.

Yes include inserts in energy vendor billings to inform individuals of the availability of all types of LIHEAP assistance.

Yes make mass mailing to past recipients of LIHEAP.

Yes inform low income applicants of the availability of all types of LIHEAP assistance at application intake for other low-income programs.

Yes utilize early application period at the beginning of the program for the elderly and handicapped.

Yes accept applications for energy crisis at sites that are geographically accessible to all households in the area to be served.

No execute interagency agreements with other low-income program offices to perform outreach to target groups.

GRANTEE State of New Jersey

statutory references

2605(c)(1)(F)

Does the grantee encourage recipients to apply for energy budget programs offered through local utility companies?

X yes

___ no

If yes, please describe the procedures.

In applying for emergency utility assistance, collateral contact is made between the HEA program agency and the utility supplier to work out an agreement that would resolve the existing emergent situation. Clients are encouraged to enter into a budget program that would ensure the continuation of utility service throughout the year.

GRANTEE State of New Jersey

statutory references

2605(b)(5)
2605(c)(1)
(B)

(benefit levels)

Heating Component

The grantee's benefit levels for heating are as follows: (Provide this information only if benefit levels have changed from the last program year survey or if no application was submitted in the previous year. A benefit payment matrix may be attached.)

$___ minimum
$___ average
$___ maximum

See subchapter 3, pages 9 and 10 of the attached 1988-89 Home Energy Assistance Handbook.

FFY 89

GRANTEE State of New Jersey

statutory references	
2605(b)(5) 2605(c(1) (benefit levels)	Cooling: The grantee's benefit level(s) for cooling are as follows: (Provide this information only if the benefit level have changed from the last program year survey or if no application was submitted in the previous year. A benefit payment matrix may be attached.) $125 minimum $125 average $125 maximun
2605(c)(1) (B)	The grantee provides in-kind and/or other forms of benefits as follows:

GRANTEE State of New Jersey

statutory references	
2605(B)(5) 2605(c)(1) (B) (benefit levels)	**Crisis Component** The grantee's benefit level(s) for crisis are as follows: (Provide this information only if the benefit levels have changed from the last program year survey or if no application was submitted in the previous year. Benefit matrices may be attached.)

*Same as FFY 88

Heating	Cooling
$___minimum	$___minimum
$___average	$___average
$___maximum	$___maximum

2605(b)(5) 2605(c)(1) (B)	The grantee provides in-kind and/or other forms of benefits as follows:
Rehousing	Payments for emergency rehousing are issued to eligible households directly to the vendor. There is no limit on the HEA dollar amount issued since the payments are determined according to the time period that the client is rehoused.
Emergency Assistance to Prevent Eviction	Emergency assistance to prevent eviction may not exceed the difference between the amount of the HEA entitlement for the program year and $900, and shall be the lowest amount necessary to prevent eviction from the residence.

GRANTEE State of New Jersey

statutory references	Weatherization:
2605(b)(5) 2605(c)(1) (B)&(D)	The State uses DOE guidelines in determining the benefit levels and types of weatherization activities.
(benefit levels)	X yes (exceptions, please note below). ___ no

2605(b)(5) 2605(c)(1) (B)&(D) 2605(k) (benefit levels)	If no, describe the factors used to determine the benefit levels or priorities used by the State and the kinds of weatherization activities and other energy-related home repairs the State will provide to an eligible household.

GRANTEE State of New Jersey

statutory references	
2605(b)(5) (benefit levels)	Describe how the grantee will assure that non-categorically eligible households will not be treated differently than categorically eligible households when determining benefit mounts. This applies to all components unless specifically noted below.

The New Jersey Home Energy Assistance (HEA) program includes an application component which ensures that any resident of New Jersey may apply and be considered for HEA program eligibility. Benefit amounts are structured to assure that the highest level of assistance will be granted to households which have the lowest incomes and the highest energy costs in relation to income and family size. New Jersey does not differentiate in setting benefit levels between categorically eligible households as specified in subsection 2605(b)(2)(A) and non-categorically eligible households.

GRANTEE State of New Jersey

statutory references

2605(c)(1)(F) Will the grantee make cash payments directly to eligible households for heating, cooling, crisis, and weatherization?

X yes
___ no

If yes, under what circumstances are cash payments made?

The State of New Jersey HEA heating assistance program issues direct one party checks to eligible households whose heating costs are included in their monthly rental cost, or whose fuel supplier has chosen not to sign a participating vendor contract with the State.

All other eligible heating assistance households are issued two party checks which are made payable to the energy supplier and the client. These checks are mailed to the client with a notice stating the amount of benefits, the purpose for which these benefits are intended, and directions regarding any questions that may arise concerning their eligibility.

Cooling assistance benefits are issued as a one party check made payable to the client.

If the grantee does not make cash payments directly to the eligible households for the above components, specify the exceptions below:

The New Jersey weatherization program issues direct vendor payments to contracted vendors and Community Action Program Agencies.

Also the HEA emergency crisis program incorporates a rehousing and eviction prevention facet.

2605(b)(7) (energy suppliers) Will the grantee pay home energy suppliers directly?

X yes (Direct energy supplier payments are only utilized in the weatherization program, rehousing and eviction prevention facet of the crisis program.)

___ no
___ other (specify)_____

GRANTEE State of New Jersey

statutory references	
2605(b)(7)(B)-(D) (energy suppliers)	Describe how the grantee will assure that the energy supplier performs what is required in this assurance. If vendor agreements are used, they may be attached.

See attached vendor agreements.

2605(b)(7)(A) If the grantee makes payments directly to home energy suppliers, how does the grantee notify the client of the amount of assistance paid?

The State of New Jersey makes payment directly to the home energy supplier only in cases of crisis rehousing, eviction prevention assistance and weatherization assistance. When such payment is made to an energy supplier for an eligible household, the client is not notified of the exact dollar amount of the assistance provided. However, with regard to weatherization assistance, the client is informed of the services which will be provided as well as the date of service provision.

GRANTEE State of New Jersey

statutory references

2605(c)(1)(F) What are the grantee's payment methods? (specify for each component)

Heating: (If payment methods vary by fuel sources, please describe.)

____vouchers/coupons
__X__two-party checks
____vendor payments
__X__check payable to the eligible household
____check to landlord
____other (specify)_____
_____

2605(c)(1) Cooling: (If payment methods vary by fuel sources, please describe.)

____vouchers/coupons
____two-party checks
____vendor payments
__X__check payable to the eligible household
____check to landlord
____other(specify)_____
_____

GRANTEE State of New Jersey

statutory references

2605(c)(1)(F) Crisis: (If payment methods vary by fuel sources, please describe.)

____vouchers/coupons
__X__two-party checks
__X__vendor payments
__X__checks payable to the eligible household
____check to landlord
____other (specify)_____
_____

2605(c)(1)(F) Weatherization:

Describe the payment method(s) used for making weatherization repairs.

__X__DOE rules
____vouchers/coupons
____vendor agreements
____check payable to the eligible household
____check to landlord
____other (specify)_____
_____

GRANTEE State of New Jersey

statutory references

2605(b)(8)(B) (owners and renters) Describe how owners and renters are treated equitably under each of the State's LIHEA components.

Heating:

Both renters and homeowners may receive heating assistance benefits. Benefits vary by fuel type and State region, with the highest benefits granted to those eligible renters or homeowners with the highest heating costs in relation to income.

Crisis:

Both homeowners and renters are eligible to receive maximum benefits under the emergency crisis program.

Cooling:

The New Jersey HEA cooling program does not consider ownership as a factor in determining eligibility.

Weatherization:

Weatherization services are equally available to both renters and homeowners.

GRANTEE State of New Jersey

statutory references	
2605(c)(1)(F)	Under the grantee's plan, may a single eligible household receive: (please check all that apply)

_____one payment for the program year for heating and cooling

__X__a heating payment

__X__a cooling payment

__X__a heating crisis payment

_____a cooling crisis payment

__X__a weatherization payment

_____other (specify)

State of New Jersey's Assurances Regarding Statutory References Cited on page nine of the LIHEAP Model Plan

2605(b)(4) The New Jersey Division of Public Welfare (DPW) will coordinate its activities under the Act with similar and related programs administered by the Federal Government and the State. The DPW supervises the Aid to Families with Dependent Children (AFDC) and Food Stamp programs and will be making automatic payments to both AFDC and food stamp eligibles. Additionally, liaison communications have been established with both the Lifeline Credit Program for senior citizens and the Low-Income Weatherization Assistance Program (see Section 10:89-5.7).

(5) The payment schedule in Section 10:89-3.6 reflects the highest level of assistance to be provided to households having the lowest income and the highest energy costs, taking into account family size. New Jersey does not differentiate in setting benefit levels between households with members receiving other public assistance benefits as specified in subsection 2605(b)(2)(A) and other households with incomes below the maximums set out in subsection 2605(b)(2)(B). New Jersey states that the assistance provided will be furnished to the above mentioned households in a timely manner, as further described in Section 10:89-1.1A(2) of the HEA Handbook.

(6) Section 10:89-5.1 provides that Home Energy Assistance Units in the county welfare agencies will administer the heating, cooling and crisis programs on the local level. Community Action Agencies will administer the Weatherization program and the Supplemental Crisis Intervention Program on the local level.

(8)(A) New Jersey provides assurance that it will not exclude households described in clause (2)(B) of Subsection 2605b from receiving home energy assistance under clause (2) of the same subsection. Additionally, New Jersey provides special energy assistance to households which are not categorically eligible. The HEA Handbook (Section 10:89-3.2) outlines the regulations and procedures for making application for the Home Energy Assistance Program in New Jersey.

(9) The State will use for planning and administering the utilization of funds under the Act an amount not to exceed 10 percent of its allotment for this fiscal year, net of transfers.

(10) The State assures that fiscal control and fund accounting procedures which were established for last year's program to assure the proper disbursal of and accounting for Federal funds paid to the State under the Act will be maintained; at least every two years the State shall prepare an audit of its expenditures of amounts received and amounts transferred to carry out the purposes of the Act.

Procedures for monitoring the assistance provided to eligible households include monthly visits to each county welfare agency by Home Energy Assistance field representatives in the New Jersey Division of Public Welfare to review program operation and identify and resolve potential problems. Also, during the summer of 1989, the field representatives will conduct a case review of a statistically valid sample of cases in each county to determine the accuracy of case processing and to ensure compliance with State and federal regulations.

(11) The State agrees to permit Federal investigations undertaken in accordance with Section 2608 and to cooperate in such activities.

(12) The State agrees to provide for public participation in the development of the plan for Fiscal Year 1989. New Jersey Division of Public Welfare will conduct public hearings on the Low-Income Home Energy Assistance Program, in several locations throughout the State. A transcript of testimony presented at those hearings will be forthcoming. The State Plan has also been published in the New Jersey Register for public comment. The program will become operational effective November 1, 1988. Subsequent to the thirty day comment period we will advise the Department of Health and Human Services of any public comments received as a result of this publication. New Jersey will satisfy the requirement in Section 2605. (a)(2) that each State conduct public hearings with respect to the proposed use and distribution of funds.

(13) Administrative Fair Hearing assurances are outlined in Section 10:89-1.1, and the fair hearing process is available to applicants and/or recipients of all types of assistance provided under this block grant.

(14) The State agrees to cooperate with DHHS in data collection and reporting requirements, as outlined in Section 2610 of the Low-Income Home Energy Assistance Act of 1981.

2605(c)(1)(A) Procedures for identifying eligible households are outlined in Subchapter 2, 10:89:2.1 Program Eligibility, and procedures for describing the manner used to determine benefit levels are established in Subchapter 3, Section 10:89-3.6(a)-(c). Emergency Energy Assistance procedures are outlined in Section 10:89-3.4. The estimated amount reserved for this assistance will be three million dollars. Any unused balance of funds reserved will be considered by the State as available for heating or cooling assistance.

SUMMARY SHEETS

Block Grants

	PAGE
Community Services Block Grant	1
Preventive Health and Health Services Block Grant	4
Maternal and Child Health Services Block Grant	7
Alcohol, Drug Abuse and Mental Health Block Grant	11
Low Income Home Energy Assistance Block Grant	12

Office of Legislative Services
September 28, 1988

SUMMARY SHEET

Community Services Block Grant

Administered by Department of Community Affairs.

FY 1988		FY 1989
$8,588,280	Allocation to Local Agencies (See attached two page list)	$8,392,316
477,127	State Priorities/Special Initiatives	466,240
477,127	Administration	466,240
$9,542,534		$9,324,796

Community Services Block Grant funds can be used by local agencies to provide a broad range of services in the areas of alcoholism, consumer protection, education, energy, health care, housing, legal aid, transportation and employment/unemployment.

Discussion Themes

PROPOSED FY 1989 EXPENDITURES OF $9.3 MILLION ARE APPROXIMATELY $700,000 LESS THAN THE AMOUNT OF FEDERAL FUNDS APPROPRIATED FOR THE BLOCK GRANT IN THE STATE FY 1989. BUDGET.

- *What accounts for the difference?*

THE $8.4 MILLION ALLOCATED TO AGENCIES IS APPROXIMATELY $200,000 LESS THAN THE AMOUNT ALLOCATED IN FY 1988. AS PRESENTED IN THE BLOCK GRANT APPLICATIONS FOR 1988 and 1989, 13 AGENCIES RECEIVED NO REDUCTION AND 16 AGENCIES RECEIVED REDUCTIONS RANGING FROM $83 to $43,022.

- *What basis was it decided to reduce the allocation? (The allocation for Union County's Department of Human Resources was reduced by $43,022, whereas the allocation for Atlantic Human Resources, Inc. was reduced by $14,298, and the New Jersey Association on Corrections was not reduced at all.)*

IN PREVIOUS YEARS THE DEPARTMENT WAS NOT ABLE TO REPORT ON THE SERVICES ACTUALLY SUPPORTED BY CSBG FUNDS OR THE NUMBER OF PERSONS SERVED WITH THESE FUNDS. FOR EXAMPLE, IN PREVIOUS YEARS THE DEPARTMENT DID NOT HAVE DATA PERTAINING TO HOW MUCH WAS SPENT ON "ALCOHOLISM SERVICES," "HOUSING SERVICES" OR "SENIOR CITIZENS SERVICES."

- *Is such information now available?*

46X

IN FY 1989 APPROXIMATELY $466,000 WILL BE SPENT ON STATE PRIORITIES/SPECIAL INITIATIVES.

- ***What State priorities/special initiatives does the department intend to undertake?***
- ***What State priorities/special initiatives have been undertaken, how successful were these initiatives and what has happened to these initiatives once funding ended?***

Summary of Grant Allocations

AGENCY	ALLOCATION FY 1988	ALLOCATION FY 1989	CHANGE FY 88-89
Jersey City Department of Human Resources	$456,878	$456,878	0
Atlantic Human Resources, Inc.	592,606	578,308	-$14,298
United Community Corporation	1,596,704	1,575,020	-21,684
United Progress, Inc.	562,880	562,880	0
Farmworkers (thru Test City Child Care Center)	40,053	40,053	0
Union County Department of Human Resources	342,750	299,728	-43,022
Paterson Task Force for Community Action, Inc.	460,855	460,855	0
Middlesex County Economic Opportunities Corp.	374,760	374,760	0
Camden County Council on Economic Opportunity	457,478	457,478	0
Test City Child Care Center, Inc.	332,361	317,273	-15,088
Somerset Community Action Program, Inc.	145,389	145,306	-83
Ocean Community for Economic Action Now, Inc.	195,040	189,812	-5,228

47X

Community Services Block Grant (Cont'd)

AGENCY	ALLOCATION FY 1988	ALLOCATION FY 1989	CHANGE FY 88-89
Check-Mate, Inc.	505,881	505,881	0
Essex County Board of Chosen Freeholders	413,842	395,368	-18,474
Bayonne Economic Opportunity Foundation	116,583	111,230	-5,353
Plainfield Action Services	176,251	173,788	-2,463
North Hudson Community Corp.	175,661	171,671	-3,990
Bergen County Community Action Program, Inc.	306,400	278,852	-27,548
Burlington County Community Action Program	155,162	148,702	-6,460
Mercer County Department of Human Services	131,648	129,573	-2,075
Morris County (thru NORWESCAP)	122,001	120,604	-1,397
Puerto Rican Congress of New Jersey, Inc.	131,892	128,975	-2,917
CAP Executive Directors' Assn. of New Jersey	55,843	55,843	0
Hoboken Org. Against Poverty & Economic Stress	188,092	188,092	0
Passaic Community Action Program, Inc.	119,786	119,786	0
NORWESCAP	171,437	171,437	0
Powhatan Indians of Delaware Valley, Inc.	29,617	29,617	0
Passaic County (thru Passaic Community Action Program)	119,577	93,693	-25,884
New Jersey Association on Corrections	110,853	110,853	0
TOTAL ALLOCATION	$8,588,280	$8,392,316	-$195,964

48X

SUMMARY SHEET

Preventive Health and Health Services Block Grant

Administered by Department of Health.

FY 1988		FY 1989
NA	Local Health Development	$77,641
$719,558	Hypertension	735,715
323,420	Rodent Control	266,272
424,135	Emergency Medical Services	416,800
15,000	Dental Caries Prevention	NA
488,840	Risk Reduction	564,127
175,000	Diabetes	142,051
222,131	Comprehensive Health Services	65,000
95,445	Rape Prevention	92,566
272,310	Administration	259,245
$2,735,039		$2,619,492

Discussion Themes

FY 1989 FUNDING DECREASES BY OVER $100,000 FROM $2.7 MILLION TO $2.6 MILLION.

- *Please explain the process the department used to reduce funding for diabetes activities by over $100,000 and to reduce funding for rodent control programs by nearly $70,000 while increasing expenditures for risk reduction by nearly $80,000.*

MANY OF THE SERVICES SUPPORTED WITH FEDERAL PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT FUNDS ALSO RECEIVE OTHER STATE/LOCAL/FEDERAL REVENUES. FOR EXAMPLE, COMPREHENSIVE HEALTH SERVICES WHICH EMPHASIZES ENVIRONMENTAL HEALTH ISSUES ALSO RECEIVED INCREASED STATE APPROPRIATIONS IN FY 1988.

- *Does the department have available a complete fiscal picture as to all sources of funding for the various programs supported by block grant funds?*

WITHIN MANY OF THE PROGRAM AREAS SUPPORTED BY THE BLOCK GRANT, VARIOUS ACTIVITIES ARE SUPPORTED. FOR EXAMPLE, IN THE AREA OF "HYPERTENSION", CHOLESTEROL, SMOKING, HYPERTENSION AND DIABETES ARE CRITICAL ELEMENTS. IN THE AREA OF "RISK REDUCTION", SMOKING AND TOBACCO USE CONTROL, NUTRITION AWARENESS, CHOLESTEROL CONTROL, CANCER CONTROL AND GENERAL HEALTH PROMOTION ARE CRITICAL ELEMENTS. THUS, ACTIVITIES TEND TO OVERLAP.

- *How do diabetes related activities within the "hypertension" element of the block grant complement or supplement funds earmarked for diabetes?*

- *How much is expended on specific items such as "cholesterol" programs within hypertension and risk reduction programs?*

- THE DEPARTMENT INTENDS TO "SCREEN" 80,000 HIGH RISK INDIVIDUALS DURING 1989. IN 1987 STATISTICS INDICATE THAT 102,000 HIGH RISK INDIVIDUALS WERE SCREENED.

- *If fewer people are to be "screened," why does hypertension funding increase?*
- *As only 2 percent of those screened are newly diagnosed hypertensives, can "screening" activities be better targeted to maximize the use of available funds?*

RISK REDUCTION PROGRAMS ARE ALLOCATED $564,127 IN BLOCK GRANT FUNDS, WHICH IS APPROXIMATELY $75,000 MORE THAN IN FY 1988.

- *What specific projects will be undertaken? Do these projects duplicate other "risk reduction" activities undertaken on a national basis?*
- *With the overall reduction in smoking and tobacco use, with the heightened public awareness of good nutrition and greater understanding of good health, there would appear to be a need for less funds. Why is funding increased?*

COMPREHENSIVE PUBLIC HEALTH SERVICES ARE INVOLVED IN AREAS OF ASBESTOS, TOXIC MATERIALS, OCCUPATIONAL AND COMMUNITY HEALTH CARE FACILITY SURVEILLANCE AND MONITORING.

- *How do these activities complement or supplement existing State/federal/local programs in these areas?*
- *How much is expended in support of "health care facility surveillance and monitoring" and aren't these activities part of the Medicare/Medicaid inspection process?*

EMERGENCY MEDICAL SERVICES PROVIDE TRAINING FOR EMERGENCY CARE PERSONNEL AND PROVIDE FOR THE SPECIAL NEEDS OF THE EMS PATIENT.

- *In view of personnel shortages in many health care professions, is an adequate supply of trained emergency care personnel available?*
- *Is any of the $416,000 being spent in support of the two trauma centers and helicopter aeromedical services and if "yes," how much?*
- *Information on page 89 indicates a "need" for $466,000. As the block grant allocates $416,800, how is the difference being funded?*

50 X

FUNDING FOR RAPE PREVENTION PROGRAMS CONTINUES TO BE REDUCED. BETWEEN 1987 AND 1988 FUNDS WERE REDUCED BY NEARLY $100,000, TO $95,000, AND IN 1989 FUNDS ARE REDUCED TO $92,600.

- *In view of the testimony presented to the appropriations committees regarding the need for additional funds, why is funding for rape prevention programs reduced when other less tangible programs are increased?*

THE PROPOSED BUDGET (p. 107) INDICATES THAT NO FUNDS ARE ALLOCATED FOR THE DENTAL CARIES PREVENTION PROGRAM WHOSE AIM HAS BEEN TO INCREASE PUBLIC INTEREST IN COMMUNITY WATER FLUORIDATION.

- *Is this program being discontinued?*

FUNDING OF $77,641 IS PROVIDED FOR "LOCAL HEALTH DEVELOPMENT".

- *What is "Local Health Development"?*

FUNDING FOR THE URBAN RODENT CONTROL PROGRAM WILL DECLINE FROM $323,420 to $266,272.

- *In terms of the overall programs in Camden, Jersey City and Newark, what impact will this reduction have on those cities programs?*

THE PLAN INDICATES THAT LIMITED FUNDS FOR RODENT CONTROL HAVE RESULTED IN "OTHER POTENTIALLY QUALIFIED CITIES" NOT DEVELOPING PLANS.

- *What other cities are in need of urban rodent control programs if funds were available?*

51X

SUMMARY SHEET

Maternal And Child Health Services Block Grant

Administered by the Department of Health.

FY 1988		FY 1989
$2,972,000	Special Child Health Services	$3,562,033
NA	Office of the Director	402,200
NA	Birth Defects Registry	83,000
NA	Community Based Services	1,192,103*
NA	Specialized Pediatric Services	1,884,730
$5,068,205	Maternal and Child Health Services	$6,396,800
NA	Office of the Director	376,050
1,194,950	Lead Poisoning	1,309,550
329,650	Dental Health	337,130
559,885	Family Planning	678,600
2,823,400	Maternal and Child Health Program	2,734,720
NA	Child Health Program	960,750**
80,300	Other Services	67,800
$757,150	Administration	$837,350
$8,877,655		$10,868,983

(NOTE: FY 1989 budget format is different than FY 1988 format which makes year to year comparisons difficult for some items.)

*Includes $295,000 for case management services.

**Includes $172,590 for case management services.

The Maternal and Child Health Block Grant provides funding for a variety of programs to improve the health status of mothers and children.

Discussion Themes

NEARLY $780,000 IS ALLOCATED FOR THE OFFICE OF THE DIRECTOR FOR PROGRAM DEVELOPMENT, QUALITY ASSURANCE AND SPECIAL STUDIES.

- ***How much will be expended on the Catastrophic Illness Childrens Program?***
- ***How much will be expended on the development of a network of pediatric HIV Treatment centers?***

52X

THE MATERNAL AND CHILD HEALTH BLOCK GRANT SUPPORTS NUMEROUS CONTRACTS WITH NON-PRIVATE AGENCIES.

- *Is a listing available as to which agencies receive funds, how much funds they receive, the services they provide and the number of clients served? For example, what 45 agencies receive the $2.7 million allocated for Material and Child Health.*
- *How much fee revenue is raised.*
- *How much Medicaid and other third party revenue is generated?*

THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROVIDES FUNDING FOR A VARIETY OF HEALTH PROGRAMS. MANY OF THESE PROGRAMS RECEIVE FUNDS FROM OTHER FEDERAL/STATE/LOCAL SOURCES.

- *Is there a comprehensive fiscal picture as to the total amount of funds being spent on various components of the Maternal and Child Health Services Block Grant available?*

STUDIES INDICATE THAT CHILDREN AND ADOLESCENTS HAVE BETTER DENTAL HEALTH THAN 10 YEARS AGO.

- *Can the $337,130 allocated for dental health be more effectively utilized in other areas such as lead poisoning?*

THE DEPARTMENT SEEKS TO DEVELOP AN "INDIVIDUAL SERVICE PLAN" FOR 80 PERCENT OF THE CHILDREN UNDER AGE 7 WHO ARE ON SSI AND SEEKS TO ENSURE THAT CHILDREN WITH AIDS/ARC HAVE ACCESS TO NECESSARY SERVICES INCLUDING CASE MANAGEMENT.

- *As most children on SSI are receiving services through the Division of Developmental Disabilities and since most children with AIDS/ARC are under DYFS jurisdiction, to what extent are these activities duplicative of existing programs.*

NO DATA ARE PROVIDED FOR 1986 REGARDING SPECIAL CHILD HEALTH SERVICES.

- *Why are no 1986 data available?*
- *What are the total number of children registered for Special Child Health Services?*

5-3X

NEARLY $1.2 MILLION IS ALLOCATED FOR "COMMUNITY BASED SERVICES." THESE SERVICES ARE ADMINISTRATIVELY RESPONSIBLE FOR CASE MANAGEMENT SERVICES PROVIDED TO CHILDREN ON THE VARIOUS AIDS WAIVERS.

- *How is the $1.2 million not duplicative of Medicaid reimbursement?*

APPROXIMATELY $9.8 MILLION WILL BE SPENT ON SPECIAL CHILD HEALTH SERVICES AND MATERNAL AND CHILD HEALTH SERVICES.

- *What percentage of funds is being spent in the Maternal and Child Health Priority Areas identified in Table XII?*

THE "SCORE" USED TO DETERMINE MATERNAL AND CHILD HEALTH PRIORITY AREAS INDICATES THAT CAMDEN'S SCORE IS 15.5 WHEREAS IN 1987 ITS SCORE WAS 14.8, NEWARK'S SCORE IS 13.2 COMPARED TO 12.8 IN 1987; ATLANTIC CITY'S SCORE IS 12.2 COMPARED TO 11.0 IN 1987.

- *Has maternal and child health care deteriorated in those areas with higher 1989 scores?*

- *If it has, what accounts for this deterioration?*

- *How effective have the various State and federal initiatives been at improving maternal and child health?*

THE DEPARTMENT'S EFFORTS AT REDUCING THE STATE'S INFANT MORTALITY RATE HAS CENTERED AROUND PROVIDING PRENATAL CARE TO MOTHERS. YET BETWEEN 1984-1986, THE PERCENTAGE OF BIRTHS STATEWIDE RECEIVING NO PRENATAL CARE INCREASED FROM 0.8 PERCENT TO 1.3 PERCENT. SIMILARLY, IN MANY OF THE TARGET AREAS, SUCH AS ATLANTIC CITY, CAMDEN AND CUMBERLAND COUNTIES, THE PERCENTAGE OF BIRTHS RECEIVING NO PRENATAL CARE INCREASED BETWEEN 1984 and 1985.

- *How effective have these various State/federal initiatives been if key statistical indicators have not improved?*

THE DEPARTMENT HAS SOUGHT TO PROVIDE COMPREHENSIVE PEDIATRIC SERVICES TO CHILDREN IN SIX SITES (THE NUMBER OF CHILDREN TO BE SERVED IS TO BE INCREASED FROM 20,000 TO 25,000) AND TO TARGET SERVICES TO FAMILIES WITH INCOME UNDER 200 PERCENT OF THE POVERTY LEVEL.

- *What six sites are being funded?*

- *Are we meeting our objectives as to the number of children served?*

THE DEPARTMENT SEEKS TO MAINTAIN THE NUMBER OF CHILDREN UNDER SUPERVISION BECAUSE OF LEAD TOXICITY AT 85 PERCENT.

- *Is the $1.3 million allocated adequate for this purpose?*

THE NUMBER OF CHILDREN SCREENED FOR LEAD POISONING HAS REMAINED RELATIVELY CONSTANT BETWEEN 55,000 AND 57,000.

- *Are those being "screened" new cases or children deemed at risk?*

THE DEPARTMENT IS ATTEMPTING TO REGISTER 95 PERCENT OF ALL INFANTS BORN WITH BIRTH DEFECTS.

- *Has this objective been met?*
- *What obstacles must be overcome?*

APPROXIMATELY 68,000 CHILDREN PARTICIPATE IN THE FLUORIDE MOUTHRINSE PROGRAM.

- *Is participation in the program based on income? What are the income criteria.*
- *Is the program limited solely due to the amount of funds available?*

THE HEALTHY MOTHERS/HEALTHY BABIES INITIATIVE HAS TARGETED TEN CITIES WITH POOR INFANT AND MATERNAL HEALTH INDICATORS.

- *Has the department considered revising the list in view of data that indicate that Cumberland County and Irvington have more serious problems than some of the ten municipalities?*

55X

SUMMARY SHEET

Alcohol, Drug Abuse and Mental Health Block Grant

The Department of Health administers the overall block grant. However, the mental health portion of the block grant is passed through and administered by the Division of Mental Health and Hospitals in the Department of Human Services.

FY 1988		FY 1989
$3,240,000	Alcoholism Control	$3,596,000
6,247,000	Narcotics and Drug Abuse Control	6,679,000
10,674,000	Community Mental Health	11,015,000
$20,161,000		$21,290,000

Discussion Themes

NO FY 1989 APPLICATION HAS BEEN SUBMITTED REGARDING THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT BECAUSE THE CONGRESS IS CONSIDERING CHANGES TO THE BLOCK GRANT. HOWEVER, THE JOINT BUDGET OVERSIGHT COMMITTEE MAY WISH TO ASK THE FOLLOWING:

- ***What changes from the existing block grant requirements are anticipated? And how will these changes impact existing funding patterns and priorities?***

J-6X

SUMMARY SHEET

Low Income Home Energy Assistance Block Grant

Administered by the Department of Human Services.

FY 1988		FY 1989
$59,723,008*	Payments to low income households (Heating; Cooling; Crisis Intervention)	$55,100,000
6,193,000	Transfer to DYFS.....(	
4,332,000	Transfer to DCA for energy crisis(	9,500,000
438,000	Transfer to Dept. of Health for..(maternal and child health care...(	
6,400,000	Administration (State, County, Other)	

*Includes funds used by counties for administrative costs.

The Low Income Home Energy Assistance Block Grant provides energy assistance to low-income households. In addition, under the terms of the enabling legislation, funds can be transferred to other programs, and the State has transferred funds to assist the Division of Youth and Family Services, to provide funds for weatherization programs through the Department of Community Affairs, and to provide funds for maternal and child health programs through the Department of Health.

Discussion Themes

THE STATE'S PLAN CALLS FOR ELIGIBILITY OF 150 PERCENT OF OMB POVERTY GUIDELINES. A REVIEW OF INCOME DATA FROM THE TWO LIFELINE PROGRAMS INDICATES THAT OVER 100,000 LIFELINE HOUSEHOLDS (WHO DO NOT RECEIVE SSI) HAVE INCOMES WHICH MIGHT QUALIFY FOR ENERGY ASSISTANCE PURSUANT TO BLOCK GRANT GUIDELINES. YET THE GOVERNOR LINE ITEM VETOED $20 MILLION IN PETROLEUM OVERCHARGE FUNDS SPECIFICALLY TARGETED FOR ASSISTANCE TO HOUSEHOLDS RECEIVING LIFELINE ASSISTANCE.

- ***How many non-SSI households which receive Lifeline benefits also receive Low Income Home Energy Assistance?***

- ***What accounts for the disparity between the number of households receiving Lifeline benefits who are potentially eligible for Low Income Home Energy Assistance and the number of such households which actually receive assistance?***

- ***What efforts can the division undertake to inform Lifeline benefit households that they may be potentially eligible for Low Income Home Energy Assistance?***

57X

SEVERAL YEARS AGO, VARIOUS NEW JERSEY UTILITIES COMPLAINED THAT THEY WERE NOT RECEIVING PAYMENTS FROM CLIENTS RECEIVING LOW INCOME HOME ENERGY ASSISTANCE. A SYSTEM OF TWO-PARTY CHECKS WAS INSTITUTED TO ENSURE THAT UTILITIES RECEIVED PAYMENT.

- *How many households receive such two-party checks?*

- *Several other states have converted their Low Income Home Energy Assistance program into a credit program similar to the State's Lifeline Credit program. Is such a program advisable in New Jersey? And if not, why not?*

SEVERAL YEARS AGO, SEVERAL COUNTIES EXCEEDED THEIR ADMINISTRATIVE ALLOCATION AND WERE PENALIZED BY THE FEDERAL GOVERNMENT

- *What steps were taken to prevent this from occurring again?*

SINCE THE INCEPTION OF THE BLOCK GRANT PROGRAM, FUNDS HAVE BEEN TRANSFERRED TO THE DEPARTMENT OF COMMUNITY AFFAIRS FOR WEATHERIZATION PROGRAMS AND ENERGY CRISIS INTERVENTION.

- *Does the division monitor the programs?*

- *How many homes have been weatherized?*

- *Should this transfer be continued in light of the overall reduction in funds?*

- *To what extent should block grant funds be used for utility deposits or to pay arrearages?*

- *Why hasn't the department used some of the $20 million petroleum overcharge funds remaining under P.L. 1987, c. 231 for utility deposits?*

5PX

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT FY 89

Division of Community
Health Services

NEW JERSEY DEPARTMENT OF HEALTH
A BETTER STATE OF HEALTH

59X

STATE OF NEW JERSEY
OFFICE OF THE GOVERNOR
CN-001
TRENTON
08625

THOMAS H. KEAN
GOVERNOR

August 11, 1988

Grants Management Officer
Procurement and Grants Office
Centers for Disease Control
255 East Paces Ferry Road, N.E.
Room 321
Atlanta, GA 30305

Dear Sir or Madam:

In accordance with the Omnibus Reconciliation Act of 1981, the State of New Jersey hereby applies for the Preventive Health and Health Services Block Grant for Fiscal Year 1989.

The enclosed application contains the necessary statement of assurances, statewide goals and objectives, description of programs to be carried out with these funds and expenditure plan. In addition, the necessary status reports for 1988 for this Block Grant are included.

Sincerely,

Tom Kean

Thomas H. Kean
Governor

Enclosures

60X

State of New Jersey

DEPARTMENT OF HEALTH
CN 360, TRENTON, N.J. 08625-0360

MOLLY JOEL COYE, M.D., M.P.H.
COMMISSIONER

APPLICATION FOR
PREVENTIVE HEALTH & HEALTH SERVICES
BLOCK GRANT
FY 89

Thomas H. Kean
Governor

Molly Joel Coye, M.D., M.P.H.
State Commissioner of Health

New Jersey Is An Equal Opportunity Employer

APPLICATION FOR
PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT FY 88
New Jersey State Department of Health
Omnibus Budget Reconciliation Act of 1981

Contents

			Page
PART I	A.	Statement of Assurances.	4
	B.	Statement of Statewide Goal and Objectives	7
	C.	Introduction	9
PART II		Dental Caries Prevention . . . . . Section 1904 (a) (1) (A)	12
		Rodent Control . . . . . Section 1904 (a) (1) (A)	15
		Hypertension Prevention and Control. . . . . (Cardiovascular and Related Diseases) Section 1904 (a) (1) (B)	26
		Health Promotion and Risk Reduction. . . . . Section 1904 (a) (1) (C)	35
		Comprehensive Public health Services	53
		Local Health Training. . . . . Section 1904 (a) (1) (D)	70
		Emergency Health Services. . . . . Section 1904 (a) (2) (F)	75
		Rape Services and Prevention . . . . . Section 1904 (a) (1) (G)	100
Part III		Proposed Budget.	107

CONTACT PERSON:

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NEW JERSEY STATE DEPARTMENT OF HEALTH
CN 364
TRENTON, NEW JERSEY 08625

PHONE: (609) 292-4043

PART I

A. STATEMENT OF ASSURANCES

PART I

A. STATEMENT OF ASSURANCES:

Through its administration, the State of New Jersey assures that:

(1) The funds allotted to New Jersey under Section 1902 of the Preventive Health and Health Services Block Grant will be used in accordance with state requirements.
Ref. Sec. 1905 (c) (1)

(2) The state of New Jersey will establish reasonable criteria to evaluate the effective performance of entities which receive funds from the allotment of the State under the Preventive Health and Health Services Block Grant Act and will establish procedures for procedural and substantive independent State review of the failure by the State to provide funds for any such entity.
Ref. Sec. 1905 (c) (3)

(3) The State of New Jersey will permit and cooperate with Federal investigations undertaken in accordance with Section 1907.
Ref. Sec. 1905 (c) (5)

(4) The State of new Jersey will identify those populations, areas and localities in the State with a need for the services for which funds may be provided under the Preventive Health and Health Services Block Grant Act.
Ref. Sec. 1905 (c) (6)

(5) The State of New Jersey agrees that Federal funds made available under Section 1903 for any period will be so used as to supplement and increase the level of State, local and other non-federal funds be made available for the programs and activities for which funds are provided under that section and will in no event supplant such State, local and other non-federal funds.
Ref. Sec. 1905 (c) (7)

(6) The State of New Jersey will put in effect a system to protect from inappropriate disclosure, patient and rape victim records maintained by the State in connection with an activity funded under the Preventive Health and Health Services Block Grant Act or by an entity which is receiving payments from the allotment of New Jersey under this Act.
Ref. Sec. 1905 (c) (8)

(7) The State assures that a Legislative Subcommittee will schedule a public hearing on the proposed use and distribution of Preventive Health and Health Services Block Grant funds in FY 88. Confirmation of this scheduled hearing along with relevant public comments will be submitted as a supplement to this application.
Ref. Sec. 1905 (b)

(8) The State of New Jersey will prepare a description of the intended use of the payments that New Jersey will receive under Section 1903 for the fiscal year for which the application is submitted. This description will include information on the programs and activities to be supported and services to be provided. This description will be made public within the State in such a manner as to facilitate comments from any person (including any Federal or other public agencies) during development of the description shall be revised throughout the year as may be necessary to reflect substantial changes in the programs and activities assessed by the State under this part, and any revision shall be subject to the requirements of public comment.

PART I

B. STATEMENT OF STATEWIDE GOALS AND OBJECTIVES

PART I

B. STATEMENT OF STATEWIDE GOALS AND OBJECTIVES:

The Preventive Health and Health Services Block Grant for FY 88 for the State of New Jersey will provide for grants and contracts for:

(1) RODENT CONTROL
These funds will be used to support urban community oriented programs providing educational, environmental sanitation and rodent control services in order to achieve measurable achievements in the environmental and residential target areas.
Ref. Sec. 1904 (a) (1) (A)

(2) HYPERTENSION PREVENTION AND CONTROL (Cardiovascular and Related Disease)
These funds will be used for establishing and maintaining preventive health service programs for the screening, detection, diagnosis, prevention, referral for treatment and the followup on compliance with treatment prescribed for hypertension, diabetes, smoking, high cholesterol, etc.
Ref. Sec. 1904 (a) (1) (B)

(3) RISK REDUCTION
These funds will be used for community based programs for the purpose of demonstrating and evaluating optimal methods for organizing and delivering comprehensive preventive health services to defined populations, comprehensive programs designed to deter smoking and the use of alcoholic beverages among children and adolescents, and other risk reduction and health education programs.
Ref. Sec. 1904 (a) (1) (C)

(4) COMPREHENSIVE PUBLIC HEALTH SERVICES
These funds will be used for providing comprehensive public health services including, responding to hazardous environmental exposures; and for the planning, development, and implementation of specialized training and continuing education programs for local health department personnel throughout the State.
Ref. Sec. 1904 (a) (1) (D)

(5) EMERGENCY MEDICAL SERVICES
These funds will be used for feasibility studies and planning for emergency medical services systems and the establishment, expansion and improvement of such systems. Amounts for such systems may not be used for the costs of the operation of the systems or the purchase of equipment for the systems.
Ref. Sec. 1904 (a) (1) (F)

(6) RAPE SERVICES AND PREVENTION
These funds will be used for providing services to rape victims and for rape prevention.
Ref. Sec. 1904 (a) (1) (G)

PART I

C. INTRODUCTION

PART I

C. INTRODUCTION:

The Preventive Health and Health Services Block Grant represents seven distinct but related projects for health services.

This application includes descriptions of the programs to be funded in Federal Fiscal Year 1988 specifying the goals and objectives of these services; the indentification of population, areas and localities of need; the methods for achieving the goals and objectives; and criteria to evaluate effective performance. For those programs funded in Federal Fiscal Year 1987 a status report is provided.

The Rodent Control Program goal is to make permanent and measureable reductions in the number of rat problems and the environmental conditions which cause rat problems in the most distressed urban residential areas of the state. Emphasis is placed on community participation and education to achieve these changes.

The Hypertension Program (Cardiovascular and Related Diseases Control) aims to reduce hypertension-related morbidity and mortality through a statewide coordinated program which seeks out persons at high risk (low-income white adults and all minority persons over 19 years of age) of undetected elevated blood pressure and target its efforts to increase the number of hypertensives under control and address the other risk factors such as diabetes, smoking and cholesterol.

The Health Promotion Risk Reduction plan is composed of five parts, the Smoking and Tobacco Use Control Initiative, the Cholesterol Initiative, the General Nutrition Awareness Campaign, the Cancer Control Initiative and General Health Promotion Activities. These five projects all contribute to promoting health and preventing disease by encouraging changes in lifestyle behavior. Smoking and Tobacco Use Control Initiative will focus on the expanding program activities to include the continued implementation of smoking legislation and evaluation of New Jersey clean indoor air ordinances. The Cholesterol Initiative will be directed toward people at high risk of cardiovascular disease while the general nutrition awareness program emphasizing decreased fat consumption will include point of purchase nutrition education in supermarkets. The Cancer Control Initiative will focus its efforts on the education and promotion of screening for women at risk of breast cancer while general health promotion activities will include the expansion of school and community health education programs.

The Comprehensive Health Services section of this application reflects those projects which the state feels are of primary importance to maintain, expand, or initiate as public health services. In FY 88, these services include continuation of the Environmental Health Hazard

Assessment segment with the goal of minimizing or eliminating the adverse public health effects caused by the unnecessary community and workplace exposure to environmental hazards and contaminants and

protecting the consuming public from products present in the marketplace that may contain deleterious substances; and education and training for local health department personnel.

The Emergency Medical Services Program aims to coordinate the emergency care services network with an emphasis on training personnel for basic, intermediate and advanced life support services and on studying, planning and monitoring programs which address special needs in EMS patient care.

The Rape Services and Prevention Program has established a network of rape counseling agencies whose efforts are coordinated with the medical care system and county prosecutors offices.

70X

PART II

DENTAL CARIES PREVENTION PROGRAM

1904 (A) (1) (A)

DENTAL CARIES PREVENTION PROGRAM
PROGRESS IN FY 88
STATUS REPORT: July 1, 1987 - June 30, 1988

FLUORIDATION EDUCATION AND PROMOTION:

The primary goals of the program has been to increase public interest to support the issue of community water fluoridation. This interest is created by disseminating relevant information regarding the dental and fiscal benefits of drinking optimally fluoridated water. The pivotal focus of the educational message is presented through a 6-page pamphlet, "Fluoridation and You...Perfect Together." This pamphlet was developed by the program in 1987, and emphases the natural occurrence of fluoride in all water supplies, the dental benefits and potential cost-savings for New Jerseyans using fluoridated water.

The Flouridation Surveillance Project of 1986 determined the average fluoride level in 370 of 628 water companies and 419 of 567 municipalities. The report was forwarded to the New Jersey Department of Environmental Protection requesting cooperation in bringing into compliance the eight water companies in 10 municipalities who fluoridate, but are below the optimal level of 1.0 PPM and the eight water companies in 18 municipalities who fluoridate, but are over the optimal fluoride level. This effort continued into 1988.

Fluoridation efforts were coordinated in opewell (Mercer County), East Hanover (Morris County), Atlantic City (Atlantic County), Florence (Burlington County) and South Orange (Essex County). In East Hanover consultation and assistance was provided to the local Citizens Advisory Committee for Fluoridation. On election day the issue of fluoridation in E. Hanover was defeated by a strong antifluoridation movement and was just defeated in Florence Township by 200 votes. Hopewell Council decided against an ordinance to fluoridate for now because of current water plant problems. Following a public hearing, the Atlantic City MUA voted unanimously to continue fluoridating their water supply as they have since 1963.

The Dental Health Program supported the efforts of the South Orange Health Department to fluoridate this community of 15,894. The support included supplying current educational materials, technical assistance and knowledgeable dental professionals who could speak on community water flouridation. The local Board of Health passed a resolution recommending that community water fluoridation become an ordinance of the municipality. This resolution generated newspaper articles, increased public comment and considerable antifluoridation activity. Two public hearings were conducted where public and expert testimony was given. On March 28, 1988, the Board of Trustees voted 4 to 2 adjust the amount of fluoride in their water supply to 1 ppm. The municipality is currently studying the engineering and fiscal aspects of this endeavor. The Dental Health Program, in cooperation with the Centers for Disease Control's fluoridation engineering staff, expect to assist with the technical aspects of installing equipment to provide community water fluoridation.

The 30 member New Jersey Task Force for Better Dental Health met on two occasions. Agenda for the meetings include reports by the Coordinator regarding statewide fluoridation activities. Representatives attending the Task Force meetings included:

Association for Children of New Jersey
Association of Retarded Citizens
N.J. Academy of Pediatrics
N.J. Business Group on Health
N.J. Dental Assistants Association
N.J. Dental Hygienists Association
N.J. Department of Education
N.J. Department of Environmental Protection
N.J. Health Officers Association
N.J. Public Health Association
N.J. State Federation of Women's Club
N.J. State Nurses Association
Society for Public Health Education
University of Medicine and Dentistry of N.J.
Fairleigh Dickinson School of Dentistry

Fluoridation activities are currently scheduled, on a limited basis, for Pennington, Pequannock, Atlantic Highlands, Avalon, Teaneck and Freehold Boro.

PART II
RODENT CONTROL
1904 (A) (1) (A)

URBAN RODENT CONTROL [Sec. 1904(a)(1)(A)]

A. INTRODUCTION AND BACKGROUND:

The Urban Rodent Control Project of the State Department of Health completed the sixth year of operation with funding from the Preventive Health and Health Services Block Grant, on June 30, 1988. In the state Fiscal Year 1988, Health Service Grants were awarded to three municipal and county health agencies to conduct comprehensive rat control and environmental improvement programs in the most distressed urban target areas of New Jersey. Prior to July 1, 1982, federal categorical rat control grant awards had assisted a collective total of 11 subprojects under the direction of this department, and for various lengths of time over a 13 year period.

During the year which started July 1, 1987, renewal grant awards supported the operation of Rodent Control subprojects in the cities of Camden, Jersey City and Newark. In addition, a Letter of Agreement provided more limited assistance to the City of Plainfield. In FY 1988, the three subproject programs continued to demonstrate significant progress toward Environmentally Improved Block (E.I.B.) and other objectives. The same three cities still show some of the greatest remaining need for improved environmental and housing conditions of any eligible urban areas in the state. A notice of availability of funds informed other agencies regarding the competitive Rodent Control grants for FY 89. Supplemental state funds were approved for the three grants in FY 88 and are projected for new grants in FY 89. A breakdown of grant period and amount of funding in FY 88 is as follows:

City	Grant Period	Grant Amount Preventive Block	State
Camden	July 1, 1987 - June 30, 1988	$122,251	$62,000
Jersey City 1/	August 1, 1987 - June 30, 1988	43,298	40,000
Newark 1/	August 1, 1987 - June 30, 1988	99,141	55,000
Plainfield	July 1, 1987 - June 30, 1988	4,586	----
		$269,276	$157,000

1/ Previous grants extended to July 31, 1987.

B. PROGRAM GUIDELINES: IDENTIFICATION OF POPULATION, AREAS, AND LOCALITIES:

In order to meet program guidelines for comprehensive activities, a number of services must be provided by cooperating agencies. The grants cover basic program activities such as central control, survey, community participation/outreach and rat killing while other agencies must provide clean-up, code enforcement, and other services with local resources. Community education remains the heart of the effort to improve awareness of the need for environmental sanitation. With smaller staffs, the current Rodent Control Programs often target larger groups in schools, day care centers, churches, and community organizations and limit door-to-door contacts to attack blocks. Subprojects are also encouraged to assist local health agencies with non-rodent control objectives wherever feasible, and to assist residents by making referrals to appropriate agencies.

With certain modifications, the department has continued to endorse the eligibility requirements previously applicable to categorical Urban Rat Control Grant Awards (42 CFR Part 51b 303). The requirements effectively identify those urban residential communities with the most serious environmental sanitation and rat problems in the state. An applicant must be a public agency or a political subdivision within New Jersey, and at least 6 percent of the premises in the target area must have active rat signs documented by a baseline survey and verified by a state conducted sample survey.

The specific guidelines which must be met before a grant application for funding can be made to initiate a new Rodent Control Project, or expand an existing target area, include the following:

1. completion of a valid survey of a proposed target area and documentation that at least 6 percent of the premises inspected demonstrated active rat signs;

2. the target area must include at least 100 urban residential blocks; the minimum size for an expansion subtarget area has been changed to 25 blocks because of the more limited resources available to current programs;

3. for a new start program, the survey results must be verified by the conduct of a state sample survey of blocks in the proposed target area;

4. the applicant must be a municipal or county agency and the application should be approved by the local health officer; and,

5. the applicant must agree to the general and specific grant compliance requirements and all other terms and conditions of the grant award.

Since July 1, 1986, applicants have had to meet the department's grant compliance requirements, instead of the contract requirement

previously in use. However, certain information is still required from Rodent Control applicants in addition to the Health Service Grant Application package, including: progress report, objectives for each subtarget area, Environmentally Improved Block plans, target area maps and plans for target area revision.

As part of the Health Service Grant process, potential applicants for FY 89 were sent Request for Applications (RFA) information, Urban Rodent Control Guidelines, and Specific Compliance Requirements.

Applications are reviewed and evaluated, and funding priorities established, based on the following factors:

1. the degree of remaining rat problem and causative conditions, both inside and outside of the existing target area;

2. the likelihood that the program described in the application will accomplish measurable progress in the target area and provide other needed services elsewhere;

3. the degree to which the proposal meets the departmental requirements of a grant application;

4. the amount of commitment of resources and interagency cooperation provided by the applicant city/county; and,

5. the population density and socioeconomic status of people in the target area, and the ability of a community to correct rat and environmental sanitation problems without grant support.

Previous Preventive Block applications have described the New Jersey Urban Rodent Control definitions and eligibility requirements which differed from those described in CFR Part 51b, 302. These standards are available to applicants in the revised Rodent Control Guidelines. No revisions are proposed in the current application.

C. GOALS AND OBJECTIVES:

Long-Range Goals

The goal of rodent control under the Preventive Health Block Grant is to identify and make permanent reductions in rat infestations and causative conditions in urban cities with deteriorated residential areas, severe socioeconomic problems, and poor environmental sanitation. To accomplish this goal, health service grants will be awarded to cities identified as having the severest rat problem by recent survey. The principal objective of the grants will be to convert at least 80 percent of the target area blocks into Environmentally Improved Block status where maintenance has been achieved and sustained for at least 12 months.

In conjunction with the specific program goal are the following long-range goals: 1) prevent rat bites and minimize the fear of rat bites; 2) improve housing and environmental sanitation; 3) initiate a

positive change in public attitudes toward preventive measures; 4) reduce economic damage and nuisances from rats; and, 5) establish effective and permanent programs for the prevention of rat problems.

Some of the principal long-range rodent control objectives include the following:

1. the placement of at least 80 percent of target area blocks into maintenance status within a two year period;

2. the achievement of Environmentally Improved Block status in a majority of blocks within two to three years of the placement of an approved target area in the "attack" phase;

3. a significant yearly reduction in premises prevalence rates for active rat signs, unapproved refuse storage, exposed garbage, and important harborage conditions;

4. the development of improved local services and increased community participation in the goals of the program;

5. expansion into eligible new target areas requiring rodent control assistance, after the achievement of Environmentally Improved Block status in original areas; and,

6. provide additional community preventive health outreach services, for example; home injury prevention surveys and intervention.

D. FY' 1989 OBJECTIVES:

Objectives for the project year starting July 1, 1988 have been established based upon the projected renewal of grant awards to subprojects in Camden, Jersey City and Newark. The objectives take into account the reduced amount of funds from the Preventive Block indicated in the approved Spending Plan No. SP-89-7-ROD for FY'89, and the estimated same amount of supplemental state funds as in FY'88.

1. Between July 1, 1988 and June 30, 1989, plans will be developed and approved for the placement of an additional 70 blocks into Environmentally Improved status from 3 cities.

2. Between July 1, 1988 and June 30, 1989, an additional 85 blocks from the following subtarget areas will achieve maintenance status: Camden areas 5 and 6, Jersey City area 5, and Newark area 3a. At least one new subtarget area will place 25 blocks into the attack phase.

3. An administrative timetable has been established for several key objectives of the State Urban Rodent Control Project in FY'89 as follows:

Objective	Timetable
a. Field and statistical evaluation of required surveys	by Nov. 30, 1988; by June 30, 1989 (1 per yr. required)
b. Meet with each Project Director and key staff, re: management assistance training and evaluation	at least 3 times per month (each program) by Project Supervisor
c. Review and assist programs with grant compliance requirements, monthly expenditure and progress reports, quarterly reports, E.I.B. plans, etc.	review within one week of receipt by Project Supervisor
d. Assessment and training re: effectiveness of rat killing	by Dec. 31, 1988 or as required
e. Conduct verification surveys required; assist community participation on request	as needed for monitoring; on request for new start or expansion; on request re: education
f. Conduct training program re: outreach, survey, rodent control and pesticides	by June 30, 1989
g. Projected timetable for health service grant applications	department approval of spending plan by Feb. 15, 1989; send RFA by Mar. 15; applications due April 30; worksheet approved June 1, 1989.

E. METHODS OF ACHIEVING GOALS AND OBJECTIVES:

An important rodent control goal is the improvement of the physical environment in approved target areas. A comprehensive approach is required of every applicant in order that the rat control and environmental sanitation improvements will have a more permanent impact. With reduced resources, this may mean that one individual on a small program may engage in several activities, for example: survey, education, rat killing and code enforcement. Each applicant is expected to address the following program elements:

1. Central Control: the management of the project will be under the direction of a Project Director whose responsibilities include the coordination of the below noted activities.

2. Community Participation/Education: project will involve residents in the goals of the program and inform, educate, and motivate the community to improve environmental sanitation.

3. Clean-up: project will take steps to improve and augment garbage, trash, and bulky waste pick-up in the target area, in addition to addressing problems with vacant lots and buildings.

4. Survey: once per year, required surveys will be conducted according to defined standards. Programs are encouraged to survey blocks with intervention activities at least twice per year.

5. Code-enforcement: rodent program will coordinate activities with city agencies to assure compliance with codes, and seek development of new codes, related to rat control, rat proofing, solid waste, and environmental sanitation.

6. Rat Killing: project will conduct this activity based on survey results and under the supervision of a certified applicator, according to guidelines of the State Program, utilizing safe and effective rodenticides.

Other areas which must be addressed by an applicant project are:

1. provide maximum opportunities for employment of target area residents;

2. assure maximum interagency cooperation;

3. establish objectives relating to a reduction of premises with rat infestation and causative conditions, including "maintenance" and Environmentally Improved Block objectives;

4. development of program plan with methodology which will be used to achieve the program goal; and,

5. provision of an adequate commitment of local resources to the project.

In addition to required activities, other activities which utilize the community outreach resources of the program are encouraged. For example distribution of childhood immunization information or home injury prevention surveys may be accomplished while conducting rodent control/sanitation activities.

Responding to rat complaints and providing services outside of the target area is permissible, but must not take priority over target area objectives.

Applicants for the operation of urban rodent control programs are expected to follow the revised State Department of Health application procedures for Health Service Grants, state rodent control guidelines, specific compliance requirements, and the terms and conditions for health service grants. Grant payments will be for personnel and other expenses necessary to conduct an effective rodent control project, operating the above described activities according to established standards of performance.

F. CRITERIA TO EVALUATE EFFECTIVE PERFORMANCE:

1. Reporting Requirements

A system has been developed to measure on a monthly, quarterly, and yearly basis, the progress achieved by local rodent control projects.

Reports will be required which detail progress toward objectives and describe program activities. Monthly progress reports, quarterly statistical, and narrative reports, survey - summaries, plans for target area revision and Environmentally Improved block areas, and progress reports in applications for funding will all be required to be submitted for state review. An evaluation of these reports will be conducted to determine progress toward key objectives, strengths, and weaknesses, justification for expansion, program priorities for the allocation of resources and program areas which are in need of further review with the local Project Director and city officials.

2. Outcome Measures Linked to Goals and Objectives

Key elements of this system, as described below, will be utilized to evaluate the performance of new ro renewal rodent control subprojects.

a. Comprehensive survey inspections of all premises of target area blocks will be conducted at least once yearly (twice for "attack" blocks) in accordance with the methodology described in the publication "Urban Rat Surveys." Premises prevalence rates for individual blocks will be determined for all causative conditions and will serve as the basis for determining the progress achieved during the survey interims. Survey results will be evaluated for validity by the state project in the following manner: (1) analysis of block survey forms and a comparison with past surveys of the same blocks; ( ) field assessment of survey teams; (3) reinspection of individual premises or, if required, the conduct of a valid sample verification survey; and, (4) a review of the complete block records for each block.

b. The measurement of progress in reducing the number of premises with rat infestations and causative conditions will be evaluated against program objectives. Principal objective measures include: (1) the number and percentage of blocks achieving "maintenance" status within a specified period of time; (2) the number of contiguous blocks sustained in maintenance for at least one year and approved as Environmentally Improved Blocks: "Maintenance" status is a block where 2 percent or less of the premises have active rat signs and either 15 percent or less of the premises have exposed garbage, or 30

percent or less of the premises have unapproved refuse storage.

Environmentally Improved Blocks are defined as contiguous blocks where maintenance has been achieved and sustained for a minimum of 12 months. Environmentally Improved Blocks become the responsibility of the City to maintain and are no longer considered a part of the target area, although monitoring and other activities by the Rodent Control Program is encouraged.

c. Site assessments will be conducted by state program staff. Some areas of performance which will be assessed relative to the progress achieved on the projects include: program management, program services, interagency cooperative services, community participation, and coordination of project component activities. All principal activities will be monitored for effectiveness, including community participation/health education, survey, clean-up, code enforcement, and rat killing.

Records assessment will be conducted periodically to include an examination of all activities conducted on randomly selected problem blocks in the period between the two most recent surveys. Field assessments will be conducted at least once per month of survey, outreach and rat killing activities.

G. AGENCIES ELIGIBLE FOR GRANTS, FY'89:

Three currently funded Rodent Control Programs and one city with a current Letter of Agreement have submitted Health Service Grant Applications for FY'89. The applications representing programs in Camden, Jersey City and Newark have documented significant remaining needs in current target areas and other areas of the cities. In addition, the city of Plainfield has documented a need to address the rat problem associated with solid-waste deficiencies in the community. Because of limited availability of grant funds, new start proposals have not been developed by other potentially qualified cities this year. Renewal of limited assistance to Plainfield in FY'89 will be contingent upon adequate funding of the three applications demonstrating the greatest need. The three programs recommended for priority Rodent Control funding in the FY'89 Spending Plan include Camden, Jersey City and Newark, as summarized below:

1. Camden - the subproject is administered by the Camden County Department of Health and Human Services, with a target area within the City of Camden. A city of very seriously deteriorated housing and a heavy concentration of health and socioeconomic problems, Camden's efforts to improve housing, sanitation and to redevelop have benefited from the Rodent Control Program and cooperating agencies. In FY'88, activities in original subtarget area one restored many blocks to E.I.B. status, while new additions were made to the E.I.B. from other

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areas. The program continues to operate an effective educational program for city schools, day care facilities and community organizations. Very good cooperation exists between agencies, for example, regarding extensive demolition of substandard housing. In FY'88, new progress and E.I.B. plans are expected for areas 5 and 6.

2. Jersey City - the subproject is operated by the City Division of Health. The City has experienced an enormous amount of redevelopment near the Hudson River, causing an increase in rat problems for nearby residential communities.

   The Rodent Control Program has plans for an expansion subtarget area near the large Newport development, and will continue to monitor the development areas in FY'89. The city contribution of resources to the program has increased in recent years, and nearly all of subtarget areas 1, 2, 3 and 4 are now in the E.I.B. area. Initial progress in the attack phase for the expansion area is expected in FY'89.

3. Newark - the subproject is administered by the City Division of Environmental Health. Newark is the largest city of the state and has the largest problem areas outside of existing target areas. During FY'88, additional progress was made in expansion area 3a. However, the lack of local resources and the high level of out-of-target-area problems have placed a great constraint on target area progress. Increased city resources are being sought for city-wide needs in FY'89, while grant resources are concentrated on intensive educational, survey, code enforcement and rat killing activities in the approved target area.

H. FY' 88 STATUS REPORT:

The following is a status report for several of the principal short range objectives which were established for the project year which started July 1, 1987.

1. Environmental Improved Blocks (E.I.B.). During FY '88, an additional 69 blocks were approved for placement into Environmentally Improved Block areas. The established E.I.B. objective had projected 90 E.I.B. for the project year.

2. Maintenance Blocks and plans for one new expansion area. Although final survey data were not available, 57 additional blocks had achieved maintenance status by April 30, 1988. One hundred and twenty (120) blocks had been projected for maintenance status for the full year. Plans were developed for a new expansion subtarget area of 25 blocks in Jersey City, to be started in FY '89.

3. Administrative timetable. During FY '88, the Project Coordinator made site visits to each of the three subprojects once per week for purposes of monitoring and evaluating progress

and providing training and management assistance. Grant compliance progress was also monitored through the review of monthly expenditure and progress reports, quarterly reports, E.I.B. plans, surveys and the development of grant applications. Four (4) FY '89 Health Service Grant Applications were reviewed and approved following approval of the Spending Plan.

PART II

HYPERTENSION PREVENTION AND CONTROL

(CARDIOVASCULAR AND RELATED DISEASES)

1904 (a) (1) (B)

PREVENTIVE HEALTH AND HEALTH SERVICE BLOCK GRANT APPLICATION
NEW JERSEY STATE DEPARTMENT OF HEALTH
Cardiovascular and Related Diseases Control Program

A. INTRODUCTION:

1. General Overview

Cardiovascular and related diseases include heart disease, cerebral vascular disease, peripheral vascular disease, and diabetes, and they account for more than 50 percent of all deaths that occur each year within New Jersey and in the United States. The impact in terms of morbidity and cost to society are staggering. The total economic cost to the nation from these diseases is almost $100 billion annually. Prorated on the basis of the size of New Jersey population from 1980 census, the annual cost to New Jersey is approximately 3.25 billion dollars.

2. Risk Factors

Cholesterol

Elevated serum cholesterol is believed to account for 30-40 percent of the cases of coronary heart disease. According to the National Institutes of Health almost 50 percent of the adult population in the United States have serum cholesterol levels greater than 200 mg/dl, above which there is marked increase in the probability of developing coronary heart disease. The Lipid Research Clinics Coronary Primary Prevention Trial did demonstrate that reduction of serum cholesterol was effective in reducing risk. The cholesterol intervention will be discussed in the Risk Reduction Section of this grant application.

Smoking

Smoking accounts for 20-25 percent of cases of heart disease and contributes significantly to cerebrovascular disease and the complications of diabetes. It is also the major cause of lung cancer and chronic lung disease. Smoking prevalence and intervention will be discussed in the Risk Reduction section of this grant application.

Hypertension

Hypertension remains a prevalent, debilitating and often fatal condition that is widespread throughout the American population. Based upon 1983 projections from national survey data, 58 million Americans are estimated to be at increased risk of morbidity and mortality from hypertension-related heart attacks, stroken and kidney disease warranting some type of therapy or systematic monitoring. Almost one person in three (29.8 percent) has hypertension and this rate represents 46 million adults at 1983 population levels. Mild hypertensives (DBP 90 to

104 mm Hg represent 15 percent of the population or approximately one-half of all hypertensives age 18-74 years.

Although cardiovascular disease mortality has declined since 1950, over one-third of the total reduction has occurred since the establishment of the National High Blood Pressure Education Program and the concurrent widespread growth of community-based hypertension control programs. Deaths from hypertension-related disease have continued to decline at a much sharper rate than those categories of cardiovascular diseases not related to hypertension. In New Jersey, age adjusted mortality rate from ischemic heart disease declined by 23.6 percent between 1970 and 1980, the decrease for cerebrovascular disease was 33.7 percent during the same period. Now that initial efforts to reduce morbidity and mortality rates in cardiovascular disease have been successfully implemented, the challenge of continuing that decline remains and steps need to be taken to catalyze further progress.

Diabetes

It has been estimated that there are approximately 190,000 diagnosed diabetics in the State of New Jersey. Ten percent of these are Type I insulin-dependent diabetics, while the remainder do not require daily injections of insulin to sustain life (Type II diabetes). The American Diabetes Association has estimated that for every known Type II, non-insulin-dependent diabetic, there is one other Type II diabetic whose disease has not yet been diagnosed. In New Jersey, then, the diabetic pool could be as high as 340,000 individuals.

Diabetes is associated with acute complications such as diabetic ketoacidosis (DKA) and hypoglycemic coma and has been implicated in untoward pregnancy outcomes. Chronic complications include accelerated atherosclerotic cardiovascular disease, blindness, renal failure, and lower extremity amputations (LEA). The coexistence of diabetes and hypertension greatly magnify the risk of these chronic complications and contribute directly to the morbidity, mortality, and cost of diabetes in the United States.

In recent years, research has demonstrated that much can be done to prevent diabetes and its complications. With weight reduction and exercise up to 50 percent of Type II diabetes can be prevented (primary prevention). Interventions aimed at people with diabetes and at health care providers can also do much to delay or prevent the development of the complications of diabetes (secondary prevention). If diabetic patients have adequate knowledge, self-management skills, and access to health

care, tremendous gains in prevention are possible. Preliminary national data suggest that New Jersey can successfully achieve the following:

Complication	Estimated NJ Incidence	Potential % Reduction	Number of Preventable Cases
DKA	2,438	70	1,707
Congenital Malformations	28	70	20
Stroke	748	85	636
Coronary Heart Disease	2,763	45	1,243
Peripheral Vascular Disease	1,333	60	800
Blindness	189	50	95
End Stage Renal Disease	130	50	65
LEA	1,008	50	504

B. GOAL AND OBJECTIVES

The goal of the New Jersey State Department of Health Cardiovascular and Related Diseases Program is to promote the reduction of Cardiovascular and related morbidity and mortality and their associated human and financial burdens through continuation of a statewide coordinated program.

LONG TERM OBJECTIVES

The long-term objectives of the New Jersey State Department of Health Cardiovascular and Related Diseases Program are:

1. To reduce the incidence of stroke by at least one-third.

2. To reduce the mortality rates from stroke and cardiovascular and related diseases by one-third.

3. To reduce the societal financial burden of cardiovascular and cerebrovascular related disease morbidity and mortality by redirecting and committing resources toward primary prevention programs.

4. To reduce the societal financial burden of diabetes-related morbidity and mortality by redirecting and Committing resources towards prevention programs.

SHORT TERM OBJECTIVES

The short term objectives of the New Jersey State Department of Health Cardiovascular and Related Diseases Program are:

1. To document statewide cardiovascular-related morbidity and related trends.

2. To establish a cardiovascular disease advisory group to assist the Program with analyzing trends, planning and coordinating activities, setting policies, and assessing funding needs for statewide CVD and related disease control activities.

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3. To assess existing statewide services and resources for cardiovascular disease control; to document and alleviate gaps and duplications; and to develop and coordinate a practical, cost-effective linkage system for cardiovascular and related disease control.

4. To award grants to agencies for the provision of cardiovascular and related disease services to the population at risk. The services include community organization, outreach, screening, risk assessment, referral, follow-up, and consumer, patient and provider education.

5. To integrate blood pressure education, detection, referral and follow-up services into routine health care interactions for all New Jersey citizens through consultation with health care professionals in public and private health care settings.

6. To provide health promotion and education for consumers, providers, and patients focusing on the primary risk factors for CVD, such as hypertension, high serum cholesterol, diabetes and smoking.

7. To design interventions to reduce the number of hospitalizations due to preventable complications of cardiovascular and related diseases.

8. To document a reduction in the number and length of hospitalizations in New Jersey due to preventable complications of cardiovascular and related diseases.

9. To develop linkages and mechanisms to interface with appropriate federal, regional, interstate and intrastate agencies.

10. To develop a statewide policy on cholesterol screening and control activities.

C. IDENTIFICATION OF POPULATION, AREAS AND LOCALITIES OF NEED:

New Jersey has 7.36 million people living in 21 counties situated on 7,468 square miles between New York and Pennsylvania, and is the most densely populated State in the nation. In 1980, 89 percent of the population resided in urban areas and 11 percent in rural areas. Males constituted 48 percent of the population, and females 52 percent. Whites constituted 83.2 percent of the population, Blacks 12.6 percent and Hispanics 6.7 percent. In 1983 the median income for White families was $31,851, and for Black families it was $16,384.

D. METHODS FOR ACHIEVING GOALS AND OBJECTIVES:

The New Jersey State Department of Health Cardiovascular and Related Diseases Program intends to achieve the stated goals and objectives:

1. Continuing to work with local health departments which serve communities with the greatest need for services.

2. Continuing to fund a network of community-based direct providers of services.

3. Continuing efforts to facilitate the integration of services into the existing health care system.

4. Developing a statewide policy on public cholesterol screening and continuing efforts to reduce coronary heart disease morbidity and mortality through cholesterol education aimed at prevention and modification of risk factors for coronary heart disease.

5. Continuing to raise public and professional awareness related to the issues of elevated blood cholesterol levels.

The New Jersey State Department of Health Cardiovascular and Related Diseases Program has targeted 80,000 high risk individuals for hypertension screening and hypertension, diabetes, smoking, cholesterol risk factor assessment and counseling during 1989, assuming that 1989 funding levels are comparable to those of 1988. This will be accompanied via continuation of grants to the fifteen currently funded agencies (nine local health departments, four family health centers and two hospitals).

The thrust of the Program in 1989 will be to continue to identify hypertensives controlled/uncontrolled and to target intensive eudcational efforts to them in order to increase the number of hypertensives under control and address the other risk factors such as smoking and cholesterol.

Salient program activities for 1989 will include:

1. Provision of continuing education programs for local health departments and funded project personnel.

2. Dissemination of resource materials to local health departments.

3. Continuation of consultation and technical assistance concerning program planning, implementation and evaluation to local health departments.

4. Facilitation of provider education among health care professionals throughout the State.

5. Follow-up of diabetics who completed education programs in local health departments.

6. Continuation of an amputation intervention plan.

7. Sensitive eye examination on high risk diabetic individuals.

8. Education and tracking of hypertensive diabetics.

9. Counseling and referral of pregnant women with diabetes, both overt and gestational.

10. Development of patient education information targeted educationally for use in high risk groups.

11. Development of cholesterol education awareness at point of purchase sites.

12. Continuation and expansion of mass media activities at all levels.

13. Publishing appropriate materials at all levels.

14. Participation in appropriate State, regional and national activities.

E. CRITERIA TO EVALUATE EFFECTIVE PERFORMANCE:

The New Jersey State Department of Health Cardiovascular and Related Diseases Program measures its progress toward achieving its goal of reducing cardiovascular morbidity and mortality rates through periodic statistical analysis of data gleaned from the New Jersey Medical Discharge Abstract System, from death certificates, and from the Uniform Bill-Patient Summaries data.

Community-based program performance is evaluated via a statistical and narrative reporting system. Community-based programs are evaluated utilizing specific performance measures and are expected to comply with the following performance standards.

1. 100 percent of the grant obligation will be met.

2. 11 percent of the persons served will warrant referral for medical evaluation.

3. 65 percent of the persons referred will arrive at the diagnosis/treatment site.

4. 25 percent of the persons served will be minorities.

5. 1.7 percent of the total screened will be newly diagnosed hypertensives.

6. Statistical and narrative evidence of adequate integration of services into the existing health care system and into the community.

7. Documentation of professional education, community education and the process and outcome measures for patient education.

Criteria used to measure the success of statewide efforts to control cardiovascular and related diseases include:

1. Current rates of cardiovascular morbidity and mortality as well as related trends, will be analyzed summarized, and documented.

2. A cardiovascular disease advisory group will be assembled to provide technical and policy guidance to the Program; a plan for promoting statewide, unduplicated cardiovascular disease control services will be developed and target dates for implementation set.

3. A program to provide education to local health departments, on a regional basis, on conducting CVD and related disease control activities per Minimum Standards of Performance and the Adult Health Services Guidelines will be planned and developed; implementation target dates will be set.

4. A statewide policy on cholesterol screening and control activities will be developed as outlined in the Cholesterol Control Section of this application.

F. STATUS REPORT (1987):

The New Jersey State Department of Health Cardiovascular and Related Diseases Program, via 16 Community-Based Hypertension Control Programs, directed hypertension screening services to 102,074 individuals in 1987, surpassing its screening objectives of 94,500 by 2 percent; of the total screened, 60.2 percent were in the target population. Elevated blood pressure (> 140/90 mm Hg.) was found in 14.2 percent of those screened; 75.2 percent of those referred for medical evaluation arrived at the physician's office and 2,177 newly diagnosed hypertensives (2.1 percent of the total population screened) were unaware of their hypertension (never told by a physician that they have hypertension). Program performance for 1987 met or surpassed established program evaluation standards.

Diabetes risk factor assessment of the 102,074 persons screened for hypertension in 1987 resulted in the identification of 4,638 diabetics (1.4 percent) of the total persons screened in 1987. In addition, 1458 individuals self-reported symptoms of diabetes were referred for medical evaluation. Of these, 72 were newly diagnosed as diabetic.

A group of 2,740 (2.7 percent) were identified as having both hypertension and diabetes.

A total of 21,984 individuals participated in educational sessions according to the following breakdown: provider education - 2,528, hypertensive participants - 8,551, non-hypertensive participants - 10,905.

Program planning efforts in 1986 resulted in the following outcomes for 1987: 1) New Jersey State Department of Health Cholesterol Task Force which will prepare nutritional guidelines for providers concerning cholesterol and also sponsor an education program for nutritionists. 2) State representation on the New Jersey Affiliate of the American Diabetes Association Task Force on Minority Initiatives. 3) Collaboration with the American Heart Association for physician provider education.

On November 16, 1987, over 250 health care professionals attended the Second Annual Cardiovascular, Diabetes and Risk Reduction Education all day conference. "Consensus Amid Controversy: Nursing Management of Multiple Risk Factors Associated with Cardiovascular Disease" planned by Program staff.

Program Management Meeting held December 2, 1987 was attended by 33 persons and provided an opportunity to distribute and describe program reporting requirements, the Fall/Winter television public service announcements, multi-media campaign, program evaluation and priorities.

An abstract entitled "Successful Detection of Hypertension Among Minorities in New Jersey: 1978-1984" was submitted and accepted for poster presentation at the Second International Interdisciplinary conference on Hypertension in Blacks in January, 1987.

The New Jersey State Department of Health Program was asked to prepare a presentation on "The Standardized Cardiovascular Disease Control Program Manual System: Development, Implementation and Long-Term Control" for the National Conference on High Blood Pressure Control held in April 1987. In addition, two abstracts were also submitted and accepted for poster presentation at this conference: "Serving the Underserved, New Jersey State Department of Health Hypertension Program Accomplishments" and "Client Self-reported Cardiovascular Risk Reduction Behavior Two Years After High Blood Pressure Education, Screening and Referral."

Via a grant with the New Jersey Commission for the Blind and Visually Impaired, sensitive eye examinations were performed on 544 persons. Of these 223 were found to have diabetic eye disease. Retinopathy was found in 129 persons (57.8 percent), 52 persons (23.3 percent) had glaucoma, 73 in 129 persons (57.8 percent), 52 persons (23.3 percent) had glaucoma, 73 (32.7 percent) had cataracts, 47 persons (21 percent) had maculopathy. These four categories are not mutually exclusive. Referral and follow-up is vigorous and virtually all of these diabetics have sought treatment.

To date 80 diabetics are participating in an intensive intervention as part of a grant with the Newark Beth Israel medical Center for diabetics at high risk of lower extremity amputation (LEA).

Over 1,000 professionals attended provider education programs planned and conducted with the American Diabetes Association, New Jersey Affiliate.

To date approximately 1,710 individuals participated in multi-session diabetes education programs funded via contracts with five local health departments. Follow-up is conducted every six months in order to document hospitalization and emergency room visits following completion of the education series. These figures will be compared to hospitalization and emergency room visits prior to education.

PART II

HEALTH PROMOTION AND RISK REDUCTION

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V. GENERAL HEALTH PROMOTION-RISK REDUCTION ACTIVITIES

A. INTRODUCTION:

Health promotion is any combination of health education and related organizational, environmental , and economic interventions designed to support behavior conducive to health. Emphasis is on personal lifestyle for maintaining health and preventing chronic illness and injury.

Injury, cancer and cardiovascular disease are the three major causes of mortality within New Jersey and account for 70% of all New Jersey deaths for persons aged 5-65. Reducing modifiable risks through a combination of health education, health protection and disease prevention is a goal of the risk reduction program.

Almost 2/3 of adults spend from one-third to one-half of their waking hours at work, therefore the worksite is the logical setting for health promotion programs. It affords the most accessible means of reaching large groups of adults in a continuing basis. It can serve as a locus for providing personal health services that are preventive in intent, and for health education programs. The risk reduction program provides consultation and technical assistance to local health departments and those industries interested in providing health promotion programs. An important part of this initiative is the role of the program as state focal point for "Healthier People." In this capacity, the program acts as liaison between the Carter Center of Emory University and registered users of "Healthier People."

Strategies to reduce injuries must be targeted to the type of injury to be prevented and toward the age group where that injury predominates. In order to effectively target prevention programs an integrated injury control surveillance system must be developed to bring together all the data pertaining to injuries and their causes within the state. To this end an intradepartmental Injury Control Task Force has been established. The task force serves as a forum for discussing activities, needs and interests related to injuries. It is currently investigating existing injury control data sources and their applicability to a statewide surveillance system. In addition, injury control is being integrated into existing program activities.

In addition to activities focused on fostering health promotion in the worksite, there are broader general health promotion efforts. The program acts as a resource for general health education consultation for local health departments within New Jersey.

Ultimately, some measure must be made assessing the impact of the health promotion activities within New Jersey. In 1982 a

random digit dialing phone survey was conducted. It is anticipated that in 1989 the Risk Reduction Program will resume behavioral risk factor surveillance using the CDC-Behavioral Risk Factors Surveillance System (BRFSS).

B. Goals and Objectives

Continue as a source of technical assistance in broader health promotion activities for agencies throughout New Jersey.

Objectives:

1. Provide technical assistance based on requests from health education providers.

2. Disseminate information on effective use of HRA's to health education providers.

3. Assist Carter Center of Emory University with training and technical assistance to all users of "Healthier People."

4. Modify C.D.C. protocol for behavioral risk factor surveillance for use in New Jersey.

5. Develop a statewide injury surveillance system.

6. Educate caregivers for the elderly on the importance of injury prevention in this high risk population.

C. IDENTIFICATION OF POPULATION, AREAS AND LOCALITIES:

As of 1980, 4,765,766 individuals were of working age (16 to 64). Approximately 2,954,774 are employed outside the home as part of the workforce. They comprise 40% of the New Jersey population.

Overall, injuries are the third leading cause of death. In terms of years of life lost prematurely before the age 65, injuries are clearly the major component. From 1979-1981 an average of 2,752 "accidental" injury deaths occurred each year within New Jersey. Nearly half (47%) of these were related to motor vehicles. Examination of deaths by type of event indicates that New Jersey has a lower overall mortality rate than the rest of the U.S. (23.9 per 100,000 in New Jersey vs 43.2 per 100,000 population). Nationally new Jersey exceeds national figures only for fire and firearm fatalities. In the 65 and older population, fires and injuries associated with fires were the third leading cause of death. In 1983, accidental deaths by fire in the 65-74 age groups were 9.3%, and 15.5% in the 75 and over age group.

The morbidity from injuries is also significant. They are the leading reason for physician office visits. Injuries account for over 25% of E.R. patients. Among acute conditions, injuries

account for 22% of all days or restricted activity, 14% of bed disability days, 16% of days lost from school, and 31% of days lost from work.

D. METHOD OF ACHIEVING GOALS AND OBJECTIVES:

The New Jersey Department of Health - Health Promotion Risk Reduction Program intends to achieve the stated goals and objectives by:

1. Continuing as a source of technical assistance in broader health promotion activities for agencies throughout New Jersey.

   a. Develop an educational program for providers on use of HRA's and conduct training programs for all registered users on the use of "Healthier People."

   b. Develop a "Healthier People" Users Directory to facilitate networking between registered users.

   c. Provide technical assistance on health education through onsite and/or phone consultation, materials development and written communication.

   d. Work with Local Health Development Services to refine health promotion standards and guidelines for local health departments and assist in their dissemination.

   e. Develop a list of all injury control data sources through members of the injury control Task Force.

   f. Contract to do behavioral risk factor surveillance modeled after the CDC protocol.

   g. Provide general health promotion information to new employees at orientation.

   h. Develop an injury prevention component for the home-care curriculum including clothing ignition burns.

E. CRITERIA TO EVALUATE EFFECTIVE PERFORMANCE:

Evaluation of the effectiveness of the proposed activities to be conducted by the Program will be made utilizing the following criteria:

1. Number of registered users who successfully implement "Healthier People."

2. Number of registered users who successfully implement "Healthier People."

3. Number of health departments with an injury control surveillance system.

4. Number of behavioral risk factors surveys reported bi-monthly.

5. Number of new employees attending health promotion information session.

6. Number of caregivers trained in injury prevention strategies as part of "Family Caregiver Education and Support Program" curriculum.

STATUS REPORT

As a state focal point for "Healthier People," the Program provided technical assistance to the 30 registered users of "Healthier People" and responded to over 50 requests for information.

The Program sponsored a training workshop for all registered users on the implementation of "Healthier People." Staff from the Carter Center conducted only two day workshop which offered registered users an opportunity for "hands-on" training.

The Role of the Program as State focal point is included as part of a core curriculum course - "Health Education and Behavioral Science" - in the Graduate Program in Public Health, Robert Wood Johnson Medical School; it is also included in the Environmental Medicine Course for second year medical students at the Medical School.

In the area of general health promotion, the Department cosponsored a program on fitness for women with the Governor's Council on Physical Fitness. Over 400 women attended the "Governor's Conference on Health and Fitness for Women."

The Injury Control Task Force sponsored a program on the National Youth Sports Coaches Association. Letters of support were sent to all 116 local health jurisdictions requesting them to bring to the attention of recreation departments in their service area the NYSCA organization. One of their primary goals is injury prevention in volunteer youth sports programs.

Five information sessions on health promotion were provided to new employees during orientation.

II. NUTRITION

A. INTRODUCTION:

Diet and diet influenced risk factors, such as hypercholesterolemia are responsible for 30% of all cancers and 30-40% of heart disease. Program efforts in previous years were directed toward an increase of public awareness of the seven Dietary Guidelines for Americans. A critical examination of each of the elements in the guidelines has revealed that the limitation of excessive dietary fat appears to have the single largest potential impact on morbidity and mortality.

Since resources to address the issues related to nutrition are extremely limited outside the area of WIC and other supplemental feeding program, an Interagency Council composed of diverse members representing major sources for nutrition education activities in the State was formed in October of 1985. Its purpose is to discuss and collaborate on the New Jersey Department of Health's statewide focused Nutrition Awareness Campaign. This campaign is primarily concerned with dietary fate and cholesterol specific interventions but will combine these interventions whenever possible with interventions addressing the other major cardiovascular risk factors.

B. GOALS AND OBJECTIVES:

Goal:

1) To change the dietary patterns of New Jerseyans by decreasing fat consumption in the adult population in order to reduce serum cholesterol and reduce cancer risk.

Objective:

2) To act as a state focal point for general nutrition information providing technical assistance to other agencies in New Jersey and provide nutritional input into chronic disease intervention programs.

C. IDENTIFICATION OF POPULATION, AREAS AND LOCALITIES:

New Jersey specific data related to nutritional status is not available, however existing nutritional data indicates that all known adult demographic groups have a majority of their members with elevated serum cholesterol (>200 mg/dl).

D. METHODS FOR ACHIEVING GOALS AND OBJECTIVES:

Stated goals will be achieved by conducting the following activities:

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1. Changing the dietary patterns of New Jerseyeans to decrease fat consumption in the adult population in order to reduce serum cholesterol and reduce cancer risk.

   a. School video contest will be conducted with State Department of Education and other cosponsoring agencies.

   b. Efforts to integrate nutrition education into existing cardiovascular disease services will continue (i.e., Hypertension screening program).

   c. The Risk Reduction Program will attempt to focus the efforts of all major sources of New Jersey nutrition information through interagency council representation.

   d. Conduct a conference for educators of high school students on nutrition and athletics in conjunction with the Governors Council on Physical Fitness and Sports as a continuation of the nutrition awareness campaign.

2. Acting as State focal point for general nutrition.

   a. Ongoing meetings and task force assignments will be conducted with the Interagency Nutrition Council.

   b. Ongoing general nutrition consultation will be provided to local health agencies upon request.

   c. Public Health nutrition input will be provided to state nutrition policies (i.e., Commission on Hunger).

E. CRITERIA TO EVALUATE EFFECTIVE PERFORMANCE:

Evaluation of outcome of nutrition activities is limited due to the lack of data collection systems. This area will be evaluated based on the following:

1. Number of submissions in video contest and the quality of submissions.

2. Number of requests for publications and consultations.

3. Number of school educators trained as part of the school awareness campaign.

4. Delineation of nutritional components incorporated into other chronic disease intervention programs.

STATUS REPORT

This year, the focus of the nutrition component of the Health Promotion Program has changed from one of providing local health departments with nutrition grants to one of educating the public and professionals in ways to decrease dietary intakes of fat and cholesterol in order to reduce cardiovascular disease and cancer risk. As a result of the activities of the Interagency Committee on Nutrition established in '86 and the new focus on cholesterol education for health professionals, the Health Promotion Program conducted a conference entitled, "Getting to the Heart of the Cholesterol Issue: Perspectives For the 1990's." This conference, attended by 150 Registered Dietitians, was cosponsored by the Department, the American Heart Association, New Jersey Affiliate; the New Jersey Dietetic Association and the New Jersey Nutrition Council.

Two local health departments worked with thirteen supermarkets conducting point of purchase nutrition education activities. These activities were geared to reduce intake dietary fat while reducing risk of cardiovascular disease and certain types of cancer. One local health department was very successful in developing four videotapes which were shown in the supermarket. The other health department successfully conducted store tours, educating shoppers to healthier food choices throughout the store. While both departments were successful in media publicity, the local cable TV network aired the store tour on several occasions. Throughout the project, both grantee agencies distributed educational pamphlets and recipes promoting healthier food choices. An impact evaluation was performed by examining data from the supermarkets' inventory systems. The ratio of high fat to low fat food items in sales over time was examined. There was no appreciable difference observed. As a result, while successful from a process standpoint, it was decided not to renew these programs due to lack of documented impact on food purchase patterns.

As the state focal point of adult nutrition activities, nutrition publications have also been reviewed and revised during this period. A directory entitled, "New Jersey Nutrition Resource Directory," was revised and published.

CHOLESTEROL CONTROL ACTIVITIES
Public Health and Health Services Block Grant

A. INTRODUCTION:

According to National Institutes of Health (NIH), there is a casual relationship between elevated blood cholesterol and coronary heart disease. The Lipid Research Clinic's Primary Prevention Trial has demonstrated that a nine percent decrease in blood cholesterol level will bring about a 19 percent reduction in coronary heart disease.

Elevated blood cholesterol is not the only risk factor which is related to coronary heart disease. The three major modifiable risk factors associated with coronary heart disease are high blood cholesterol, cigarette smoking and high blood pressure. Other modifiable risk factors are obesity, inactivity, diabetes mellitus, stress and oral contraceptives.

B. GOALS AND OBJECTIVES:

The goal of the State of New Jersey Department of Health, Cardiovascular Disease Control Program is to promote the reduction of coronary heart disease morbidity and mortality rates among New Jersey citizens.

LONG TERM OBJECTIVES

To reduce the mortality and morbidity rates from ischemic heart disease by 10 percent by 1995.

SHORT-TERM OBJECTIVES

1. Consult with a minimum of twenty community-based health agencies across the State in regard to the Cholesterol Control Program.

2. Provide health promotion and risk reduction education programs for patients, consumers, and providers with a major emphasis on cholesterol reduction, high blood pressure control and smoking cessation.

3. Develop a State policy in regard to cost-effective public cholesterol control and screening programs.

   a. Implement at least two cholesterol screening pilot projects in selected health agencies.

   b. Identify individuals at high risk (> 240 mg/dl) for elevated cholesterol and refer them into existing health care systems for medical evaluation and treatment.

   c. Develop a cost-effective cholesterol control model program suitable for replication by statewide health agencies.

4. Present cholesterol education modules prepared by the American Heart Association and National Institutes of Health to 1,000 physicians via the existing health agency networks in New Jersey.

5. Disseminate scientifically accurate cholesterol information by electronic media (PSAs) and printed matter.

6. Develop and distribute easy-to-read basic cholesterol information in order to meet the health education needs of minorities and the hard-to-reach segments of populations at risk.

7. Develop point-of-purchase public education information for consumers.

C. IDENTIFICATION OF POPULATIONS, AREAS, AND LOCALITIES OF NEED:

New Jersey is a State with a population of approximately 7.36 million people, 48 percent of whom are males and 52 percent females. Blacks and Hispanics represent 19.3 percent of the population.

No specific segments of the adult population have been designated as being at higher risk for elevated blood cholesterol than others. Level of risk for coronary heart disease due to elevated blood cholesterol can only be determined when blood cholesterol is actually measured on adults, either by their primary care physicians or in a public health cholesterol screening strategy. Since less than 10 percent of adult Americans know their blood cholesterol levels, efforts will be made to publicize the importance of all adults "knowing their number." Individuals having high blood cholesterol (> 240 mg/dl) or borderline high blood cholesterol (200-239 mg/dl) can be appropriately targeted for risk-reduction activities.

D. METHODS FOR ACHIEVING GOALS AND OBJECTIVES:

The pilot projects will be selected based on the following criteria:

1. A successful history of programmatic activity in at least one area of cardiovascular disease control in the health agency.

2. Demonstrated ability to initiate a new program and bring to fruition.

3. Possession of where with all to plan and conduct and evaluate a cost-effective cholesterol screening program.

The above mentioned objectives will be achieved using worksites, schools, local health departments, HMOs, community health centers and pharmacies as channels of activities. Also, county medical societies will be contacted with the intention of reaching physicians.

The implementation of at least two pilot projects in selected health agencies will provide useful data and insight into the specifics of

the Cholesterol Control Program, and will demonstrate models for replication in other parts of New Jersey.

Needless to say, cholesterol education will not only continue to be integrated with the existing community-based high blood pressure control programs. In addition, the network of usable social resources for education such as industries, schools, churches and pharmacies will be continuously expanded to cover a higher proportion of populations at risk for coronary heart disease due to high cholesterol levels in the blood.

E. CRITERIA TO EVALUATE EFFECTIVE PERFORMANCE:

Success of statewide cholesterol control activities will be measured by the following criteria:

1. A minimum of 20 community-based health agencies will receive consultation regarding cholesterol control activities.

2. A minimum of 20 health promotion/risk reduction education programs will be conducted for patients/providers/consumers on cholesterol reduction, hypertension control, and smoking cessation.

3. A State policy on a cost-effective public cholesterol screening strategy will be developed.

   a. A minimum of two agencies will pilot a cholesterol screening program and assist in its evaluation.

   b. 100 percent of individuals identified as having an elevated blood cholesterol reading at the screening programs will be offered counseling on cholesterol control and referred for medical evaluation; 65 percent of referred individuals will arrive for medical evaluation.

   c. Results of piloting activities will serve as the basis for finalizing the policy for a screening strategy which will be disseminated statewide.

4. Cholesterol education modules developed by the American Heart Association and the National Institutes of Health will be presented to a minimum of 1,000 physicians through existing health agency networks in New Jersey.

F. STATUS REPORT (1987):

The major activities of the State of New Jersey Department of Health in Cholesterol Control in 1987 were as follows:

1. Dissemination of NIH cholesterol documents on a large scale.

2. Development and integration of a cholesterol education program among 15 Community-Based Cardiovascular Disease Programs.

3. Distribution of cholesterol policy and procedures to health departments and industries.

4. Development of a new Intake Form with a section on Cholesterol Assessment.

5. Collaboration with American Heart Association, New Jersey Affiliate, on physician cholesterol education.

6. Cooperation with Citizens for High Blood Pressure to modify cholesterol screening and laboratory procedures.

7. Planning, implementation and evaluation of the Second Cardiovascular and Risk Reduction Conference with major emphasis on cholesterol issues.

8. Collaboration with State Health Department Laboratory and Local Health Development Services to modify New Jersey Laboratory Laws in order to make cholesterol screening more accessible.

In 1988, the State of New Jersey Department of Health integrated a Cholesterol Control Program with its established network of community-based cardiovascular disease projects throughout the State. It is projected that by the end of 1988, 100,000 individuals will have been assessed for cholesterol risk, counseled concerning dietary management of fat and cholesterol and questioned in regard to knowing their cholesterol number. All individuals with elevated cholesterol levels will have been referred for medical evaluation. In addition, 20,000 consumers, patients and professionals will have been educated concerning cholesterol by the end of 1988 in New Jersey.

Presently, a statewide Task Force on Cholesterol has planned a conference titled, "Getting to the Heart of the Cholesterol Issue: Perspectives for the 1990's" which will be presented by the American Heart Association in cooperation with the New Jersey State Department of Health, Cardiovascular Disease and Health Promotion/Risk Reduction Programs. This conference is designed to update nutritionists across the State concerning NIH recommendations pertaining to cholesterol guidelines.

About 500 health care providers, such as local health officers, hospitals, HMOs and others have already been contacted by the Department of Health and provided with special American Heart Association, New Jersey Affiliate, guidelines on the development of a cholesterol education program for physicians throughout the State. Later in 1988, this program will be augmented by a separate physician education module title, "Cholesterol-Current Concepts for Clinicians," which has been developed by the National Heart, Lung and Blood Institute of the National Institutes of Health.

The above mentioned activities constitute the major aspects of the development of a cholesterol counseling protocol to be utilized by health care providers in the State of New Jersey.

IV. CANCER CONTROL

BREAST CANCER DETECTION

A. INTRODUCTION:

Breast Cancer is the most prevalent cancer and is a leading cause of cancer deaths among American women. In New Jersey, an estimated 5,100 new cases of breast cancer were diagnosed in 1986; correspondingly, there were an estimated 1,600 breast cancer deaths among New Jersey women that same year. Since primary prevention of breast cancer is currently not possible effective screening methods for early detection must be implemented to reduce this high number of deaths.

To facilitate state-of-the-art breast cancer screening in New Jersey, the NJSDH is currently participating in a program sponsored by the American Cancer Society, New Jersey Division, Inc. entitled "the Breast Cancer Detection Awareness Program." This educational program is offered through participating New Jersey hospitals and consists of a physical breast examination, instruction on breast self examination, and, to eligible participants, a reduced fee mammogram. Eligibility, as determined by the program guidelines, involves asymptomatic women aged 35 and older, who have never had a mammogram. The target date for this program is May 14, 1988. The State Health Department has primary responsibility for analysis of program results.

Another activity in this area in which the State Health Department is involved is the utilization of consortium groups to provide affordable, state-of-the-art breast cancer screening to the women of New Jersey. Since it has been shown that with increased numbers of women receiving screening mammograms, a reduction in cost can be achieved, a pilot project has been designed based on this idea. To implement this pilot project, a task force has been formed in one New Jersey county, Mercer. The members of this task force include representatives of the hospitals, local health departments, and voluntary community service agencies in Mercer County. The components of the pilot project include educational programs in both public and professional communities, promotional programs with existing radiology facilities, and an ongoing evaluation component.

B. GOALS AND OBJECTIVES:

Goal:

To increase the utilization of state-of-the-art breast cancer screening using mammography with physical breast examination among New Jersey women.

Objectives:

Using the Mercer County Pilot Project as a template, form the necessary consortia in other New Jersey counties to develop programs based on similar objectives.

Goal:

To inform key decision makers of the need for third party reimbursement for screening mammograms.

Objectives:

1. Gather data on comparative treatment costs of breast cancer at early verus late stage at diagnosis.

2. Combine treatment cost data with preliminary utilization data from the Mercer County Pilot Project to prepare a position paper on screening mammography reimbursement to be presented to the State Department of Insurance.

C. IDENTIFICATION OF POPULATION, AREAS, AND LOCALITIES:

Though no specific etiological factor has been isolated in the development of breast cancer, age is used as the basic determinant of risk group status. Based on the age distribution of incident cases and data from the HIP study, women aged 40-70 will be the target group of participants in programmatic efforts.

D. METHODS FOR ACHIEVING GOALS AND OBJECTIVES:

To accomplish the above-referenced goals and objectives the following activities will be conducted:

1. Increasing the utilization of state-of-the-art breast cancer screening.

   a. Continued implementation of the Mercer County Pilot Project (MCPP) will serve to demonstrate to other New Jersey communities the results of consortia building to provide affordable, state-of-the-art breast cancer screening.

      i. educational programs will be disseminated to the general public and the medical community on the benefits of modern low dose mammography with physical examination in breast cancer screening. These programs will serve to improve the utilization of existing services and create further demand for future services.

      ii. promotional programs throughout the community will inform the public of facilities that provide state-of-the-art breast cancer screening, the types of screening services available and the costs of services provided.

2. Coordination and monitoring of increases in screening services for evaluation of pilot project impact.

a. A data exchange program will be implemented between participating radiology facilities and the State Health Department. As the central repository of data collection and analysis, the NJSDH will provide ongoing evaluation of the Mercer County Pilot Project. The results will be used for program expansion to other counties.

3. Utilization of available methods to prioritize a selected community in the state for implementation of a program with objectives similar to the Mercer County Pilot Project.

   a. Identification of other areas in the State for implementation of similar projects will be accomplished through analysis of data available from the NJSDH:

      i. the four regions of New Jersey will be mapped by breast cancer incidence and mortality characteristics. The data will be examined by stage at diagnosis and incidence: mortality ratios.

      ii. using a survey instrument available from the NJSDH, an infrastructure survey will be conducted in areas with indicated need for increased utilization of state-of-the-art breast cancer screening. This survey will assess the current capability of existing facilities in these areas to accommodate increased screening volumes.

4. Using the Mercer County Pilot Project as a template, form the necessary consortia in other New Jersey counties to develop programs based on similar objectives.

   a. The preliminary results of the Mercer County Pilot Project will be used to expand the consortia building concept to other New Jersey counties. Used in correlation with program prioritization methods and infrastructure surveys, a model program will be developed and presented to potential task force members in other Counties.

5. Procurement of data on comparative treatment costs of breast cancer at early versus late stage at diagnosis.

   a. Treatment cost data from third party payors will be obtained to develop an economic model of early breast cancer detection. Based on the hypothesis that early detection of breast cancer is a cost-effective practice, the costs involved in treating early versus late-stage breast cancer will be compared.

6. Combining treatment cost data with preliminary utilization data from the Mercer County Pilot Project to prepare a position paper on screening mammography reimbursement to be presented to the New Jersey Department of Insurance.

a. The results of the goals and objectives of this application will be the development of a position paper that presents evidence on the cost effectiveness of early breast cancer detection and the successful demonstration of increased screening volume resulting in decreased costs for screening services. This position paper will be presented to key decision makers to support the proposal that screening mammograms be at least partially reimbursed through third party payors.

E. EVALUATION PROCESS:

For overall evaluation of the goals and objectives, sufficient time will not have passed to evaluate a reduction in breast cancer mortality for the purposes of this proposal. However, a down-shift in stage at diagnosis may be evidenced in the participating regions approximately 2 years following the implementation of screening projects that are the result of this program.

Additional evaluation criteria include:

a. development of consortia in the selected community;

b. Number of persons receiving mammograms;

c. Ratio of screening mammograms indicating negative vs. nonnegative results;

d. Number of women educated in the selected community;

e. Number of health professionals educated in the selected community; and

f. Movements towards acceptance of third party reimbursement for screening mammography by insurance providers.

STATUS REPORT

BREAST CANCER DETECTION AWARENESS PROGRAM

The State Health department is currently participating in a demonstration program sponsored by the American Cancer Society, New Jersey Division, Inc. entitled "the Breast Cancer Detection Awareness Program." This educational program is offered through participating New Jersey hospitals and consists of a physical breast examination, instruction on breast self examination, and, to eligible participants, a reduced fee mammogram. Eligibility, as determined by the program guidelines, involves asymptomatic women aged 35 and older, who have never had a mammogram. The initial program was held on May 16, 1987 and the State Health Department had primary responsibility for analysis of program results.

The Program was successful in educating women of New Jersey of the importance of breast cancer screening. Fourteen percent of the participants were determined positive from the breast examination component, which is an indicator that some women who had breast cancer symptoms were attracted to the Program. As the results of the BCDAP, there were 21 women for whom breast cancer cure is more likely because their disease was detected at a localized stage.

A subsequent program, planned for May 14, 1988 will be provided and efforts will be made to determine the outcome of the participants who are non-negatively screened. These follow-up efforts are important to ensure that women who have suspicious preliminary results receive necessary diagnostic evaluation.

Eventhough a large number of women (4,964) received a baseline mammogram as a result of the Breast Cancer Detection Awareness Program, there is a need for at least 1.2 million screening mammograms annually in New Jersey. Special events such as the BCDAP can be useful in focusing attention on the need for reducing the barriers to breast cancer screening for a sustained increase in the use of this technology.

MERCER COUNTY PILOT PROJECT

The New Jersey Department of Health has formed a consortium with Mercer County hospitals, local health departments, and voluntary community service agencies to conduct a Pilot Project designed to increase the utilization of state-of-the-art breast cancer screening in Mercer County. This project, which was planned in 1987, officially started to provide mammograms through participating hospitals and radiology facilities on February 1, 1988 and will continue for one year. A press conference to kick off the project was held by Mill mathesius, Mercer County executive to inform Mercer County residents of the purpose and need for this type of screening program. In addition, the Department of Health has actively participated in coordinating the activities of them edia campaign being conducted by participating hospitals and radiology facilities through the development and dessimination of educational brochures for both patients and physicians throughout the Mercer County area.

PART II

COMPREHENSIVE PUBLIC HEALTH SERVICES

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A. INTRODUCTION AND BACKGROUND

New Jersey is a highly industrialized state with a significant concentration of chemical, petroleum, petrochemical, and radiopharmaceutical manufacturing, storage, and distribution facilities. Being located on the eastern seaboard, New Jersey also serves as a main corridor for the interstate transportation of hazardous materials of domestic and foreign origin. A complex network of rail lines, roadways, and navigable waterways facilitates the movement of these materials throughout the state.

Presently, New Jersey has three nuclear generating facilities located in Salem and Ocean Counties and must also consider the effect of the nuclear generating stations in the neighboring states of New York and Pennsylvania. The impact that this industrialized complex might have on the environment and the health of the residents of the state is compounded by the fact that New Jersey is densely populated. The health care system servicing this population consists of approximately 122 hospitals, 256 long-term care facilities, 183 residential care facilities, 61 homes for the aged, and approximately 234 miscellaneous health care facilities. The number of food, cosmetic, and drug manufacturing and distribution facilities is estimated at 3,800 and there are approximately 70,000 retail food establishments statewide.

Because of the close proximity of this industrialized complex to areas of dense population, there is a critical need to supplement the emergency response network with highly trained professionals in the event a disaster occurs involving hazardous materials associated with these industries. The potential for contamination of various consumer goods from environmental sources, such as an uncontrolled release of a chemical agent, or through other avenues such as a misapplication of a pesticide continues to exist. A team of specially trained and prepared individuals could provide guidance and assistance to the health care, food, and drug industries. Local health, police, fire, and emergency management officials, as well as other state and federal agencies, would benefit from the services of this specially trained unit in handling emergency situations and protecting the health, safety, and well-being of the public. Additionally, these specially trained individuals would supplement and enhance the Department of Health's existing Emergency Response Unit in responding to man-made and natural disasters.

A second area of concern is that of the public health risk and degree of hazard associated with contaminated man-made and naturally occurring recreational waters. New Jersey's travel and tourism industry is the second largest industry in the state with a major attraction being its recreational waters, such as lakes, rivers, bays, and the Atlantic Ocean which are extremely vulnerable to adverse environmental factors. An increase in morbidity may occur if the presence of unhealthy levels of hazardous chemicals and/or pathogenic microorganisms are not readily identified and control methods are not employed to reduce or eliminate exposure.

Thirdly, another major concern is that of patients and residents in the state's health care facilities who must be provided with facilities that are adequately maintained in a safe and sanitary manner. As mentioned previously, there are 826 health care facilities which contain approximately 83,600 patient beds and serve a state population of 7,515,000. With the constant threat of nosocomial infection, that is, health care facility acquired illness, increasing surveillance and monitoring of these establishments is necessary to ensure that comprehensive infection control measures are being taken and sound environmental health and safety principles are being practiced by the treating facilities.

Another area of major concern is the increasing incidence in threats of consumer product tampering (e.g. foods and drugs). These criminal actions, many of which have been widely publicized, have heightened the consumer's awareness of product safety and wholesomeness resulting in a significant increase in the reporting of allegations of suspected product tamperings. The New Jersey State Department of Health must expeditiously respond to all threats/reports of consumer product tamperings to determine the validity of such threats and initiate the necessary protective actions due to the potential for death and serious injury.

Lastly, the New Jersey State Department of Health is continually and increasingly receiving requests for assistance concerning occupational health related problems and/or exposures to chemical and physical agents which originate from many different sources. Agencies making these requests include local health officers, private industry employers, state and municipal supervisory personnel, and employees and employees' representatives from both private industry and government agencies. Because state, county, and municipal employees are not protected by the provisions of the federal Occupational Safety and Health Administration, the servicing of these specific requests must be given priority at a state level.

B. GOALS AND OBJECTIVES:

The primary goal of this project is to assure that any and all adverse public health effects caused by the unnecessary exposure to environmental hazards (e.g. physical, chemical, and biological), and the direct and indirect effects of natural disasters (e.g. floods, earthquakes, and drought) are minimized or eliminated. It is recognized that this will substantially enhance and improve existing efforts to address environmental problems.

The objectives of this project are as follows:

1. To protect the citizens of this state from environmental hazards found in the community and the work place.

2. To protect the citizens of this state and the touring public from hazards associated with recreational bathing waters and reduce or eliminate said hazards.

3. To enhance the quality of health care in this state through the improvement of environmental health and safety conditions maintained in the hospitals, long-term care, residential care, and ambulatory care facilities operated in this state.

4. To prevent/eliminate the potential for the contamination of consumer products with harmful and deleterious substances and protect the consuming public from products present in the marketplace that may contain hazardous substances that have the potential to cause acute or chronic illness or injury.

5. To increase public awareness and industry responsibility.

C. IDENTIFICATION OF AT-RISK POPULATIONS, AREAS, AND LOCALITIES EXPOSED TO DISASTERS

The potential for the occurrence of man-made and natural disasters and environmental accidents, and the presence of occupational, community, and institutional health hazards is statewide. However, since there are several areas of the state which are extremely vulnerable to said types of incidents, initial emphasis will be given to these areas which are as follows:

1. The northeast metropolitan corridor adjacent to the Arthur Kill, Raritan Bay, and newark Bay waterways (Middlesex, Union, Essex, and Hudson Counties), Monmouth and Cumberland Counties, and the southwest Delaware River ports and terminals (Camden and Gloucester Counties) where there are significant concentrations of chemical manufacturers and petroleum refineries.

2. Municipalities located within the Emergency Planning Zone and the Ingestion Pathway Zone of the three fixed nuclear generating facilities located in Salem and Ocean Counties.

3. Health care facilities operated within the state.

4. All recreational bathing waters of the state with special emphasis on the bathing beaches of the Atlantic Ocean located along the coast of Cape May, Atlantic, Ocean, and Monmouth Counties.

D. METHODS OF ACHIEVING GOALS AND OBJECTIVES

In order to achieve the goals and objectives of this project, the following methodologies will be employed:

1. Provide comprehensive training to staff personnel on hazardous material assessment procedures, hazardous substance handling, industrial hygiene and occupational health principles, personal safety, decontamination procedures, toxicological effects (acute and chronic) of hazardous materials, environmental sampling, institutional infection control techniques, etc. The staff chosen to perform these duties are professional sanitarians who already possess a sound knowledge of environmental sciences, organic chemistry, epidemiology, toxicology, and sanitary engineering

through formal education programs and in service training. Staff personnel will be geographically located throughout the state in order to enhance an expeditious response to such environmental emergencies.

2. Identify, more precisely, the critical and vulnerable industries located in the previously defined target areas. This will be accomplished through an informal canvass of establishment inventories. Additionally, during the course of routine visits and inspections and special investigations of the health care facilities, food establishments, and institutions, a review of existing emergency contingency plans will be made. Internal and external hazard assessments will also be conducted and recommendations will be made regarding sound emergency action procedures and incident mitigation techniques which are to be employed in the event of the presence of an adverse environmental condition.

3. Expeditiously respond to man-made and natural disasters, proceed with a critical assessment of the situation, augment the department's existing emergency response capabilities, and cooperate with other responding agencies to minimize the public health impact of such an event. This is to include making a determination as to the potential for occurrence and adverse effects due to the loss of public utility services (water, power, etc.) on critical processing points in the food industry (refrigeration, timing devices on retort operations, etc.) and vital life support systems in the health care facilities and homes in the affected areas; and, contamination of the food and water supply.

4. In conjunction with the Division of Occupational and Environmental Health in the Department of Health, assist in the conduct of occupational health studies and investigations in response to reports of worker's exposures to toxic or potentially toxic substances. This will include the performance of on site environmental surveys; collection of samples in order to identify and quantify chemical vapors, gases, and particulate contaminants; and the administration of employee questionnaires in order to obtain medical and occupational histories of the "at risk" workers.

5. Integrate with the response network already existing between all local, state, and federal emergency responders which will aid in providing an effective and efficient coordinated effort by all parties involved in the incident.

6. In conjunction with the Division of Occupational and Environmental Health in the Department of Health, respond and provide technical support and assistance in making field assessments of hazardous materials emergency incidents. This will include the use of environmental monitoring field equipment such as combustible gas indicators, dosimeters, air sampling devices, etc. to provide an immediate determination of any potential health hazards present.

More accurate and reliable laboratory support services will be provided for confirmation of analyses.

7. Perform comprehensive inspections of recreational bathing facilities to ensure substantial compliance with established regulations and administrative guidelines for operation. This includes the performance of site surveys, sampling for contaminants when necessary, review of records and written policies, and the initiation of appropriate remediation when a hazard is identified.

8. Respond to and investigate complaints from citizens or referrals from other government agencies involving incidents of suspected contamination or adulteration of consumer products through alleged criminal tampering, manufacturing defects, or other mechanisms, such as the use of unsafe or previously contaminated ingredients or components.

9. Maintain a comprehensive inspection program aimed at identifying deficiencies in infection control and environmental health and sanitation practices in the health care facilities of this state and initiate the appropriate compliance actions deemed necessary to expedite the abatement of the cited deficiencies.

E. CRITERIA TO EVALUATE EFFECTIVE PERFORMANCE

1. Reporting Requirements

   a. Hazard assessment and preparedness survey reports of the critical facilities visited in the target areas.

   b. Detailed inspection/survey reports to be utilized for every environmental health hazard assessment activity conducted at a health care facility, work place, recreational bathing site, or community.

   c. Detailed incident reports for each response to a hazardous material episode, natural disaster, or consumer product contamination/adulteration investigation.

   d. Monthly, interim, and annual reports reflecting the project's activities and achievements regarding emergency responses, environmental hazard surveys, institutional, occupational, and community health hazard assessments, training programs, etc. This includes direct services provided by the department as well as those services which may be provided by local health agencies via health services grants. These reports will be reviewed and evaluated in order to determine the progress made toward meeting the project's objectives. This information will also be utilized in determining the need and providing justification for continuation and/or expansion of activities, realignment of priorities, and allocation of resources.

2. Outcome Measures Linked to Goals and Objectives

The effectiveness of this project will be evaluated by using the following methods:

a. Compliance to Recommended Corrective Action

Once an initial assessment is made of the potential environmental or consumer product hazards, recommendations concerning emergency action procedures will be made and plans of correction will be discussed. Subsequent followup visits will be made as needed to ascertain if voluntary abatement of the potentially hazardous conditions has been achieved.

b. Estimated Adverse Effects Without Intervention

Through the development of sound emergency procedures and response plans which are implemented by the expeditious response of trained personnel, the adverse health effects associated with man-made and natural disasters can be minimized/eliminated, as well as those associated with community and work place exposure to hazardous materials and consumer product contamination. The best way to evaluate the efficacy of this action is to imagine the catastrophic potential if such an action was not provided.

F. FY 1988 PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT STATUS REPORT OF EXPECTED ACCOMPLISHMENTS (Prepared June 15, 1988)

1. Staff Preparedness & Training

As in previous years, a concerted effort was made during this period to provide comprehensive training to the appropriate department staff on the topics of hazardous materials incident response, consumer product safety, infection control, and environmental and occupational health. This was accomplished through the following mechanisms:

a. Periodic in service training sessions on such topics as food tampering investigation; environmental radiation detection and decontamination procedures; and respiratory protection.

b. Staff representation at various seminars and training sessions. This will have included the following:

(1) A one day seminar entitled "Regulatory Trends in Infectious Waste Management and Their Impact on Hospital Operations" sponsored by the International Association of Hospital Central Service Management.

(2) A two day conference entitled the "4th Annual Environmental Exposition."

(3) A one day seminar entitled "Body substance Isolation" sponsored by Marrick Educational Services which was held in Cambridge, Massachusetts.

(4) A one day seminar entitled "Infectious Wastes Handling and Disposal" sponsored by the National Solid Waste Management Association which was held in Washington, D.C.

(5) A two day seminar entitled "The Fundamentals of Groundwater Contamination" sponsored by Geraghty & Miller Associates which was held in Arlington, Virginia.

(6) The "4th Annual Conference on Solid Waste Management" sponsored by the New York Legislative Commission on Solid Waste Management and the Council of State Governments which was held in New York City, New York.

(7) A two day symposium entitled "Incineration of Infectious Wastes" sponsored by Randolph, Breyer & Associates, Inc. which was held in Washington, D.C.

(8) A two week training course entitled "Chemistry of Hazardous Materials" sponsored by the Federal Emergency Management Agency and the New Jersey Office of Emergency Management.

(9) The 15th Annual Educational Conference sponsored by the Association for Practitioners in Infection Control which was held in Dallas, Texas.

c. The development and provision of the following training session for state, county, and local public health officials (e.g. Sanitarians, Health Officers, and Environmental Health Specialists) on a specific topic of major importance:

A one day short course entitled "Safe Drinking Water for Us and Future Generations" (attended by approximately 150 public health professionals).

d. Procurement and distribution of educational and reference materials to department staff covering the topics of hazardous materials, infectious waste management, and occupational health. These publications are of extreme value to the field staff and are being utilized to their fullest extent.

It is estimated that a total of 650 man hours of training has been provided to department staff (total accrued training time for entire participating staff). This training, combined with the technical reference materials that have been distributed, has definitely expanded the staff's knowledge in the areas of hazardous materials, consumer product safety, infection control, and environmental and occupational health, and has increased their ability to respond to and deal with alike situations in a proficient manner.

The final area dealing with staff preparedness was the continued procurement and distribution of personal protective devices and environmental testing equipment, such as communications services, protective clothing, and air monitoring equipment. Having these items enabled the field staff to expeditiously respond to and adequately assess hazardous materials incidents and work place complaints.

2. Institutional Asbestos Assessment

In response to the State Commissioner of Health's declaration of a limited state of emergency with respect to a major initiative of asbestos hazard abatement in school buildings, two staff members from the Field Operations Program of the Division of Community Health Services were temporarily assigned to the Asbestos Control Program for the purpose of inspecting school buildings to help ensure that the abatement areas have been adequately cleaned and meet established clearance criteria for reoccupancy. During the period July 1-August 31, 1987, the aforementioned staff assisted in the evaluation of 60 schools statewide where asbestos removal projects had occurred.

Additionally, the entire staff of the Field Operations Program have been trained in the recognition of potential asbestos hazards. Through the imparting of this general knowledge, overt asbestos hazards will be identified during the course of staff's routine activities in the various institutions such as child care centers and correctional facilities and an intradepartmental referral process will be initiated to the appropriate agency to adequately address all problems encountered.

3. Food Protection

a. Livestock Toxicity Alert System

Since New Jersey has a significant agricultural industry, a need has been recognized to establish an interagency livestock toxicity alert system in order to assure both a rapid reporting system and a prompt response by the units responsible for investigating the health aspects of a livestock poisoning incident.

Incidents involving livestock exposure or the potential for exposure to toxic substances have occurred in the past whereby the expertise in several divisions in the Department of Agriculture and Department of Health was required. It became apparent that a formal mechanism was needed to address these problems and assure a quick, responsive, and effective approach in preventing the contaminated food stuffs from entering into the marketplace.

An intricate communication and response network has been devised that utilizes the expertise of veterinarians, physicians, sanitarians, laboratory specialists, and

toxicologists. This will facilitate the expeditious and proficient investigation of such an incident that may require sampling and analyzing specimens, conducting on site investigations to determine the cause, and preventing or removing contaminated food from the marketplace. This alert system was finalized on July 1, 1982.

Fortunately, there was not a need to activate the incident response system during this reporting period.

b. Hazardous Waste Site Project

The New Jersey Department of Environmental Protection (DEP) is continuing to identify and categorize hazardous waste sites in this state. It is the Department of Health's concern that these sites may be located in areas that could pose a significant risk to the safety of certain food supplies (e.g. agricultural areas, food processors, distribution facilities, etc.) via off site migration of the contaminants or direct contamination as a result of improper storage.

As a result, a cooperative effort is being made between DEP and the Department of Health to study and assess the potential for contamination of these vulnerable food supplies and intervene, when appropriate, to mitigate the hazards associated with these toxic waste sites.

At the time of this writing, no major investigations were performed under this project during this reporting period. It should be mentioned, however, that constant hazard assessment is being performed during the course of routine activities in the aforementioned facilities to ensure that harmful and deleterious chemical agents are handled, stored, and transported in a fashion so as not to have an adverse impact on the vulnerable consumer commodities, such as food, drug, and cosmetics that are in close proximity to the hazardous materials.

c. Consumer Product Contamination/Tampering

During this reporting period, approximately 75 consumer complaints will have been received and subsequently investigated under the auspices of this grant which involve suspected contamination/tampering of foods, drugs, or cosmetics. During the reporting period, one major episode was investigated as follows:

In December 1987, the investigation of a cyanide tampering threat directed at cheese products sold at a supermarket in this state was conducted. The investigation did not reveal any actual product contamination, but as a precaution, the supermarket disposed of all cheese products.

d. Import Surveillance Project

A formal working arrangement was established between the Consumer Health Services Unit of the New Jersey State Department of Health and the U.S. Food and Drug Administration (FDA), New York District Office, for the increase in the surveillance of imported food commodities entering the Port of New York/New Jersey. As a priority initiative of the FDA to expand surveillance coverage of imported food commodities for the purpose of identifying adulterated and/or misbranded items, this innovative cooperative venture will allow for the augmentation of surveillance activities through the utilization of trained state agents. Primary emphasis has been placed on low acid canned foods.

The selected imported products are inspected for visual defects such as swollen cans, leakage, corrosion, and/or badly dented units caused by abusive or rough handling. Over 100 such shipments will have been inspected during the reporting period. Commodities inspected include mushrooms, fish products, bamboo shoots, hearts of palm, artichoke hearts, pimentoes, baby corn, water chestnuts, pickled tomatoes and cucumbers, pepper strips, oriental sauces, asparagus spears, and assorted canned fruits.

To date, 83 of 84 lots were found to be satisfactory. One shipment of Victoria brand pepper strips in No. 19 cans were found to have an excessive number of defective cans. Of the 126 units examined, 14 were found to be defective with leaking and corroding cans caused by rough handling. The shipment was embargoed. The importer was ordered to examine and sort the entire shipment; unsatisfactory cans were segregated and later destroyed. The satisfactory units were released from embargo and allowed to be offered for sale.

e. Pesticide Residue Surveillance Project

In January 1988, the Consumer Health Services Unit of the State Department of Health entered into a cooperative agreement entitled "Dietary Exposure to Pesticide Residues in Food: Fruits and Vegetables." Other agencies participating are the New Jersey Department of Environmental Protection (Office of Science and Research and Bureau of Pesticide Control) and Rutgers University.

The objectives of this project are four fold:

- To examine crops of economic importance in New Jersey and compare pesticide residues in New Jersey produce with those on the same crops grown in other states and other countries.
- Identify contaminants in these products that are not part of the U.S. FDA's regular pesticide multiresidue screen.

- Develop new and more sensitive methods for looking at pesticide residues and their metabolites in foods.

- Begin to quantitate dietary intake of pesticide residues in food for the purpose of improving the exposure assessment portion of quantitative risk assessments.

Project activities performed under this grant include the provision of field support services for the collection of samples. The sampling protocol calls for the collection of 48 samples of fresh tomatoes, potatoes, and apples that are being offered for sale in New Jersey supermarkets. At the time of this reporting (June 1988), 12 lots of tomatoes and 9 lots of potatoes were sampled, analyzed, and found to be in compliance with established standards (tolerances) for pesticide residues.

4. Occupational and Community Health Activities

a. Occupational Health

The Occupational Health Program within the New Jersey State Department of Health has the capability to investigate complaints associated with health conditions in the work place. These investigations, with subsequent implementation of recommended control and improvement in work practices, should significantly contribute to the reduction of occupationally related exposures and diseases in this state.

With an increase in the number of work place complaints received by the Department of Health, there was a need for additional trained personnel to augment the existing occupational health staff. Through this grant, additionally trained department personnel will have participated in the following occupational health related activities:

(1) An ongoing interdepartmental program of testing ambulances (which also includes invalid coaches) to insure that ambulance patients and personnel are not exposed to unsafe levels of carbon monoxide (CO). Several years ago, a survey indicated that more than a third of all ambulances tested had excessive interior levels of CO. As a result, it was decided that each of the approximately 1,800 ambulances in this state will be tested to determine whether interior levels of CO are safe for patients and personnel.

The following methodology was employed in this testing program:

- Determine the interior CO levels in each ambulance utilizing appropriate air monitoring levels and standardized testing procedures.

- Through a comprehensive physical examination, identify all CO entry points in the ambulance.

- Issue appropriate recommendations for corrective action.

- Conduct retests in order to evaluate the effectiveness of the corrective action taken.

It is estimated that approximately 175 ambulances will have been tested by department personnel during this grant period. To date, the inspections have revealed that approximately 30 percent of the ambulances tested exceeded the acceptable level of 10 parts per million of carbon monoxide above ambient background levels.

(2) As with ambulances, there is a concern over the chronic and unnecessary exposure of operators and occupants of school buses and police and maintenance vehicles (e.g. snow plows, garbage trucks, etc.) to unsafe levels of carbon monoxide. As a result, the Department of Health has developed an inspection and testing program to effectively evaluate the level of carbon monoxide intrusion into the interior of these vehicles. It is estimated that approximately 10 vehicles will have been tested by September 30, 1988. The testing methodology employed was identical to that used in the ambulance testing program as outlined previously.

(3) An inspectional program of the commercial and government operated breathing air compressing operations to ensure that this air which is used by divers, firemen, hazardous material handlers, etc. is of the appropriate quality so as not to adversely affect the health and safety of the user. Existing state regulations are applied as well as industry recommendations and the Occupational Safety and Health Administration's General Industry Standards (Subpart I, 1910.134) to determine adequacy of operations. Site visitations include a comprehensive examination of the installation, maintenance, and operation of the air compressing operations, as well as monitoring of the breathing air manufactured for carbon monoxide, carbon dioxide, odor, and visible oils and moisture.

During this reporting period, it is anticipated that approximately 35 such facilities will have been inspected. If a facility produces compressed air that is considered substandard due to the presence of objectionable odors or elevated levels of carbon monoxide and/or carbon dioxide, management will be instructed to discharge the compressed air to waste, discontinue operations, and make the necessary repairs and/or alterations to the compressing system. Subsequent retesting will be performed to ensure that the appropriate corrections have been made and the air quality is acceptable before resuming operation.

(4) It is estimated that approximately 20 miscellaneous investigations will have been performed in response to employee and resident complaints dealing with the possible existence of community and work place health hazards (e.g. inadequate ventilation, insanitary conditions, air borne chemical contaminants, etc.).

b. Community Health

(1) Nuclear Accident Preparedness and Response

As previously mentioned, New Jersey has three nuclear generating stations located within its boundaries (Salem and Ocean Counties). As part of the state's Radiological Emergency Response Plan, the Department of Health is responsible for providing certain critical field services in order to protect the health of the public in the event of a radiation accident. These activities include the sampling of milk, soil, vegetation, and crops to be analyzed for radioactive contamination; evaluating the level of sanitation at evacuee congregate shelters; maintaining department liaison and providing technical assistance at the Emergency Worker Decontamination Centers; and augmenting the services provided by local and county officials in assessing the affected area during the recovery and reentry phase of the disaster (e.g. food sanitation, water supply protection, rodent control, etc.).

In accordance with the requirements of the Federal Emergency Management Agency, staff participated in two emergency preparedness drills during this reporting period. Key department staff continue to receive technical training and procedural briefings in these areas so that they are capable of responding to and performing in an effective and efficient manner in the event of an actual incident. Additionally, detailed standard operating procedures governing the conduct of ingestion pathway sampling of milk, cheese, frozen desserts, vegetables, fruits, eggs, meats, meat products, shellfish, vegetation, and soil have been developed during this reporting period utilizing current U.S. Department of Agriculture (DA) and U.S. FDA recommendations and guidelines as a foundation. These procedures will be tested and evaluated during the next annual exercise which will be held in November 1988.

(2) Medical Waste Disposal

Over the past several years, there has been a growing public concern and fear (founded or otherwise) over the handling and disposal of potentially infectious medical wastes. The department has experienced a corresponding increase in the incidence in reports of alleged mishandled

or improperly discarded items such as used needles and syringes, pathology specimens, and isolation waste. Parallel issues, such as the washing ashore of medical wastes on our resort beaches, promiscuous dumping or abandoning of medical wastes on our public thoroughfares and neighborhoods, and the rampant hysteria of contracting AIDS by those who come in contact with these kinds of wastes, have significantly contributed to this increase in public awareness and concern.

The citizenry of this state, as well as government agencies and the industrial sector, have turned to the department not only for advice pertaining to the public health significance of medical waste disposal, but for action since the department regulates the largest generators of medical wastes: the health care industry, clinical laboratories, and blood banks.

In response to this, the department will have performed the following major activities during this reporting period:

- approximately 40 field investigations involving the promiscuous and indiscriminate dumping of medical wastes and the alleged improper transport and disposal of medical wastes entering municipal solid waste transfer stations and sanitary landfills.

- increased surveillance of generators of medical waste in this state to ensure that the materials are handled, transported, and disposed of in an approved fashion;

- the continued development of draft revisions of State Department of Health regulations and standards governing medical waste handling and disposal within the health care facilities of this state which are comprehensive in nature and are reflective of current public health and environmental protection concerns;

- enhanced coordination of administrative and field response efforts with the New Jersey DEP's Division of Solid Waste Management in the investigation of reported cases of improper medical waste disposal practices and in the joint development of agency regulations, guidelines, and policies;

- the provision of educational services to health care practitioners solid waste management personnel and the general public in the area of the proper handling and disposal of medical wastes; and,

- the provision of technical guidance and assistance to state legislators to aid in the development of needed legislation to appropriately address medical waste management issues in this state.

(3) Recreational Bathing Waters Hazard Evaluation

During the summer of 1985, several major bathing beaches were ordered closed due to sewage contamination until such time as the water quality improved to a level deemed not a public health threat. Since then, recreational water quality has become a major department initiative and concern. As a such, the following activities were performed during this grant period:

- the revision of comprehensive regulations for all recreational bathing waters which not only address bacteriological hazards but chemical hazards and safety issues as well that were designed to safeguard the public's health while using public recreational bathing facilities;

- performance of comprehensive environmental surveys, when needed, of critical recreational waters which include sampling for bacteriological and chemical analysis to determine the quality and degree of safety of the recreational bathing waters;

- departmental participation in the Interagency Cooperative Coastal Monitoring Program aimed at monitoring the bacterial levels of ocean and bay waters along the New Jersey coast. Through this monitoring program, the department was able to identify points of pollution and notify the public of the dangers recreational bathing contact in specified areas. Furthermore, the conduct of comprehensive sanitary surveys has resulted in the identification and subsequent elimination of previously unknown sources of pollution; and

- participation in the development and implementation of an epidemiological study (a two year study; Summers of 1987 and 1988) designed to examine the health effects of swimming in ocean waters. This study is a joint effort of the New Jersey State Departments of Health and Environmental Protection; New Jersey Medical Society; the U.S. Public Health Service's Centers for Disease Control; and a group of doctors representing an environmental health concern group called "Save Our Shores."

(4) Support to Local Health Agencies

Throughout this reporting period a concerted effort was made to provide comprehensive consultation, technical assistance, and training to local health agencies in the area of environmental health. This has been accomplished through the following services:

- on site assistance in evaluating environmental health hazards;
- maintenance of reference library to be used by local health agency staff; and
- loaning of environmental monitoring equipment to local health agencies. This includes instruction on the various equipments' operation, maintenance, and limitations.

Due to fiscal constraints, no funding was available for health services' contracts for the provision of certain environmental and occupational health oriented local programs.

(5) Hazardous Materials Emergency Response Incidents

It is estimated that approximately 15 incidents involving the unnecessary and uncontrolled release of hazardous materials (e.g. spills and fires) will have been investigated during this grant period. To date, episodes involving such toxic and hazardous substances as ammonia, chromic sulfate, and pesticides were investigated which required either technical assistance/support or on site assessments and environmental monitoring. Through the expeditious response of adequately trained and properly equipped personnel, the health hazards associated with these incidents were minimized and, in some cases, eliminated.

5. Health Care Facility Surveillance and Monitoring Program

During this reporting period, it is expected that 50 comprehensive inspections will be performed as a means of augmenting the existing state regulatory program aimed at identifying deficiencies in infection control and environmental health and sanitation practices in the health care facilities of this state. In addition to the site visitations, the necessary departmental administrative procedures were initiated to ensure expeditious abatement of the identified deficiencies on the part of the health care facility owners and/or operators.

128X

LOCAL HEALTH TRAINING
PREVENTIVE HEALTH SERVICES BLOCK GRANT
FY 89

A. INTRODUCTION AND BACKGROUND:

The public health delivery system in New Jersey is provided by local health departments (county, municipal) with support from community service agencies and state agencies. All local health departments are required to provide certain basic services in Administration, Environmental Health, Communicable Disease, Maternal and Child Health and Chronic Disease. These services are implemented by public health professionals such as Health Officers, Sanitarians, Nurses and Health Educators.

The New Jersey Department of Health recognizes local health officials as extensions of itself responsible for effective, efficient program management that addresses state or local public health issues. Knowledge and skills necessary to keep local officials current are provided by the Department of Health via a public health training program. Training activities are conducted by Department of Health staff as appropriate or state colleges and universities.

B. GOALS AND OBJECTIVES:

The goal of the local health training program is to provide specialized training, education, examination and licensing for public health officials. FY 89 training objectives are as follows:

1. Provide an academic and field training program for individuals preparing to enter public health as Sanitarians (Environmental Health Specialists).

2. Provide a continuing education program of selected content as indicated by professional organizations in public health.

3. Develop criteria for maintenance of license/certification of certain public health officials.

4. Develop legislation and regulations to address training issues in a timely manner.

5. Provide a quarterly training bulletin of continuing education opportunities for state and local officials.

6. Develop a licensing examination for Health Officers and maintain the examination for Sanitarians.

7. Coordinate all training seminars or workshops of interest to local health officials offered by the Department of Health.

8. Develop training and technical assistance for local health officials with observed deficiencies in performance of Minimum Standards.

9. Develop the Annual Conference of State and Local Health Officials.

10. Develop the Annual State Health Aid Conference for local health officials.

C. IDENTIFICATION OF TARGET GROUPS AND LOCAL JURISDICTIONS OF HIGHEST NEED:

Local health departments are responsible for providing 21 core or mandated services in public health. Local officials are the primary providers of public health service, serving 7.5 million people. In order to provide a quality service, local officials must be adequately trained on a continuing basis.

The evaluation process of local health department compliance with Minimum Standards continues to point out deficiencies in the functional areas of Maternal and Child Health, Chronic Disease and Administration. Local jurisdictions in the greatest need who serve the highest risk populations will continue to be targeted for intensive training and technical assistance.

D. METHODS OF ACHIEVING GOALS AND OBJECTIVES:

1. Identify and contract with an educational institution for academic preparation of individuals preparing to enter public health as Sanitarians. The Department of Health provides partial funding for the Environment and Public Health course given by Rutgers University and for field training assignments in local health departments throughout New Jersey. Completion of this course and a field training assignment are requirements for admittance to the Sanitarian licensing examination.

2. The Department of Health will make continuing education opportunities available to local health professionals through a grant to an educational institution, which will be responsible for administering the process. A committee including local health officials representing the New Jersey Health Officers Association and the New Jersey Environmental Health Association and representatives of the Departments of Health and Environmental Protection will develop a request for proposals outlining areas of interest to local health officials and this RFP will be distributed to educational institutions throughout the State.

3. Identify appropriate professional organizations to provide the Department of Health with guidance and oversight for development of a license maintenance program.

4. Identify and work cooperatively with elected officials to gain desired amendments to licensing legislation.

5. Provide a quarterly training bulletin to all local health officials.

6. The Department of Health will identify and contract with an educational institution or testing service for the development and maintenance of a Health Officer licensing examination. An agreement with Rutgers University to continuously update and revise the Sanitarian licensing examination will also be continued. Replacement of old questions with new ones on an ongoing basis will extend the useful life of the examination.

7. Staff will inform local officials and coordinate planning of training seminars.

8. Review evaluations outcomes to determine local jurisdictions in need of specialty training or technical assistance.

9. Develop a planning committee of local officials for annual conferences to determine areas of interest/need.

E. CRITERIA TO EVALUATE PERFORMANCE:

1. Fifty candidates for licensing as Sanitarians will successfully complete an environmental/public health course.

2. -500 local officials will attend 8 continuing education courses.

   -100 local officials will attend a Health Aid Services Conference.

   -300 local and state officials will attend the Annual Conference of State and Local Health Officials.

   -6 local health departments will be provided specialized training and technical assistance.

3. Legislation amended to require continuing education for Health Officers and Sanitarians. Regulations developed and implemented.

4. Same as above.

5. 4 training bulletins will be developed and provided to all local health officials.

6. Licensing examinations for Health Officers and Sanitarians are developed, updated and valid.

7. All Local Health Development Services staff are informed of training opportunities for local officials. Local officials are involved in planning of training opportunities.

8. 80% of local health jurisdictions will be in compliance with Minimum Standards.

9. Annual Conference planned and implemented.

10. Annual State Aid Conference planned and implemented.

F. STATUS REPORT (1988):

The New Jersey Department of Health Evaluation and Training Unit conducted 50 reevaluations of local health jurisdictions for compliance with Minimum Standards of Performance and 111 follow-up site visits to local health departments and community service organizations previously evaluated to determine progress in eliminating program deficiencies.

The following specialized continuing education programs were conducted:

	# Attending
- New Jersey Symposium on Rabies	200
- Effective Writing	15
- Entomology	25
- Communication Skills	10
- Role of Board of Health	143
- Micro Computers	17
- Alcoholism	8
- Right-to-Know	30
- Fiscal Management	20

Other Training Opportunities:

- Annual Conference of State and Local Officials	300
- Health Aid Conference	130

Other specific training efforts included the development of a video program for local board of health members and elected officials to help define local board role in service delivery, the distribution of a quarterly training bulletin to all local health officials in October 1987, January 1988, and April 1988, the completion and implementation of an exam for Sanitarians, and the administration of the licensure process for Health Officers and Sanitarians (3 exam dates for Health Officer and Sanitarian were scheduled, 3 exams were conducted, a total

of 63 candidates were tested, 58 new licenses were issued, and 1301 licenses were renewed).

The basic environmental/public health course was offered by Rutgers University for individuals interested in licensure as Sanitarians. A total of 54 students enrolled, and 46 students completed the course.

PART II

EMERGENCY HEALTH SERVICES

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FY89 PREVENTIVE HEALTH BLOCK GRANT APPLICATION
OFFICE OF EMERGENCY MEDICAL SERVICES

A. INTRODUCTION:

Each year, more than three million New Jersey residents and visitors require emergency medical care. The patients, who range in age from the newborn to the elderly, experience a wide variety of traumatic, medical and surgical emergencies.

The goal of the Emergency Medical Services system is to save lives. Over the years, the New Jersey Office of Emergency Medical Services (OEMS) has concentrated on providing a systems approach to emergency response and emergency medical care. If all the machinery and personnel were not in place, and acting in a coordinated manner, the loss of life would be tremendous.

A sophisticated system of emergency medical care, such as the one found in New Jersey, needs ongoing funding to maintain itself. The "new generation" of mobile intensive care units, trauma centers, and other dedicated critical care services have the potential to save the lives of not only motor vehicle accident victims, but also other persons who become seriously ill or injured. OEMS has worked to implement such services in New Jersey.

Through its leadership, and using several funding sources (including the Preventive Health and Health Services Block Grant), the Office has been able to encourage a number of projects and activities relating to the establishment, expansion, and improvement of various aspects of New Jersey's system. The 1987 Status Report (Jan. 1 - Dec. 31, 1987), which accompanies this application, discusses progress on these aspects.

B. GOAL AND OBJECTIVES FOR THE COMING YEAR:

Goal:

To reduce the deaths, disabilities, pain, and suffering experienced by patients needing emergency care.

Objectives:

1. Manpower and Training: Assure that there is an adequate supply of appropriately trained emergency care personnel at the basic life support, intermediate life support, and the advanced life support levels.

2. Special Needs in EMS Patient Care: Study, plan for, implement, and monitor programs which address special needs in EMS patient care, including prehospital basic life support ambulance and invalid coach transportation, mobile intensive care and EMT-Intermediate services, trauma, poisoning, and disaster planning.

3. Data Management and Program Evaluation: Provide service in data management and program evaluation in order to support and improve the planned efforts.

C. IDENTIFICATION OF POPULATION, LOCALITIES, AREAS WITH NEED FOR THE SERVICE:

Programs of the Office of Emergency Medical Services are targeted throughout New Jersey. Depending upon the specific activity, various sections of the state or various target populations may be emphasized.

1. Manpower and Training

The training programs are planned to meet manpower needs for emergency care personnel and to provide continuing education, recertification, and career ladder opportunities for existing EMS personnel. Programs are given at the first responder, basic life support (BLS), intermediate life support (ILS), and advanced life support (ALS) levels and ultimately improve the quality of care delivered to the EMS patient.

a. Emergency Medical Technicians (EMTs)

Emergency Medical Technician basic and refresher training will be offered at numerous sites in New Jersey to members and employees of basic life support volunteer, paid, hospital-based, and municipal ambulance services. Special EMT training programs for underutilized sources of manpower (e.g., high school students, nurses, and senior citizens) may also be conducted. Future plans include the implementation of an EMT course designed especially for those employed by industries. This course would be designed to meet OSHA recommendations.

b. EMT-Intermediate (EMT-I)

The Emergency Medical Technician-Intermediate (EMT-I) became an approved level of prehospital provider in five rural counties of New Jersey with passage of P.L. 1985, Chapter 351 on November 7, 1985. This legislation permitted specially trained persons to provide cardiac monitoring, arrhythmia recognition and defibrillation, administer intravenous (IV) fluids, and insert special airways. This care is geared primarily to patients with trauma and cardiac problems. Funds for testing and certifying EMT-I candidates will be provided under this grant.

c. Advanced Life Support (ALS)

The formal advanced life support training programs for paramedics will be supported through other funding sources and are not part of this application.

2. Special Needs in EMS Patient Care

A number of "special projects" have been developed to address various needs related to provision of quality patient care. Areas to be emphasized in the coming year include: (1) the continued availability of technical assistance, quality assurance, and monitoring to providers of basic life support prehospital ambulance and invalid coach services (including those covered under the regulations), (2) the continued planning, technical assistance, and monitoring of selected critical care services (i.e., mobile intensive care (MIC) services, trauma centers, the statewide poison system), and (3) the continued involvement in disaster planning for the emergency care component of natural or manmade disasters. Target populations and areas of need will depend upon the topic.

a. Prehospital Ambulance and Invalid Coach Providers

Technical assistance will be provided to selected ambulance and invalid coach services.

b. Mobile Intensive Care (MICU) and EMT-Intermediate Services

The mobile intensive care programs already cover all residents of Atlantic, Bergen, Burlington, Camden, Cape May, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, and Union counties. All approved programs are now operational. Hunterdon Medical Center has been granted special permission to operate an MICU for 16 hours daily to care for residents of Hunterdon County. (The program became operational in the Spring of 1987. EMT-I service is available 24-hours-a-day in Hunterdon County.) All programs will continue to receive technical assistance and quality assurance review.

EMT-I programs began operation in the Summer of 1987. Pilot programs exist in the rural counties of Sussex, Warren, Hunterdon, Salem and Cumberland.

c. Trauma Centers

The two Level I Trauma Centers, University Hospital, Newark, and Cooper Hospital/ University Medical Center, Camden, will continue to provide Level I trauma care to those who are critically injured.

The Commissioner of Health appointed an Ad Hoc Committee on Trauma in August 1987. This committee has been charged with addressing issues such as: 1. development of criteria and processes for designation of Level II trauma centers; 2. trauma triage protocols; 3. development of helicopter trauma triage protocols; 4. reimbursement; 5. statewide trauma registry; and 6. communications. Work on this

group of issues, and other trauma-related activities, will continue this year.

d. Poison System

The New Jersey Poison Information and Education System (NJPIES), located at Newark Beth Israel Medical Center, will receive technical and planning assistance and program monitoring from OEMS staff funded through the Preventive Block. Operational funding for NJPIES will come through a special state appropriation.

e. Disaster Planning

Disaster planning is concentrated about the annual drills for the state's two nuclear generating facilities (Oyster Creek in Ocean County and the Salem Nuclear Generating Facility in Salem County) and in periodic exercises for the Newark International Airport disaster plan and drills of the National Disaster Medical Services system. OEMS is also involved in state plans to be ready to respond to natural disasters or to mass casualty incidents, other than those above.

3. Data Management and Program Evaluation

OEMS uses data processing to evaluate the delivery of patient care, to provide fast customer (or client) service, and to enhance its operations.

During the next year, the system used to evaluate the MICU services will be improved and fiscal operations will be automated. The existing certification and licensure systems will be maintained and refined. The certification system prepares cards and certificates for several thousand EMTs and other students each year. OEMS is now able to issue certificates (or failure notices) within a week after testing. The licensure system prepares 1,000 permits and licenses each year. OEMS is able to enter applicable information into the computer data base and issue the appropriate provider or vehicle license within a half hour after the provider or vehicle passes a survey at the central office.

D. METHODS OF ACCOMPLISHING OBJECTIVES:

1. Manpower and Training

Trained manpower helps to assure the best possible care for emergency patients. Training is an ongoing concern. New and innovative approaches to upgrade training need to be explored, especially for shift workers and EMS personnel in the rural farming areas. New Jersey's emergency medical services system depends to a large extent on volunteers. These people leave EMS service for various reasons --leading to a high attrition rate

(about 36% do not renew their EMT certifications, for example). Skills are also changing in the field and there is a constant need to learn new procedures. In an attempt to increase provider skills, renowned speakers are featured at periodic seminars and training sessions. Courses will be presented for Emergency Medical Technicians and Emergency Medical Technicians-Intermediate. Special pilot courses may be implemented, as warranted.

a. Develop and provide basic or introductory training programs and refresher programs to meet manpower needs.

(1) Emergency Medical Technician: Continue basic and refresher Emergency Medical Technician (EMT) training.

All EMT training in New Jersey is either given under OEMS auspices or the auspices of the New Jersey State First Aid Council. OEMS is the sole certifying agency for EMT graduates, regardless of the source of their training. A well-defined procedure already exists for conducting formal EMT basic and traditional refresher courses. Course sites have been identified in all New Jersey counties and there is a large cadre of instructors and instructor-trainees.

Once an EMT coordinator or instructor sees the need for a traditional course, he/she applies to OEMS for a contract to give the course at one of the permanent training sites. OEMS then decides, based on local input and records of currently certified EMTs in the county, whether the course is really needed, and should be funded. Each approved funded course is given under a letter of agreement which takes the place of a Health Services Contract. The amount of final payment depends on the type of course offered and the number of "affiliated" students enrolled. After the course is given, course statistics are submitted for evaluation and recordkeeping purposes.

Several unfunded or non-funded course offerings will also be approved. These additional courses are approved for EMT certification because of local interest and need at locations which do not desire funding, when OEMS monies may be inadequate to fund all interested sites, or through local community colleges which may offer the EMT course for college credit and charge a tuition fee. OEMS still remains the testing and certifying agency, regardless of whether or not an EMT course is funded or non-funded.

Non-traditional methods of becoming an EMT are also available. These include the successful training programs for nurses, senior citizens, and high school students, which will be repeated, as interest and funds permit.

OEMS handles all EMT certifications. Certification is for a three-year period.

The Department of Health, in conjunction with the New Jersey State First Aid Council, previously developed a new method of "refreshing" a person's EMT certification. Continuing education credits can be awarded for particular units of study. When a candidate has earned 28 credits over a three-year period, he/she is eligible to sit for the EMT written and practical recertification exams. The traditional EMT refresher course is also offered. Individuals who are certified as EMTs in special programs (e.g., nurse, senior citizen, high school student) are refreshed under the same criteria as traditionally trained EMTs. Recertification of all EMTs is by practical and written examination.

It is projected that approximately 4,000 EMT candidates will enroll in the traditional basic and refresher EMT courses during the coming year, using several funding sources (Preventive Block, Highway Safety, New Jersey State, local), where applicable. This figure includes those enrolling in special EMT courses, including those offered through the New Jersey State First Aid Council. Block grant funds will also be used to pay for EMT written testing by the National Registry.

(2) EMT-Intermediate: Continue intermediate EMT training

The intermediate level emergency medical technician (EMT-I) is a relatively new level of EMS prehospital care provider. EMT-Is function most appropriately within the New Jersey EMS system as a supplement to basic life support in the rural areas. To date, nine rural hospitals have become participating hospitals in the EMT-I program. These facilities are: Sussex County--Wallkill Valley General Hospital, Newton Memorial Hospital; Warren County--Hackettstown Community Hospital, Warren Hospital; Hunterdon County--Hunterdon Medical Center; Salem County--Memorial Hospital of Salem County; Cumberland County--Newcomb Medical Center, Bridgeton Hospital, and Millville Hospital. The EMT-I Advisory Committee of OEMS has been formed and consists of administrators, physicians, EMT-I

coordinators from the hospitals, and the coordinators of the EMT-I didactic programs. Treatment protocols and an operating manual have been written. OEMS staff and the EMT-I program sites are working closely with the area first aid and rescue squads in this training effort. EMT-I training monies are provided through other funding sources. Since EMT-I is a fairly new level of provider, refresher courses are unnecessary this coming year. Block grant funds will be used to provide for evaluators and National Registry EMT-I written tests involved in the certification process for EMT-Intermediates.

(3) Advanced Life Support

Formal advanced life support training programs for paramedics will not be supported through this grant.

2. Special Needs in EMS Patient Care

Emphasis will be placed on several "special projects" during the coming year. These efforts will assist in expanding and improving the state's EMS system and will benefit both the consumers and the providers of EMS services. Methodology for accomplishing the objectives will vary according to the activity.

a. Provide technical assistance to selected prehospital ambulance providers

(1) Ambulance Regulations: Regulate proprietary, municipal, and hospital-based ambulance and invalid coach services which are covered under the regulations.

Specific activities will include:

(a) Survey and relicense (as appropriate) non-volunteer services.

(b) Enforce regulations (e.g., issue warning letters and fines).

Computerized records are maintained for each provider and each vehicle. Eligible providers and vehicles are licensed to provide service. Unannounced surveys and spot checks are used to enforce the regulations.

(2) Voluntary Programs: Work cooperatively with the volunteer squads to assure quality patient care.

Specific activities will include:

(a) Update voluntary guidelines for volunteer services.

(b) Continue the voluntary ambulance inspection program to assure that volunteer squads meet acceptable patient care standards.

(c) Continue the carbon monoxide testing program, using trained state and volunteer staff.

b. Provide technical assistance and monitoring to the existing and emerging mobile intensive care (MIC) consortia and the EMI-Intermediate system.

Services in this area will be provided by OEMS staff (funded both by this grant application and through other sources).

Areas to be emphasized include:

(1) Provide technical assistance in areas of particular concern to all the consortia, including implementation of the new advanced life support strategy based on recommendations of the Governor's Council on Emergency Medical Services.

(2) Monitor MIC and EMT-I programs on a regular basis, including periodic riding visits, run form audits, annual site visits, and inspections with submission of written reports.

(3) Continue development of mobile intensive care and EMT-I standards, guidelines, regulations, and protocols, as necessary, to assure homogeneity among the programs.

(4) Examine patient origin in the MICU programs to assure vehicles are strategically placed; add MIC and/or EMT-I units as needed.

c. Provide technical assistance and monitoring to aid in establishing a statewide trauma care network for care of the severely injured trauma patient.

Service in this area will be provided by OEMS staff (funded both by this grant application and by other sources) and by members of the Commissioner's Ad Hoc Committee on Trauma.

Areas to be emphasized include:

(1) Provide continued technical assistance and ongoing monitoring to the two Level I Trauma Centers.

(2) Make further recommendations concerning trauma care in New Jersey.

(3) Continue to assist the mobile intensive care consortia and EMT-Intermediate services in assessing their existing capabilities for trauma care and revise trauma treatment protocols to reflect state-of-the-art in trauma care.

d. Support activities of the statewide New Jersey Poison Information and Education System (NJPIES).

OEMS staff will continue to work with NJPIES during the coming year, as well as continue to monitor and evaluate the work of NJPIES.

e. Participate in Departmental plans for responding to natural or manmade disasters.

Participate in disaster planning and drills (e.g., for civilian repatriation and evacuation from abroad, nuclear plant emergencies, or natural disasters).

3. Data Management and Program Evaluation

During the coming year OEMS will continue its evaluation of BLS, ILS and ALS training and ALS and ILS operations. Findings will be used to improve the functioning of New Jersey's EMS system.

Data Needs:

OEMS staff will work to improve evaluation of MICU services and to upgrade the system used to evaluate MICU services. The use of grant and other funds will also be improved by automating fiscal operations. Staff will work to make existing systems more effective; new applications will be developed, as needed.

The existing certification system and the licensure system are key factors in OEMS' day-to-day operation. The certification system certifies several thousand EMT and other students each year. The licensure system issues over 1,000 licenses and permits yearly. Each system includes features, such as on-line look-up to instantly check the status of a certified EMT or a licensed vehicle. These features will be enhanced and expanded over the coming year. The feasibility of new features, such as methods for local services to enter and report data directly into the OEMS system, will be investigated.

E. EVALUATION:

Each applicable activity will be evaluated on an individual basis. The following descriptions briefly outline current practice or what is planned in some of the areas.

1. Manpower and Training

a. Emergency Medical Technicians: A "performance report" form has been developed which gives the number of students eligible for certification in relation to the number tested and the number enrolled. Courses are looked at 60 days after completion to ascertain the total number of students who were trained and certified. Courses are compared with written and practical exam "norms" at the regional and statewide levels. The mean test scores for a class are compared with the means from other courses to see if the students did as well as they could. If a course does especially poorly, the coordinator is counseled in an attempt to solve or resolve any instructional problems he/she may have. Field representatives monitor evaluator performance against an established protocol to see if they affected the practical examination result. New practical evaluation check sheets have been developed to increase objectivity during the practical exam.

Each course is assigned a field representative who monitors progress of the course and acts as liaison between OEMS and the course coordinators. The representatives provide technical assistance in case of difficulties during the course.

Both EMT basic courses and traditional refresher EMT courses are evaluated using these mechanisms. EMT continuing education (C.E.) offerings are also evaluated. Organizations which wish to sponsor one-time courses or workshops submit their plans to OEMS for evaluation and assignment of C.E. units. Courses offered by recognized groups, such as the American Red Cross and the American Heart Association, already have credit assigned to them because of internal monitoring.

b. Intermediate EMT: The EMT-I didactic training program is evaluated in much the same manner as the regular EMT training. An evaluation form is also given to each EMT-I student so that students can comment on the course content and instructor effectiveness. Additionally, followup evaluations are done to see how the EMT-I functions in the field. Hospitals which coordinate EMT-I runs will submit a reporting form, similar to that submitted by the paramedic programs, to OEMS. Quality assurance audits will be conducted, as will a yearly site visit.

2. Special Needs

a. Prehospital Ambulance Providers: The principal OEMS employee involved with these activities keeps records on the numbers of visits and the numbers of vehicles inspected. Records are also kept on the services which are "spot checked" by OEMS staff and others.

b. Mobile Intensive Care and EMT-I Services: Each mobile intensive care program and EMT-Intermediate service must submit quarterly reports to OEMS as part of the designation condition. These reports are tallied on a statewide basis and trends and gaps are identified. Additionally, periodic official inspection visits are made to the program to assure it is proceeding according to recognized guidelines; reports are filed on these visits. Programs which consistently fail to meet standards risk an "observation period" which could lead to "dedesignation" of the program.

c. Trauma: The two Level I Trauma Centers will continue to operate under the evaluation criteria developed for them during the demonstration phase.

d. Poison: Criteria for evaluating the effectiveness of the New Jersey Poison Information and Education System are written into the contract between the department and NJPIES. Additionally, NJPIES is periodically evaluated against criteria in the enabling legislation which helped to create the service.

e. Disaster Planning: OEMS staff participate in planning and drills and keep applicable records and logs.

F. AGENCIES FOR SUBCONTRACTS:

The type of agency chosen for subcontracts depends upon the type of activity which is planned. The following list gives some examples.

EMT Basic and Refresher Training: community colleges, vocational schools, hospitals, health departments, not-for-profit agencies

Intermediate EMT Evaluation and Testing: Subcontracts not applicable

Critical Care Areas: Individual institutions will not require contracts to provide mobile intensive care or to address most special needs (e.g., trauma)

SUMMARY

The Emergency Medical Services portion of the Preventive Health Block Grant will focus on three areas:

1. manpower and training to assure there is an adequate supply of appropriately trained prehospital emergency care personnel at the basic life support, intermediate life support, and advanced life support levels;

2. special needs in emergency patient care, such as prehospital ambulance and invalid coach transportation, critical care services (e.g., mobile intensive care and EMT-Intermediate programs, trauma care and poisoning), and disaster planning; and

3. data management and program evaluation in order to support and improve the planned aspects of New Jersey's EMS system.

The Office of Emergency Medical Services is the sole certification agency for programs for standard emergency medical technician (EMT) and EMT-Intermediate training. OEMS sets standards for various EMS services and helps to assure that the citizens of New Jersey and visitors to our state receive quality emergency care. It is important to the health and well-being of all New Jerseyans that a strong EMS system be maintained.

FUTURE PLANS

1. Continue a variety of training programs for all levels of emergency care personnel.

2. Continue to develop and implement new and additional emergency medical training courses for audiences and areas hardest to cover (e.g., industries, farms).

3. Continue training and certification regulations or standards for emergency personnel.

4. Continue to develop pilot programs for training untapped reservoirs of persons to deliver emergency care at the local level (e.g., high school students, nurses, senior citizens).

4. Continue technical assistance to the critical care facilities and systems, including site visits to provide ongoing evaluation of the mobile intensive care and EMT-Intermediate programs.

5. Continue to enforce regulations for mobile intensive care and EMT-Intermediate facilities and personnel.

6. Continue to enforce ambulance/invalid coach regulations.

7. Continue to monitor, evaluate and improve New Jersey's EMS system.

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8. Continue to meet the mandates of the Governor's Council on Emergency Medical Services.

RESOURCES NEEDED

12	Salaries	158,500
	a. Coordinator Health Projects III (EMS) b. Administrative Analyst II (DP) c. Public Health Representative II (EMS) d. Principal Clerk Stenographer e. Clerk Typist	
19	Fringe Benefits (24%)	38,040
21	Printing	3,000
23	Medical Education	1,000
24	Clothing (Patches)	3,000
30	Travel	4,200
31	Telephone (4 x $1100)	4,400
33	Automobile Insurance	300
34	Data Processing	1,000
36	Professional Services (evaluators and written exams)	84,100
	80 EMT-I exams $35/$2,800 24 EMT-I evaluators $75/$1,800 . 5,000 EMT National Registry written exams $15/$75,000 60 EMT evaluators $75/$4,500	
38	Other	2,785
45	Rent-Motor Pool	3,000
58	Indirect Cost (31%)	49,135
63	Contracts	113,540
	13 Refresher EMT courses $2,480/$32,240 8 Basic EMT @ 6,400/$51,200 4 Combo EMT @ 7,525/$30,100	
	Total	$466,000

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STATUS REPORT
JANUARY 1, 1987 - DECEMBER 31, 1987
EMERGENCY HEALTH SERVICES PORTION
PREVENTIVE HEALTH BLOCK GRANT

SUMMARY

Areas of concentration for EMS system establishment, expansion and improvement during 1987 were (1) manpower and training, (2) special needs in EMS patient care, and (3) data management and program evaluation. Office of Emergency Medical Services staff were able to accomplish or encourage a number of activities in these areas, as well as to maintain the office's programs.

MANPOWER AND TRAINING

Goal: To assure an adequate supply of appropriately trained emergency care personnel at the basic life support, intermediate life support, and the advanced life support levels.

Training programs were conducted to meet the manpower needs for emergency care personnel and to provide continuing education, recertification, and career ladder opportunities for existing EMS personnel. Continuing support for training programs helps to improve and upgrade the EMS system. Courses were presented for several levels of personnel, including emergency medical technicians (EMTs), EMT-Intermediates (EMT-Is), paramedics, physicians and nurses.

1. Emergency Medical Technician (EMT) Training and Practice

Basic and refresher EMT training is offered in accordance with state and federal guidelines. The following table (Table 1) shows the number of EMT basic and refresher courses during 1987. Table 2 breaks down the training by training semester.

A combination of funding sources helped the Office of Emergency Medical Services (OEMS) to provide the EMT courses at various locations around the state. Also, some courses during the past year were offered at no cost to OEMS (local fees were charged and/or sponsors were found).

The number of active New Jersey ambulance corps personnel (all types) is estimated to be about 17,000, according to the New Jersey State First Aid Council. Although OEMS has certified over 35,000 EMT-As since 1975, certification is only valid for a three-year period (e.g., certifications before 1985 have already expired). Moreover, the "burnout" and attrition rate is very high for ambulance personnel nationwide. We also know that many people have dropped their squad affiliations after only one or two years of service. Therefore, EMT training must be an ongoing job, if New Jersey is to keep its pool of currently working and certified EMTs.

OEMS has computerized a master file and compiled statistics on currently certified EMTs. EMTs with expired certifications may still be riding on some of the volunteer squads, however, because training requirements can be set locally. Demographic EMT counts and local input have been used when making decisions on where EMT courses will be held. Paramedics have also been added to a computerized master file to aid in recertifications. These computerized lists aid in mailing to the prehospital providers, newsletter mailings, and notifications of policy changes.

OEMS uses the Atlantic Emergency Medical Services Council's written EMT test. The Council's testing service offers a question bank from which test items are pulled. OEMS has an in-house machine to score the tests and to do item analysis. The Department of Health's data services were used to print the cards, certificates, and withholding notices during the first half of 1987. These functions can now be done within the OEMS program.

Three EMT training regions operate throughout the state. Each has an EMS Coordinator and an Assistant EMS Coordinator (field representative) who monitors the progress and quality of courses in the region and who acts as a liaison between OEMS and the regional coordinators. It is anticipated that in late 1988 field offices will be available in the three areas. There is a large cadre of instructors and instructor-trainees working under the direction of the EMT course coordinators. The regional coordinators have formed groups which meet monthly to discuss training matters and to share information. These meetings have also been used for updating any policy changes with the coordinators. Two statewide EMT Coordinators meetings were held during this year.

Several specialty groups were targeted for EMT training, including registered nurses and high school students. The following programs were conducted:

4	registered nurse programs
2	high school student courses (Monmouth and Camden Counties)

Camden County Vocational School has added an EMT program for credit (to begin in the fall of 1988). The course will be taught for two hours, five times a week for a full semester. Equipment and materials were purchased by the school board which fully supported this urban high school program.

Two instructor training institutes were conducted for 70 participants. Three evaluator training institutes were conducted to upgrade evaluator's skills and knowledge on practical evaluation techniques. Updated practical evaluation sheets were designed and utilized for all testing in 1987. These sheets provide an objective evaluation tool for the EMT practical examination process. About one hundred-twenty (120) evaluators were updated at these training institutes. Additionally, OEMS sponsored a well-attended weekend training symposium for the EMS community. The program included pediatric emergencies, aircraft incidents, and workshops of general interest.

150X

Two special instructor training institutes were conducted for 120 instructors who had taught in the New Jersey State First Aid Council's training program. These courses were structured to meet the special needs of these instructors. Basic teaching skills were not addressed, as the participants were already active instructors, but the objectives and components of the federal Department of Transportation's EMT curriculum were stressed. These special ITIs were necessitated by the First Aid Council's agreement to accept the emergency medical technician as the level of EMS training needed to provide basic life support care in New Jersey and the accompanying surge in the number of persons who would be EMT trained.

Continuing education programs for basic life support personnel are approved by OEMS. A total of 179 approved CEU programs were conducted in 1987. A total of 28 continuing education units (CEUs) allows a candidate to fulfill the educational requirement for EMT refresher training. The candidate is then eligible to take the EMT certification examination to remain current as an EMT.

OEMS continued to work with the Healthcare Information Network (HIN), Princeton, to produce the monthly, half-hour, continuing education television program, "EMS Vitals." The show covers various topics in the standard EMT curriculum and carries 1/2 CEU from both OEMS and the National Registry of Emergency Medical Technicians. Over 500 sites nationwide, including about 55 health care facilities in Jersey, can pick up the satellite broadcasts. The potential nationwide audience was increased to over 900 sites in late 1987 when HIN was purchased by the Hospital Satellite Network.

2. EMT-Intermediate (EMT-I)

Enabling legislation (P.L. 1985, Chapter 351) for EMT-I was approved November 7, 1985, and calls for a three-year pilot EMT-I program in the state's rural counties, which allows EMT-Is to do cardiac monitoring, initiate intravenous (IV) therapy, perform cardiac defibrillation, use an esophageal obturator airway and apply the MAST garment. Intermediate life support became operational in August 1987.

EMT-Intermediate programs are operating in the areas served by four of the nine participating EMT-I hospitals (Warren Hospital, Hunterdon Medical Center, Memorial Hospital of Salem County and Millville Hospital). The EMT-Is who serve the area around Memorial Hospital of Salem County and Millville Hospital respond in nontransport vehicles and use the transport capabilities of the area's volunteer first aid and rescue squads. The EMT-Is who serve Hunterdon Medical Center and Warren Hospital respond in the volunteer first aid and rescue squad vehicles.

EMT-I treatment protocols and operational policies have been developed. A standardized EMT-I run report was developed to be utilized on a statewide basis. A statewide data report for submission to OEMS was also developed.

All EMT-Is function under the direction of on-line medical control from accredited Advanced Cardiac Life Support emergency department physicians. In case of radio failure, the EMT-Is use the statewide EMT-I treatment protocols. A patient care report form must be submitted on each intermediate life support call. Additionally, audits of charts and vehicle inspections are conducted by OEMS staff to further assure quality care is given.

The EMT-I didactic program was revised to meet the new national Department of Transportation standard for EMT-Intermediate. OEMS reviewed pilot training proposals and awarded contracts to Morristown Memorial Hospital (for Warren and Sussex Counties) and to Underwood Memorial Hospital (for Cumberland and Salem Counties). Each of these "project facilities" taught didactic programs in 1987. A total of 42 students successfully completed their EMT-I didactic training. A Spring 1988 didactic program is planned with Underwood Memorial Hospital as the project facility.

The advanced life support training programs for paramedics, physicians and nurses were supported through other funding sources and were not part of this application.

TABLE 3: 1987 EMT-INTERMEDIATE TRAINING PROGRAM

	Total Students
Underwood Memorial Hospital	28
Morristown Memorial Hospital	15
Total	43

TABLE 4: EMT-INTERMEDIATE STATISTICS
(as of February 18, 1988)

Number of Certified EMT-Is Per County	
Cumberland	3
Hunterdon	11
Salem	16
Sussex	4
Warren	9
Number of Certified EMT-Is	43
Number of RN/EMT-Is (approved by skills)	3

Number of Approved EMT-I Units

Cumberland	1*
Hunterdon	7**
Salem	1*
Sussex	0
Warren	4**
Total	13

* Are Nontransport vehicles
** Three squads have two approved EMT-I units

Number of Submitted ILS Treats in 4th Quarter 1987

Memorial Hospital of Salem County	240
Hunterdon Medical Center	6
Warren Hospital	2
Total	248

SPECIAL NEEDS IN EMS PATIENT CARE

Goal: To study, plan for, implement and monitor programs which address special needs in EMS patient care, including prehospital ambulance and invalid coach transportation, mobile intensive care, trauma, poisoning, disaster planning, and helicopter aeromedical services.

A number of "special projects" were developed to address various areas related to the provision of quality patient care. These areas include: (1) the availability of technical assistance, quality assurance, and monitoring for providers of basic life support prehospital ambulance and invalid coach services (including those covered under regulations for non-volunteer services), (2) the continuation of planning, technical assistance and monitoring for selected critical care services (including mobile intensive care programs, the trauma centers, and the Poison Information and Education System), (3) the continued involvement in disaster planning for the emergency care component of natural or manmade disasters, and (4) the continuation of involvement in the issue of helicopters to provide EMS care and transportation.

1. Prehospital Ambulance and Invalid Coach Services

a. Ambulance Regulations

The ambulance and invalid coach regulations took effect on April 15, 1985, as New Jersey Administrative Code 8:40-1.1 et seq. In recognition of the crucial need for these regulations, the Department required covered services to comply with the regulations by October 1, 1985.

153X

As of December 31, 1987, there were:

-142 total non-volunteer providers
- 79 licensed providers (licenses for several municipalities and industrial squads are in process)
-509 total non-volunteer vehicles
-480 licensed vehicles

During 1987, a greater number of providers went out of business than was experienced in the past. The main reasons cited were insufficient Medicare and Medicaid reimbursement and the high cost of insurance.

During an average month, OEMS receives applications to license 16 new vehicles and notices that 20 vehicles have been removed from service--a net decrease of 4 vehicles each month. Most of the vehicles are removed from service during the summer relicensure surveys and at the end-of-the-year relicensure cycle. Department staff performed numerous spot checks around the state. Warning letters, three fines, and two licensure revocations were issued in 1987. An administrative hearing was held for one provider who challenged a revocation order. The decision of the independent administrative law judge upheld the revocation and was strong enough to create case law.

b. Voluntary Programs

The New Jersey State First Aid Council has adopted its own standards for ambulance patient care equipment for its member squads in the volunteer community which are exempted by law from the regulations. The Department continues to work with the Council to phase-in the standards and to implement monitoring procedures. A specific form is available to survey volunteer squads which wish to have their vehicles certified by OEMS under provisions of N.J.A.C. 8:40.

Pneumatic testing over the years has confirmed that many ambulances do have severely defective resuscitators and suction devices. This testing program is mandated for regulated services and is available on request to volunteer squads. During 1987, new pneumatic test equipment was designed and ordered to meet the new patient care standards for oxygen powered resuscitators. This equipment should be available in 1988.

The CO testing program continued in 1987 on a voluntary basis for the volunteer providers and as a mandated part of the ambulance and invalid coach regulations for covered providers. The bulk of the CO testing is performed by staff from the Environmental Health Services/Field Operations Section of the Department of Health and by volunteer staff. Reports are returned to OEMS for inclusion in the files of the regulated providers.

Serious problems with Ford E350 ambulances continued to be of concern this past year. OEMS received reports from other states in 1986 that several ambulances had caught fire and personnel had been splashed with gasoline which spurted out of the tank's filler line. Working with information supplied by officials, Virginia EMS (where the problem was identified), Ford representatives and others, OEMS released a health hazard alert notice to all known New Jersey volunteer and non-volunteer ambulance, invalid coach and MICU services. OEMS participated in federal data collection efforts on the problems and provided technical assistance to the state's affected services. A major recall of all Ford E350 vehicles took place in 1987 to correct the problems which had been identified so far. Dispite recommended corrections, some services continue to report difficulties and it is thought this could be a long-range problem.

2. Mobile Intensive Care (MIC) Consortia

Mobile intensive care programs are operating in areas where 95% of the state's population lives. The programs serve patients with a variety of life threatening problems, including those with cardiac emergencies, severe trauma from accidents, entrapments, respiratory arrests, drug overdoses, poisonings, and drownings. The 37 medical control points were guiding 57 MICU vehicles at the end of 1987 and treated 87,929 advanced life support patients during calendar year 1987.

One program (at Chilton Hospital) expanded its hours of operation from 12 hours a day to 24 hours a day. The MONOC consortium and Community Memorial Hospital added "beach vehicles" during the summer to handle the increased visitor population. These vehicles operated from May 1 through September 30.

Yearly formal inspection visits are made to each mobile intensive care program to assure it is proceeding according to recognized guidelines. Lengthly reports are generated and provided as feedback to the sites. Additionally, since November 1, 1983, supervisory personnel from OEMS perform quarterly field visits to all programs and audit a minimum of 10% of all MIC advanced life support run forms. This helps to assure that completed ALS calls were necessary and that the care which was rendered was appropriate. Less than 5% of all cases reviewed are found to be inappropriate ALS cases. Extensive inservice training has been conducted with each MICU program and the MICU coordinators and clinical coordinators, addressing necessary documentation and appropriate ALS care.

Reports must be submitted to OEMS at the close of each quarter. The data is compiled and analyzed and summary reports are generated. These program reports help OEMS in program monitoring and were also sent to the Health Care Financing Administration during the waiver period as a reporting requirement of the waiver.

The mobile intensive care services waiver with the federal Health Care Financing Administration expired on October 31, 1987. Since then, each hospital-based MICU bills for its own service (previously the receiving hospitals did the billing for the MICU services). Data collected during the waiver period show that New Jersey has met its projections in the waiver, including staying under HCFA "caps" for the total number of vehicles and total annual costs for the service.

3. Trauma Centers

The OEMS Task Force on Multiple Trauma in the late 1970s found that over 35,000 people were admitted to New Jersey hospitals annually because of trauma-related injuries (including fractures, dislocations, internal injuries, and open wounds). OEMS research identified over 14,000 serious injuries per year in the state. In partial response to this need, two Demonstration Level I Trauma Centers were named in 1981. These centers received formal designation in August 1987 when the Commissioner of Health notified them of permanent status and formed an Ad Hoc Committee on Trauma to examine the current status of trauma care in New Jersey.

The Committee has been charged with addressing issues such as development of criteria and processes for designation of Level II trauma centers, trauma triage protocols, development of helicopter trauma triage protocols, reimbursement for care of the multiple trauma patient, the feasibility of a statewide trauma registry (including systems evaluation), and communications.

The center at Cooper Hospital/University Medical Center, Camden, has been in operation since November 8, 1982. It opened with six beds and went to eight beds on October 1, 1983. In May 1984, Cooper opened a 10-bed Trauma Intensive Care Unit (TICU). In 1987, there were 891 trauma admissions at Cooper; of these, about 810 lived to discharge.

University Hospital's Trauma Center, Newark, has been open since July 1, 1982. In 1987, the unit saw 1,500 trauma admissions, with about 1,400 living until discharge.

4. Poison Information Center

The New Jersey Poison Information and Education System (NJPIES) began operation on February 1, 1983. A toll-free number, 800-962-1253, is available around-the-clock to contact the System. Teletype access for the deaf is also available. During 1987, the Center received the bulk of its funding from a special state appropriation.

NJPIES received 61,852 calls for assistance in 1987. The general public called 83% of the time, 13% of the calls came from hospitals, and the remainder came from a variety of other sources (e.g., schools, workplaces). The majority of the calls were for accidental poisoning exposure.

Children under the age of five (over 50% of the calls) appeared to be the ones most affected by poisonings, as measured by stated age of the

victim. The types of poisoning exposures most reported involved medications (31%), home products (23%), pesticides (9%), plants (9%), and industrial (8%). Most poisons had been ingested.

In addition to meeting the American Association of Poison Control Centers criteria for designation as a regional poison control center, NJPIES also continues to meet the criteria developed for it by the New Jersey Legislature under P.L. 1982, Chapter 177.

5. Disaster Planning and Response

Each year, state agencies participate in disaster drills for the two nuclear power generating stations (Oyster Creek in Ocean County and Salem Nuclear Generating Facility in Salem County).

During these drills, OEMS staff assist the local officials in defining and meeting EMS-related needs, collaborate with other Health Department staff, alert the field and/or Health Department staff to changing conditions, act as a central clearinghouse for EMS information, and service requests for assistance.

As possible, OEMS staff also collaborate with military, federal, state, and local representatives on the EMS aspects of the mass repatriation program.

6. Helicopter EMS

The Department of Health in cooperation with the New Jersey State Police has participated in a joint effort to expand aeromedical services to residents of and visitors to New Jersey through a statewide public sector system pursuant to P.L. 1986, c. 106. In conjunction with two hospitals (University Hospital, Newark, and West Jersey Health Systems, Voorhees) designated by the Commissioner of Health, a formal aeromedical training program was developed and implemented to provide specialized training for the medical component personnel from the participating hospitals. The New Jersey State Police will provide the aviation component. New Jersey's aeromedical program will become operational in the summer of 1988. New Jersey is the first, and to date the only, state to pass legislation to establish and operate a statewide public sector aeromedical system.

DATA MANAGEMENT AND PROGRAM EVALUATION

GOAL: Provide services in data management and program evaluation in order to study and improve various aspects of New Jersey's EMS system.

During 1987, staff dramatically transformed the EMS personnel certification system. Under the old system, a student had to wait three months or more to receive a certification or a failure notice. With the new system, almost every student has a certification or failure notice in his/her hands a week or so after testing.

In addition, the licensure system was totally revised. The old system used dBase II on a CP/M based micro computer. The software and the computer were obsolete and were unable to handle an increased data load. The software was rewritten for, and the data were transferred to, an IBM compatible personal computer.

OEMS continued to study the system's effectiveness in dealing with cardiac arrests. Cardiac arrest data from 1985 and 1986 indicated that between 8% and 18% of the cardiac arrest cases treated by the mobile intensive care units were discharged from the hospital alive. The 1986 data were further analyzed to determine any identifiable trends. Findings were presented at the 1987 American Public Health Association convention.

Data processing was also used as part of the evaluation of New Jersey's mobile intensive care network. Over 80,000 calls annually were measured on a number of key indicators to generate quarterly and annual reports. These reports can be broken down into data at the facility, regional and statewide level. During the year, a series of special reports were prepared and submitted to the Health Care Financing Administration as part of the MICU services assessment.

PART II

RAPE SERVICES AND PREVENTION

1904 (a) (1) (G)

PREVENTIVE HEALTH AND HUMAN SERVICES BLOCK GRANT APPLICATION

NEW JERSEY STATE DEPARTMENT OF HEALTH

RAPE CARE PROGRAM

A. INTRODUCTION:

Violence, in its various forms comprise one of the most serious public health problems within New Jersey and in the United States. It is fostered in a culture that values agression as a means of dealing with problems.

Sexual Assault is a category of violence that is largely "invisible" to society. It included sex crimes against women, children and men, including sexual abuse and rape. The injuries that result to the victim are both physical and emotional.

Each year, thousands are sexually assaulted and/or abused. For New Jersey, most recent statistics available from the State Police's Uniform Crime Report (1986) reflect a total of 2,531 reported rapes - a four percent increase in the reporting of rape from 1985 to 1986, with an estimated 90% of the total number of rapes remaining unreported.

B. GOALS AND OBJECTIVES:

Goal 1:

Coordinate the statewide program of care to the rape victim on a regional and areawide basis.

Objectives:

1. Assess the availability and quality of care currently provided to rape victims in the state on an areawide and regional basis.

2. Develop and implement a confidential statewide reporting system to analyze frequency and trends in rape incidence.

3. Implement a quality of care assurance program for the rape victim.

Goal 2:

Provide local agency input into the statewide rape care program.

Objective:

1. Provide representation to meetings of the New Jersey Coalition Against Sexual Assault.

2. Integrate the Coalition's work into the program development.

160X

3. Develop a plan to include local health departments participation in sexual assault/abuse identification and prevention efforts throughout the state.

Goal:

Develop and implement public and professional programs geared toward the prevention of rape and sexual abuse.

Objective:

1. Review literature in developing written public and professional education programs designed to identify situations and factors associated with higher risk of rape and sexual abuse and assist in the understanding of the management of rape and sexual abuse victims.

2. Assist rape care agencies with incorporating public and professional education into the agency programs.

3. Provide technical and financial assistance to agencies in expanding services to include specialized prevention presentations within the perspective school systems.

C. IDENTIFICATION OF POPULATION, AREAS AND LOCALITIES:

According to the 1980 census, New Jersey ranks ninth among all states in population, but is fourth smallest in the nation. Of the state's 7.4 million residents, the 1980 census showed that 3,839,411 were females.

No age and race victimization data are currently available for New Jersey. The New Jersey State Police surveyed the age, sex, race and ethnicity of all reporting victims during August - December 1977. Their findings indicate that in absolute number, slightly more are white than black or other racial or ethnic origin. Most, (88.5%) are under 34 and 596 or more than 98% of the victims are female. The single largest group of reporting victims is white and between the ages of 18 and 21.

D. METHODS OF ACHIEVING GOALS:

The following activities will bring about the achievement of the Program's Goals Objectives:

1. Continue to fund a network of local community based rape crisis programs on a county wide basis.

2. Continue to document the incidence of rape to establish trends in reporting and assess the availability of services for rape victims.

3. Continue to conduct annual site visits to Rape Care Programs funded by the Department to evaluate program performance and compliance with terms of the grant.

4. Continue to promote interdepartmental input into the statewide planning and coordination of care of sexual assault and abuse victims.

5. Continue to provide technical assistance to local agencies in the development and implementation of public education and professional training programs.

E. EVALUATION PROCESS:

A comprehensive approach to treatment for the rape victim includes physical, emotional and preventive care. The evaluation will assess:

1. The quality of physical care provided to the rape victim by the emergency medical facility:

   a. by monitoring the amount of time it takes for a victim to receive treatment upon arrival at the hospital,

   b. by monitoring physician/victim interaction to assess degree of sensitivity exhibited on the part of the physician performing the rape exam and,

   c. by establishing to what degree the emergency medical facility adheres to established standards.

2. The quality of services provided by coordinating agencies:

   a. by monitoring activities of the agencies providing services under contractual agreement with the Rape Care Program.

3. The degree to which workshops and seminars impact on preventive care:

   a. by asking workshop seminar attendants to complete questionnaires related to their quality and comprehensiveness.

In general, the evaluation will assess the availability and delivery of well coordinated and comprehensive services to the rape victim in New Jersey.

REPORTING REQUIREMENTS

A confidential standardized rape reporting form will be utilized by any agency providing care to the rape victim under contractual agreement with the Department of Health.

OUTCOME MEASURES LINKED TO GOALS AND OBJECTIVES

Outcome measures involving the rape victim are difficult to predict. The present availability and quality of care indicate the need for the on-going development of a comprehensive statewide program.

The data reporting system presently in place will identify the number of victims served, amount of time spent during the interview and will address present trends. These findings will assist with the on-going development of prevention and education programs addressing sexual assault and sexual abuse.

STATUS REPORT

RAPE CARE PROGRAM (FY 88)

The Department of Health's Rape Care Program, established for the purpose of developing and implementing a coordinated, statewide plan for the systematic care of the rape victim, has been successful in implementing this plan in 16 of New Jersey's 21 counties with Federal Preventive Block Grant funds. The goal of this coordinated approach is to ensure that the medical, legal and psychological needs of the rape victim are addressed in an orderly manner.

In FY 1988, Department efforts in rape were directed toward:

1. the coordination of efforts with intergovernmental agencies to develop uniform rape reporting,

2. outlining a plan to develop and implement regional and areawide training and education for various personnel who provide services to rape victims,

3. expanding the availability of services to rape victims in high risk areas, and

4. developing a strong network of service providers to identify systematic approaches to regulating adherence to standards for rape victim treatment by the Department of Health.

During this period a newly developed confidential uniform statistical form was utilized by Health Department funded local community based rape crisis programs to document each time a rape victim entered the treatment system. Information collected will identify present trends and will aid in the development of prevention and education programs targeted at high populations.

It is difficult to discuss activities levels at community rape crisis centers since they are on different reporting cycles and our data management system has only been fully operational for the 1987 grant year. However, in 1986 we did have four agencies on our reporting system. These same agencies continued on the system through 1987 and therefore lend themselves for comparative analysis.

In 1986, rape care agencies in Cumberland and Union Counties, Roosevelt Hospital in Middlesex County and United Hospital in Essex County served 1,239 cases. These same four agencies served 1,391 cases in 1987. This represents an increase of 12.3% when comparing 1987 to 1986. Overall, 21 different rape programs reported serving 2,882 cases statewide in 1987.

Request for additional training from contracting agencies continues to be a priority particularly as they relate to issues around child sexual abuse and violence against women. To address this concern, two regional training sessions are scheduled for September and will address domestic sexual assault and abuse. On-going efforts have also been directed towards local community based rape crisis programs who request assistance in developing

and implementing in - service training for staff. Because child sexual abuse continues to be an issue of national concern, the Rape Care Program has been designated by the Department of Health to provide input into the planning and activities of the Governor's Task Force on Child Abuse and Neglect. A "Best Practice Manual for the Diagnosis and Treatment of Child Abuse" will culminate the efforts of this group.

The visibility of the program continues to increase. Request for assistance in program development, resource materials and local network appearances have become overwhelming. Additional state funds have enabled the expansion of rape victim services to high risk areas of Burlington, Hudson and Gloucester and Passaic Counties.

Interagency and intra-agency networking continues to be a primary source of resource referral to the Rape Care Program. Representatives from relevant governmental departments and divisions collaborate regularly to assess the quality of service provided to victims through coordinated efforts.

Of significant importance is this program's representation on the State Attorney General's Task Force to develop standards to ensure the rights of crime victims. These standards were presented to the public in April during the Crime Victims Rights annual conference.

L07327

Preventive Block Grant
Proposed Budget
October 1, 1988 to September 30, 1989

Program	Amount
Administration	$ 259,245
Emergency Medical Services	416,800
Comprehensive Health	142,051
Rodent Control	266,272
Local Health Development	77,641
Hypertension	735,715
Diabetes	65,075
Risk Reduction	564,127
Rape	92,566
Total	$2,619,492

166X

MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT FY 89

Division of Community Health Services

167X

STATE OF NEW JERSEY
OFFICE OF THE GOVERNOR
CN-001
TRENTON
08625

THOMAS H. KEAN
GOVERNOR

August 11, 1988

Bureau of Maternal and Child Health and
Resources Development
Office of Maternal and Child Health
Parklawn Building
5600 Fischers Lane, Room 605
Rockville, MD 20857

Dear Sir or Madam:

In accordance with the Omnibus Reconciliation Act of 1981, the State of New Jersey hereby applies for the Maternal and Child Health Services Block Grant Program for Fiscal Year 1989.

The enclosed application contains the necessary statements of assurances, goals and objectives, description of population areas and localities needing Maternal and Child Health services, planned utilization of funds, and data that the state intends to collect respective of the activities to be conducted.

A status report for the 1988 Block Grant will be forthcoming. The status report for 1987 has been submitted. The application also identifies a contact person within the Department of Health as requested.

Sincerely,

Thomas H. Kean
Governor

Enclosures

168X

State of New Jersey

DEPARTMENT OF HEALTH
CN 360, TRENTON, N.J. 08625-0360

MOLLY JOEL COYE, M.D., M.P.H.
COMMISSIONER

APPLICATION FOR
MATERNAL & CHILD HEALTH SERVICES
BLOCK GRANT
FY 89

Thomas H. Kean
Governor

Molly Joel Coye, M.D., M.P.H.
State Commissioner of Health

New Jersey Is An Equal Opportunity Employer

169X

REPORT OF INTENDED EXPENDITURES
MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
NEW JERSEY STATE DEPARTMENT OF HEALTH
OCTOBER 1987 - SEPTEMBER 1988

	Pages
Part I	
Statement of Assurances	1 -5
Part II	
Introduction	6 - 7
Overview	
Section I Maternal and Infant Health Needs	
II Child Health Needs	
III Children with Special Health Needs	
Description of Population, Areas and Localities Needing Maternal & Child Health Services [Sec. 505(1)(A)]	8 - 49
Part III	
Section I	
Statement of Goals and Objectives [Sec. 505(1)(B)	50 - 57
Section II	
Planned Utilization of Funds-Types of Services [Sec. 505 (1)(C)	58 - 66

Contact Person:

Leah Z. Ziskin, M.D., M.S.
Assistant State Commissioner of Health
New Jersey State Department of Health
Division of Community Health Services
CN 364
Trenton, NJ 08625
(609) 292-4043

170X

PART I

STATEMENT OF ASSURANCES

STATEMENT OF ASSURANCES

As stipulated under Section 509 (b) of this Act, the New Jersey State Department of Health (the State health agency of New Jersey) shall be responsible for the administration of programs specified by the Maternal and Child Health Services Block Grant. Through its administration, the State of New Jersey assures:

1) That the State will prepare and transmit to the Secretary a report describing the intended use of payments the State is to receive under this title for FY89 and this will include:

   (a) a description of those populations, areas, and localities in the State which the State has identified as especially needing maternal and child health services;

   (b) a statement of goals and objectives for meeting those needs;

   (c) information on the types of services to be provided and the categories or characteristics of individuals to be served;

   (d) data the State intends to collect respecting activities conducted with such payments.

2) That a fair method for allocating the funds allotted to the State under this title among individuals, areas and localities needing maternal and child health services will be utilized in making these allocations.

   Ref. [Section 505 (2) (a)]

172X

3) That guidelines, standards and methods of assuring quality concerning the appropriate frequency, content, referral and follow-up of health care assessments and services will be applied to all services assisted by the State under this title.

4) That the funds allotted to New Jersey under this title will only be used to carry out the purpose of this title or to continue activities previously conducted under the consolidated health programs.

Ref. [Section 505 (2) (B)]

5) That no person shall on the grounds of sex, age, race, color, national origin, handicap, or religion be excluded from participation in or denied the benefits of, or be subject to discrimination under any program or activity funded in whole or in part with funds made available under this title.

Ref. [Section 505 (2) (B) and Section 508 (a) (1-2)]

6) That a substantial proportion of the sums expended by the State for carrying out the Maternal and Child Health Services Block Grant will be for the provision of health services to mothers and children, with special consideration given to the continuation of the funding of special projects previously funded.

Ref. [Section 505 (2) (c) (i)]

7) That a reasonable proportion of the funds allotted, based upon the State's previous use of funds under this title will be used for the purposes of: (a) assuring that

mothers and children, in particular those with low income or with limited availability of health services, have access to quality maternal and child health services;

(b) reducing infant mortality and the incidence of preventable diseases and handicapping conditions;

(c) reducing the need for inpatient and long-term care services;

(d) increasing and maintaining the number of children appropriately immunized, especially preschool children;

(e) increasing the number of low income children receiving health assessments and follow-up diagnostic and treatment services;

(f) promoting the health of mothers and children especially by providing preventive and primary care services for low income children and prenatal, delivery and post partum care for low income mothers;

(g) providing rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI of the Social Security Act.

(h) providing services for identifying, treating and follow-up of children who have special health care needs or are suffering from conditions leading to the development of special health care needs.

Ref. [Section 505 (2) (c) (ii) and Section 501 (a) (1) (2) (3)]

8) That if the State imposes any charges for the services provided with funds allotted under this title, they will be

pursuant to a public schedule of charges. Under such a schedule, charges will not be imposed to low income mothers or children and charges will be adjusted to reflect the income, resources and family size of the individual provided the services.

Ref. [Section 505 (2) (D)]

9) That the New Jersey State Department of Health, in administering the Maternal and Child Health Services Block Grant, will participate in the coordination of activities with the early and periodic screening, diagnosis and treatment program (EPSDT) under Title XIX of the Social Security Act to ensure that duplication of effort does not occur.

Ref. [Section 505 (2) (E) (i)]

10) That the New Jersey State Department of Health, in administering the Maternal and Child Health Services Block Grant will participate in the arrangement and carrying out of coordination agreements described in the Section 1902 (a) (11) concerning coordination of care and services available under this title and Title XIX.

Ref. [Section 505 (2) (E) (ii)]

11) That in administering the Maternal and Child Health Services Block Grant, the New Jersey State Department of Health will coordinate services and activities with other related Federal grant programs, including supplemental food programs for mothers, infants and children, related education programs, and other health, developmental

disability, and family planning programs.

Ref. [Section 505 (2) (E) (iii)]

12) In accord with the provisons of P.L. 100-93 no person or institution who has been barred from participation in Medicaid or Medicare because of fraud will be eligible to receive payment from funds provided throrough Title V.

The State of New Jersey further assures that the description of programs and activities carried out under the Maternal and Child Health Services Block Grant, and this statement shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during development of the description and statement and after its transmittal. The description and statement shall be revised throughout the year as may be necessary to reflect substantial changes in any element of such description or statement, and any revision shall be subject to the requirements of public comment.

Ref. [Section 505]

In accordance with Section 505 the full report describing the intended use of payments the State is to receive under the Maternal and Child Health Services Block Grant will be submitted to the Secretary no later than October 1, 1988.

This document constitutes the report required by Section 505 (1) of the intended use of the funds the State of New Jersey is to receive during federal fiscal year 1989 and documentation concerning the statement of assurances required under Section 505 (2) of that Act.

PART II

INTRODUCTION

INTRODUCTION

Since 1936, the New Jersey State Department of Health has been authorized in legislation to act on behalf of the State of New Jersey to participate in federal grants under the Social Security Act for the provision of health services to mothers and children and handicapped children. (Ref. N.J.S.A. 26:2-60, L1936, C62, P.156.)

The purpose of the activities undertaken by the Department in administering Title V of the Social Security Act over the past 50 years has been to:

"extend and improve as far as practicable under the conditions in the state.

1) services for reducing infant mortality and otherwise promoting the health of mothers and children; and
2) services for locating and for medical, surgical, corrective, and other services and care for and facilities for diagnosis, hospitalization, and after care for, children who have special health care needs or who are suffering from conditions leading to the development of special health care needs."

As a result of the amending of Title V of the Social Security Act by the Omnibus Budget Reconciliation Act of 1981 the purpose of these programs has been broadened, and the states have been assigned the role of assuring the availability of preventive and primary health care services for mothers and children of the state.

Towards this broad objective, several categorical programs concerning mothers and children were added to Title V for the state to administer. These programs were the Supplemental Security Income-Disabled Children's Program, the Lead Based Paint Poisoning Prevention Program, the Sudden Infant Death Syndrome Program, and the Adolescent Pregnancy Program. These separate programs have now been folded into the Department of Health's, Division of Community Health Services. Within the Division, the activities under the Maternal and Child Health Block Grant are located within the Division's Maternal and Child Health Services, and Special Child Health Services.

In developing the MCH Block Grant Plan for FY89, special attention has been focused on the continuation of the interagency cooperation and planning between the Department of Health and the Department of Human Services to enhance the services provided by the two agencies for pregnant women, infants and children through Title V and Title XIX . As a result of a maternal and child health initiative outlined in the Governor's 1986 State of the State address, and subsequent state budgets, an interagency committee has developed the necessary plans to implement an enriched package of prenatal and child health services to pregnant women, and young children below the federal poverty level and implement the provisions of the Sixth Omnibus Budget Reconciliation Act of 1986. The development of this new interagency initiative has enhanced the state's efforts to meet the needs of low-income mothers and children. This resulting program, called HealthStart, is now operational. The program's staff is located within the Division of Community Health Services.

PART II

SECTION I

MATERNAL AND INFANT HEALTH NEEDS

OVERVIEW

The basic concern of the Maternal and Child Health Block Grant is the health of the state's families and their children. In New Jersey, there are approximately 1,700,000 women age 15 to 44 and 1,008,000 families with minor children and 2,390,000 children under 21 years of age. The state's population of women and their families is, however, made up of several specific subpopulations, which because of their health and social status, are at risk of pregnancy loss, premature death and unnecessary disability. The needs of these specific subpopulations will be described in the following three sections of this part.

Section I, Maternal and Infant Needs, will describe both statewide characteristics as well as characteristics of specific high risk populations which must be considered in identifying the perinatal health needs of New Jersey.

Section II, Child Health Needs, will present the general pattern of mortality and morbidity experienced by the state's children. The section will focus on certain needs which are amenable to public health interventions.

Section III, Children with Special Health Needs, describes the needs of chronically ill and handicapped children.

181X

INTRODUCTION

This section will focus on the current assessment of need for services designed to improve the health of mothers and infants. Particular attention will be focused on the state's problem of infant mortality. Despite the fact that the state leads the nation in many socio-economic areas, in 1984 New Jersey's infant mortality rate ranked 32 among the fifty states. The analysis presented here will attempt to identify factors which cause the state's high infant mortality rate, and adversely influences the health and well being of so many of the state's mothers and infants.

ASSESSMENT OF NEED

Based on 1985 population estimates, there are 1,752,694 women in their reproductive years (15 to 44 years) in New Jersey. In the state, there are an estimated 554,072 female adolescents (10 to 19 years) who are either approaching or who have entered their reproductive years, but have yet to enter adult society. The distribution of these two population groups by county is presented in Table I. Essex County has the greatest percentage of women in their reproductive years (12.0%) and adolescent women (12.0%). The table shows the counties ranked according to their percentage of these groups of women. The counties generally have the same rank for women age 15 to 44 as for adolescent women.

In 1986, 108,446 infants were born to New Jersey residents. This gave the state a general fertility rate (births per 1,000 women age 15 to 44) of 61.86. As can be seen in Figure I, this rate is 3.5 percentage points above the general fertility rate for 1984, though it is still a continuation of the lower fertility rates which began in New Jersey after 1972. Despite this generally stable general

fertility rate, the number of births to New Jersey residents has increased since 1976. As shown in Table Ia, the number of live births to New Jersey residents was at its lowest point in 1976. Since then the number of live births has increased by 17,897, with over half of that increase since 1983.

To insure that all mothers and infants of the state receive quality medical care, the Maternal and Child Health Program works cooperatively with the Medical Society and the state's seventy- one maternity hospitals. The MCH Program analyzes vital statistics data on all deliveries and gathers information from maternity and newborn services reports (Table II a, b). This information is compiled and reported back to the hospitals so that care within the state's maternity units can be charted and measured. Monitoring of services also serves to encourage and enhance the development of high quality perinatal care. The program also reviews all fetal, infant and maternal deaths that occur in the state. This detailed review process enables the program to identify problems that adversely affect mothers and infants and to work with medical and public health professionals to address identified problems.

The focus of statewide activities for Maternal and Child Health Services, under the Block Grant is the improvement of maternal and infant health and particularly the reduction of infant mortality in New Jersey. This focus on infant mortality grows out of the fact, that this one rate is widely understood and studied as an indicator of maternal and infant health. Correcting the problems that cause excess infant mortality will result in a general improvement in the health of both mothers and their children. In making infant mortality the focus

of programatic activities is tis recognized that not all issues of concern to maternal and child health can be considered through a discussion focused on infant mortality. One such issue, which requires special focus in New Jersey, is the impact of Human Immunodeficiency Virus (HIV) infection on the health of women and children in the state.

184X

Infant Mortality

Infant Mortality has been declining in New Jersey as well as in the United States since the mid 1950's. However, in New Jersey, it is still unacceptably high, especially among non-white infants. In 1986 the state's infant mortality rate was 9.8 deaths per 1000 live births. This rate dropped from 10.8 deaths per 1000 in 1985 after remaining unchanged between 1984 and 1985 (Figure IIa). The non-whites infant mortality rate in 1986 decreased from 18.7 to 18.0 deaths per 1000 live births (Figure IIb).

As shown in the graphs (Figures IIb, IIc) the neonatal and infant mortality for non-white infants has remained higher than that of white infants. This can also be seen in Table III: the non-white infant mortality is nearly twice that of white infants.

The causes of infant deaths in New Jersey in 1986 are presented in Table IVa. Conditions in the perinatal period are the group of causes which accounted for 72 percent of all neonatal deaths and 48 percent of infant deaths. Within this group the major causes, prematurity and related respiratory complications accounted for the majority of deaths. The other leading cause of infant deaths was congenital anomalies, which accounted for 165 deaths or 16 percent of all infant deaths.

There were 349 postneonatal deaths in 1986 with Sudden Infant Death Syndrome accounting for 33 percent of these deaths. Congenital anomalies were the cause of 19 percent of post-neonatal deaths.

Table IVb and c show the causes of infant deaths for white and non-white infants. As previously noted, the overall non-white infant mortality rate is twice that of whites. This is also true for many of the major causes of death. For example, the infant mortality rate due

185X

to perinatal conditions among non-whites (1002.6 per 100,000 live births) is over twice that of whites (385.6 per 100,000 live births). However, there are some notable exceptions. For infant mortality due to congenital anomalies, the mortality rates are similar.

Mortality rates for infectious causes, especially as a cause of post-neonatal deaths, are much higher for non-whites. The death rate due to meningitis and encephalitis among non-whites (17.7) is over 7 times that for white infants (2.4). Though the number of deaths for any one of these infectious causes is small, they cause a disproportionate number of non-white post-neonatal deaths. They contribute to the three-to-one ratio in non-white to white post-neonatal mortality. This excess in potentially preventable deaths indicates the presence of a continued need for improved access to primary pediatric care services.

Table V presents several indicators of maternal and infant health for the state, its counties, and its major municipalities over 30,000 population. The infant mortality rate in the state varies from a low of 0.0 deaths per 1000 live births in Fairlawn Boro and Old Bridge, to 19.6 in Willingboro. There are five areas with infant mortality rates of 18 deaths per 1000 live births or over. Four cities (Atlantic City, Willingboro, Orange, Newark) and the other area is the remainder of a county with its major city removed (Cumberland County).

186X

Factors Associated with Excess Infant Mortality

To understand the reasons for this pattern of infant mortality in New Jersey, various characteristics of the state's maternal population and its medical care system must be analyzed. Many of the factors which are known to be associated with infant mortality, such as low birth weight and the lack of prenatal care are frequently reflections of poverty and its perinatal effects.

Low Birth Weight

Birth weight is the strongest predictor of infant mortality. The rate of infant mortality and incidence of developmental disability is lower in many European countries than in the United States or New Jersey, because these countries have fewer low birth weight infants. The high frequency of low weight babies among minority and disadvantaged groups in New Jersey is the major reason their infant mortality rates are twice those of the majority white population. Table VIa presents infant mortality rates for different birth weight groups of babies born in 1985. The 1,323 infants born weighing 1,500 grams (3 lb, 5 oz.) or less make up only 1.25 percent of the state's births, yet they account for 66 percent of the state's neonatal deaths and 46 percent of all infant deaths. Of these 1,323 infants, 493 (37.3%) died within their first month of life. If the delivery of half of these 1,323 premature births could be delayed until these infants weighed more than 2500 grams (5lbs.,8 oz.), the number of neonatal deaths would be decreased by 245 and the neonatal mortality rate would fall to 4.8 deaths per 1,000 live births. Table VIb shows

187X

the distribution of the percent of low birth weight and very low birth weight infants by county. Essex County ranks first in the greatest percentage of these very low birth weight and high risk infants. Essex County is followed by eight other counties which have very low birth weight rates in excess of the state's overall percentage of 1.25 percent.

Lack of Prenatal Care

Another factor important in reducing infant mortality which has a strong age and race distribution, is the early use of appropriate prenatal care. Table VIIa shows the percentage distribution by age and race of women beginning prenatal care in the first trimester, and of those who received no prenatal care at all. For all races, 78.2 percent of women began care in the first trimester. Adolescents, regardless of race have a much lower percentage beginning care during these early months. In 1986, 37.8 percent of adolescents under the age of 15 began care early. This percentage, has decreased from 1985 (45.3%) and 1984 (40.9%). The percentage of older adolescents receiving care in the first trimester in 1986 (52.4%) also decreased since 1985 (54.1%).

Black women, regardless of age, have a lower percentage (65.8%) beginning care in the first trimester. For all age groups, except adolescents, a lower percentage of black women began their prenatal care in the first trimester when compared to white women. For older adolescents the percentages are nearly equal, while for younger adolescents the percentage is higher for white adolescents.

In 1985 the percentage of women receiving no prenatal care during their pregnancy showed a sharp rise over previous years. This

increase has continued for 1986. In 1984 0.78% of all mothers received no prenatal care. In 1985 the percentage was 1.29 and in 1986 it was 1.34. Differences can be seen though, between 1985 and 1986. The percent for older adolescents also increased from 2.56 in 1985 to 3.55 in 1986 as did the percentage of women 20.24 receiving no prenatal care from 1.46 to 2.02. Percentages for all other ages declined.

Many of these younger women may delay seeking prenatal care due to lack of financial resources. The higher Medicaid eligibility criteria adopted in July 1987, and the increased rates of reimbursement available through HealthStart, adopted in April, 1988 may reverse the recent trend toward higher numbers of pregnant women delivering without antenatal care.

In 1985 Hudson County accounted for a significant portion of women with no prenatal care, ranking number one in the state for this parameter. During 1986 Passaic County rose alarmingly from eighteenth in the state for women having no prenatal care to number one. Table VIIb shows the counties ranked according to the percentage of mothers who received no prenatal care in 1986 as compared to 1985. The percent of women receiving no prenatal care increased in 3 of the 21 counties. Passaic County experienced the greatest increase (0.60 in 1985 to 5.43 in 1986). The other counties with increases above the state average were not as dramatic: Atlantic (1.06 in 1985 to 2.12 in 1986), Camden (1.89 in 1985 to 1.97 in 1986) and Salem (0.44 to 1.05). Hudson County experienced a decrease from 3.18 in 1985 to 1.78 in 1986 bringing it from first to fourth. Maternal and Child Health Services staff have begun efforts to understand the increase in women with no prenatal care in Passaic. Certificates of live births were checked to

189X

verify that the increase was not due to coding errors. The Maternal and Child Health Epidemiologist then met with the Paterson (Passaic County) Healthy Mothers, Healthy Babies Coalition to share the problem and attempt to identify possible causes. Coalition members cited two major factors that may be contributing to the problem. First, the county has a large number of illegal aliens who are hesitant to identify themselves to the health care system. Second, one of the five maternity hospitals in the county has curtailed services because of financial problems. The hospital has closed its prenatal clinic.

Adverse Social Environment

The social environment of the mother and her infant is another factor influencing infant mortality. For all races, 22.7 percent of births in 1986 occur to unmarried women (Table VIII). This percentage is unchanged from 1985. There is a strong age pattern to the percentage of births occurring to unmarried women. For the 10,168 births that occurred in 1986 to adolescents, (19 years or less) 78 percent of these mothers were unmarried. Also when these births are separated according to race, marked differences can again be seen. The percent of births to unmarried mothers is highest among black women (63.7%) and lowest for other non-white racial groups (6.2%). The percentage of births to unmarried women falls sharply for whites and other non-white racial groups as the age of the mother increases. For black women the decline is much more gradual and falls only to approximately 26 percent.

Adolescent Pregnancy

As part of the social environment one factor which should be considered in an effort to reduce infant mortality is excess

190X

fertility, that is, unwanted, unplanned, or medically contraindicated pregnancies. Table VIII shows the 1986 births of New Jersey according to the age, race and marital status of the infant's mother. Births to adolescent mothers are at high risk for infant mortality, and a broad range of social and developmental problems due in part to the immaturity of the mother, her frequently unstable home environment, and the poverty and lower educational achievement associated with early child bearing. In 1986, there were 10,168 births to women under the age of twenty. Teenage pregnancies represented 9.4 percent of the state's total births, which represents a small decrease from 1984 when adolescent births accounted for 10.3 percent of the state's births. This small decrease in the percentage of births to adolescent mothers is a result of the increased number of births to older women, and not a change in the adolescent fertility rates.

Table IXa shows that there are marked differences within the state when the state's fertility rate is broken down by age of mother, race, and county. There are some general patterns which can be readily seen. For all age groups, non-white fertility rates are higher than white. This difference is most striking in the very young adolescent, (10 to 14 years) where non-white females have nearly eight times the birth rate of their white peers. This difference also exists for older adolescents, (15 to 19 years) where there is a three fold difference. When the adolescent fertility rates for the state's major cities are examined, (Table IXb) there are five cities whose adolescent fertility rates for both young and older adolescents are three times the respective state rate (Atlantic City, Camden, New Brunswick, Trenton, and Paterson).

When broken down according to racial groups, the percentage of births from teenagers changes from 23.3 percent of births to black mothers to 6.5 percent for white mothers and finally to 3.0 percent of births to mothers of other non-white racial groups.

Table X shows the individual county birth rates for adolescent mothers age 15 to 19 years for 1977 and the years, 1980 through 1986. Since 1981 changes in the rates have been small. In 1981 the lowest fertility rate for adolescents 15 to 19 years of age was recorded. In 1986 the state's fertility rate for adolescents 15 to 19 years of age increased slightly in comparison to its previous 5 year average.

Progress in lowering the adolescent birth rate has been slow at both the state and county level. An analysis of county fertility rates for 1986 in comparison to their five year (1981-1985) average rate indicates that thirteen counties have decreased their rates in 1986, and eight had increased. Of the thirteen counties with lower rates in 1986, seven showed moderate improvements (a change of more than 5.0 %) while only three counties had a moderate increase. The southern counties of Atlantic, Salem, Cape May and Cumberland which have been targets for special action under the MCH Block Grant, all achieved reductions in their fertility rates. In 1986 both Salem and Cape May Counties saw a sizable decrease in the number of births to adolescents 15-19 years of age. The other two counties had less sharp decreases.

In an effort to address the many social, economic and public health issues associated with adolescent pregnancies and to begin to plan an approach to reduce the rate of adolescent pregnancies, an important step has been taken by the state. In January 1987

legislation was signed by the Governor to create an Adolescent Pregnancy Task Force. The Task force was created within the Department of Health and was charged to compiling and analyzing available data on the problem, and existing programs in New Jersey designed to address them, and to make recommendations on public policies to establish a comprehensive and coordinated approach to prevent adolescent pregnancy. The Task Force has completed its work and the final report is in preparation .for presentation to the Governor and Legislature.

SPECIFIC INTERVENTIONS TO REDUCE INFANT MORTALITY

Healthy Mothers - Healthy Babies

Based on the needs assessment done for the MCH Block Grant in FY85, and the priority ranking of municipalities, special projects were developed as a result of the Governor's Initiative to Reduce Infant Mortality. State appropriated resources were directed to meet the maternal and infant needs of target populations through the local planning effort of local Healthy Mothers / Healthy Babies Coalitions. State funds were also be used to support the development of high risk outpatient maternal-fetal medicine services at the perinatal centers serving the target communities. This initiative is now entering its fourth year. Table Vb shows infant mortality rates for HM/HB cities compared with the remainder of New Jersey. From 1985 to 1986 the infant mortality rate in HM/HB cities dropped 10.6% compared with 8.9% for the rest of the state. The neonatal portion of that rate decreased 18.3% for HM/HB cities compared with 7.9% for the rest of New Jersey. Though there has not yet been any improvement in

the low birth weigth rates for these cities, there has been gains in improved access to prenatal care. A point of concern is the continued rise in the very low birth weight rate in these cities, and an increasing fetal mortality rate.

HealthStart

The implementation of the State's SOBRA expansion of Medicaid services for pregnant women and childrn upto two years of age began with the expansion of eligibility on July 1, 1987 and the adoption of the HealthStart regulations in February 1988. There are currently 59 certified maternity service providers, and 111 certified pediatric service providers. All MCHS funded prenatal and pediatric primary care providers are required to become HealthStart certified providers. THe MCH funded services will also be participating the the HealthStart Evaluation process and a common data system is bering developed. It is hoped that through this joint initiative the prenatal and pediatric services availalbe to women and children below the poverty level will be expanded, and the early use of prenatal care and preventive pediatirc services will increase.

Perinatal HIV Infection

There is a growing Maternal and Child Health issue which has to be incorporated into the state's needs assessment which does not significantly affect the state's infant mortaltiy rate, this is perinatally transmitted HIV infection and pediatric AIDS. AIDS contributes only slightly to infant mortality. In 1986 there were 6 postneonatal deaths attributed to AIDS (Table IV a,b,c). This small contribution to deaths under one year of age cannot mask the

seriousness of infection to maternal and child health.

In New Jersey the major route for pediatric transmission is parental risk factors. Only 9 percent of pediatric AIDS cases in New Jersey are attributed to exposure to contaminated blood products. Nationally 17 percent of pediatric cases are attributed to this route of infection. Table XI shows the distribution of reported AIDS cases in women by county. Of the non-prisoner female cases, 81 percent are in the primary reproductive years; 29 percent are 20-29 years of age and 53 percent are 30-39 years of age. Eighty percent of the cases among women in their reproductive years occured in four counties (Essex, Hudson, Passaic, Union). Over half of these cases came from Essex County. It is clear from this distribution that the major focus of the epidemic is the northern metropolitan counties.

The transmission categories for females with AIDS is based on intravenous drug use. Intravenous drug abuse (IVDA) was attributed to be the source of infection in 65 percent of female cases, and 26 percent due to heterosexual contact. Much of the heterosexual spread of HIV infection is because of sexual involvement with a IVDA male.

Where as the homosexual AIDS cases are 73 percent white nationally, the perinatally acquired cases of AIDS are 62 percent black, 25 percent Hispanic, and only 12 percent white. In New Jersey the minority distribution of the disease is even more marked. New Jersey's pediatric AIDS cases are 60 percent black, and 21 percent Hispanic. This urban, minority focus to pediatric AIDS in New Jersey is similar in several respects to the broader issue of low birth weight and infant mortality. Though there are many aspects to pediatric AIDS which will require specific HIV focused prevention activities, the pattern of infection and therefore the needs for

services among at risk women and their children follows the distributional pattern of infant mortality and low birth weight.

Prioritization

Because the resources available are not sufficient to address all of the state's documented perinatal problems, the Department of Health targets its efforts to improve perinatal health through the identification of high risk groups within the state's maternal and infant population. To assist in the allocation of these limited resources, a priority ranking formula has been developed by the Maternal and Child Health Services. This formula ranks the state's major municipalities and counties according to their three year weighted standardized rates of infant mortality, perinatal mortality, adolescent births, low birth weight and the number of low income women and children.

This ranking, shown on Table XII, provides a score of zero to the state average rate for these indicators. Areas that have scores better than the state average for these indicators are scored lower on the scale and are given a score with increasingly negative value. These areas are not shown on this table. As areas exceed the state's average for these indicators their score increases.

There are twenty six municipalities with scores in excess of the state's average and they are presented in this table according to their ranking for FY1989. For comparison purposes the rankings for FY1988 and FY1987 are also shown. The rankings for the three years show the relative stability of the areas of increased need. Though the ranked order for individual cities has changed over the three years, the list of cities has remained quite constant. Of note in the

FY1989 rankings is that Camden City has again replaced Atlantic City as the city with the highest score. Atlantic City on the other hand has continued at its new position as third on the ranking. Also Irvington, which moved from twelfth to ninth on the list in FY1988 has now moved to seventh.

PART II

SECTION II

CHILD HEALTH NEEDS

198x

INTRODUCTION

One of the specific programmatic objectives for the FY88 MCH Block Grant was the organization of a separate Child Health Program, which will focus specifically on the primary health care needs of the state's children. This was achieved in FY88. As part of that program development processin FY89, a revised process for the assessment of child health needs will be created. The needs assessment that is included in this document is not structurally revised, though it reflects the most recent data now available.

Needs Assessment

Based on the 1980 census there are approximately 2.38 million children under the age of 21 in the state. Twenty percent of the state's children are under the age of five and forty-seven percent are between the ages of 5 and 15. Though 17 percent of the state's overall population is non-white, 27 percent of the children under the age of five, and 25 percent of the children age 5 to 15 belong to minority racial groups. As can be seen in Table XIII, 22 percent of the children in the state reside in the two North Jersey counties of Essex and Bergen. In Essex County 56.6 percent of the children are non-white, while in Bergen County only 10.3 percent of children are minority children. The high density of children in the northern urban areas of the state is contrasted with the state's seven rural southern counties, which combined together have only the same 22 percent of the childhood population of the state. This distribution of the children in the state follows the pattern of the general population, where 89 percent of the state's population resides in the state's northern urban areas.

Children in Poverty

A major factor which affects the health and welfare of children is the stability of their family structure and the ability of that family's financial resources to meet their needs. According to the 1980 census, 15 percent of the children in New Jersey were being raised in families below the poverty level. More than 117,000 families in the state had children under the age of 17 and were living in poverty. Within this group of poor families, 63,000 (54%) had children under the age of 6. In addition, 80,000 of these families in poverty (68%) had a female head of the household.

In 1981 there were 351,000 children under the age of 21 who received Medicaid coverage because their family qualified for Aid to Families with Dependent Children (AFDC). As of March 1988, this number had decreased to 260,554. The number of children eligible for Medicaid in 1988 is 74.3% of the number eligible in 1981, and 89% of the number eligible in 1986.

Table XIV shows the number of children that were eligible for Medicaid coverage by county as of February 1988. Though 11 percent of children statewide are sufficiently poor to be covered by this program, 25.8 percent of the children in Essex County and 20 percent of children in Cumberland and Hudson Counties are covered by Medicaid. This is in contrast to Bergen, and Morris Counties where 2 percent or less of children qualify for the program. The distribution of children eligible for Medicaid services provides a clear pattern of the distribution of children living in poverty. The need to provide for greater access to primary care for poor children has been recognized by the state. The expansion of the Medicaid Program to provide coverage to children up to age two whose family's income is

under the poverty level has occured. In addition the pediatric component of the HealthStart is now providing expanded preventive health services to children under the age of two. The number of children under one year of age enrolled in Medicaid has begun to increase slightly after several years of steady decline. This increase is attributed to the expanded eligibility.

Changes in Family Structure

The changing composition and circumstances of the family in New Jersey must be recognized as having a major impact on the needs of children. These changes directly affect the social environment of the child, but indirectly affect the medical needs as well. In New Jersey, in 1980, there were more than 205,000 households with children headed by a single parent. Eighty-eight percent of these households were headed by a woman. Based on Census figures for the number of children in these families, it is estimated that 400,000 children, or 22 percent of the state's children under the age of 17 are raised in single parent households.

Two additional factors which reflect the changes in the way children are raised are the number of working mothers, and the number of children in organized day care settings. In New Jersey in 1980 more than 53 percent of the mothers with children under the age of 17 were working. Of these working mothers, 155,000 (16%) had children under the age of six. This increase in the number of working mothers is reflected by the number of children in day care settings. According to the 1980 census, 90,000 children over the age of three were in organized day care settings. This represents one half of the preschool children over the age of three in the state.

Health Status

Mortality

A major achievement in public health over the last century has been the reduction of childhood mortality. In 1986 in New Jersey, the mortality rate for children ages 1 through 4 years was 46.8 per 100,000. This represents an increase from the rate in 1984 (43.6), but still below the mortality rate in 1982 (53.1). The mortality rate for children 5-14 years of age in 1986 was 23.9 per 100,000,essentially unchanged fron the rates of the past two years. The mortality rate for 15-24 year olds in 1986 (75.7) was also unchanged from that experience in the two previous years. Because of the low rate of mortality among children, routine vital statistics are an insensitive measure of major aspects of the health needs of children. Despite the limitation, a review of the age specific causes of death shown in Table XV indicates the deaths from motor vehicle, and other injuries constitute the major causes of childhood mortality. The individual cause specific rates for 1986 reamin the same as those of 1984.

The identification of effective prevention strategies has been the focus of attempts to address these causes of mortality. There have been several major preventive efforts begun to reduce morbidity and mortality due to injuries. In 1983, legislation was enacted requiring the use of child restraints or safety belts for all children under 5 years of age when they are being transported in motor vehicles. This approach was extended to all front seat passengers regardless of age in 1985. The establishment of a statewide poison control center has provided an effective method of education,

information and intervention for accidental poisonings with over 55,000 calls being received each year.

Morbidity

One measure of serious morbidity in children is the rate of hospitalization. This is not a pure measure of the incidence of serious medical conditions, since there are many social and economic factors which may influence the physician's decision to hospitalize a child. However, in aggregate, the data does provide some general insights into the pattern and causes of hospitalization in children.

Table XVI shows the number and rate of hospitalizations in New Jersey in 1980 for different age groups of children by race. This table also shows comparable national hospitalization rates. The overall admission rates for each age group show that children age 1 to 4 in New Jersey, are hospitalized at a greater rate than expected based on national rates. This fact is of note since all other children in the state have rates lower than national figures. The difference in hospitalization rates for children age 1 to 4 is due in a large part to the marked difference in hospitalization rates for white and non-white children. There are higher rates of hospitalization across all age groups for non-white children, but in no other age group is the difference as marked as it is for children 1 to 4 years of age.

When the admissions are analyzed according to the diagnosis responsible for the hospitalization, as shown in Table XVII, there are slightly different patterns by age groups. Respiratory conditions have the highest rates of admission for children age 1 to 4 and 5 to 14 years of age, and the second highest in adolescents age 15 to 17.

As children get older, admission rates for other conditions decrease and admissions for treatment of injuries become the most common cause for hospitalization. In absolute terms the hospitalization rates due to injuries are relatively constant over all the age groups.

Communicable Diseases

Table XVIII presents age specific occurrence of selected communicable diseases in children for 1987. The number of measles cases in 1987 (39) is a marked decrease from the number of cases in 1986 (881). This reflects the end of the major outbreak of measles in the three county area of Passaic, Hudson and Essex Counties. The number of mumps cases, however, is increaed slightly from 51 in 1986 to 76 in 1987.

Table XIX shows the immunization levels for school age children in public schools for the 1986-87 school year. The overall compliance rate of 98.4 percent exceeded 95 percent target level. This represented an overall improvement in statewide immunization levels, with improvements occurring in all but one county. The immunization levels for school age children in private schools also improved (98.5 vs 97.8%) and exceeded 95% in all but one county (Hunterdon). The marked change in the percentage of private school children fully immunized in Hunterdon County (84.4 % in 1986 vs 96.3 in 1985), is the result of the small number of children involved. It is based on only 17 children not being appropriately immunized.

There was also an improvement in the percent of preschool children completely immunized. In 1986-87 all counties had preschool immunization rates above 85 percent, and all but one were over the 90 percent level. This is in comparison to the 1985-86 school year when three counties were below 85 percent and two additional ones were just

fractionally above that level. This improvement reflects the efforts made to improve immunization levels following the measles outbreak, and to counter the anticipated effects of the vaccine price increases. Part of that effort was the Child Health Program's regional training and inservice program for local public health nurses who provide child health services

Injuries

A review of the 1986 Age Specific Mortality Rate for Children indicate that the counties of Warren (114), Atlantic (90), Essex (60.9) and Ocean (59) were significantly higher than the state rate 46.8 per 100,000 for 1 through 4 year olds. Also significantly above the state rate 23.6 per 100,000 for children 5-14 years of age were Camden (32.4), Passaic (37.3) and Atlantic (37.1) counties.

Accidental injuries were the only cause of death in children 1-4 age in Warren County with other accidents 4 times the motor vehicle rate. Both rates were the highest in the state. In Hunterdon, Salem and Sussex Counties, accidents were the only cause of death in children 5-14 years of age. In Hunterdon County, Motor Vehicle accidents were the only cause of death. In Sussex County, deaths from motor vehicle accidents accounted for twice the rate for other accidents, while in Salem County, the motor vehicle and non-motor vehicle rates were equally distributed.

Since motor vehicle accidents include E810-825 and other accidents include E800-809, 826-929, more information will be needed to specifically target the problem and to develop intervention strategies. Staff of the Accident Prevention and Poison Control Program will be working with the staff of the divisions of Epidemiology

and Disease Control and Research, Policy and Planning in the development of injury control activities in the department and to assist in developing a more detailed analysis of the pediatric component of injury in the state.

Lead Poisoning

The heavy metal lead is a neurotoxin which widely contaminates the world of young children, and in particular, is highly concentrated in the paint of older homes. The developing nervous system of children, especially those who are malnourished or anemic, is particularly sensitive to lead's toxic effects. In 1986, for the first time in recent years, a case of serious lead encephalopathy was reported. This shattered the belief that serious symptomatic lead poisoning was a thing of the past in New Jersey. In 1987, two serious lead encephalopathy cases were reported in one of our project cities. Both cases reflect the tragic consequences when private providers continue to omit lead screening from their on-going primary care service delivery, even in high-risk communities.

Table XX shows current information on the known number of children screened and found to have elevated blood lead levels. For the State, excluding residents in the state schools for the mentally retarded, 2.3 percent of the 58,798 children screened have had elevated levels of lead in their blood.

As shown in the table, a few municipalities have very high positivity rates. This is generally due to only testing clearly identified high risk children. However, in cities where more general screening is performed, unacceptably high rates still exist. The cities of Irvington and Newark which screen a significant number of

children, identified 8.5 percent and 8.6 percent as having elevated blood lead levels. Other cities such as Orange, Trenton and Paterson have rates of 3.5 percent or higher. Table XXI evaluates progress toward meeting our stated objectives of insuring that identified children receive appropriate medical management in a timely manner, and that environmental clean up of the child's environment occurs in accordance with state laws and regulations. There were 1664 children with elevated levels of lead that were under active case management, and in 86% of the cases the follow-up was current. Through the efforts of the staff at the funded projects all of these objectives of identified cases were met.

The Department of Health revised the Minimum Standards of Performance for Local Boards of Health and they were approved by the Public Health Council in December 1986. Childhood Lead Poison Prevention is a core activity under these requirements. The department has developed a community needs assessment of all 567 municipalities and has prioritized them from the highest risk (Priority I) to the lowest risk (Priority III). The total number of Priority I cities is 69. Using the new prioritization criteria, 100 percent of the high risk cities have begun some screening for lead poisoning. However, only about one-third of the estimated 155,000 at risk population in these cities are being screened each year. Table XXII lists the Priority I cities with the number of high risk children under 5 years of age living in each, as well as, the communities hazard score.

The Accident Prevention and Poison Control Program has prepared a draft revision of the Childhood Lead Poison Prevention regulations

for the State Sanitary Code. The new regulations require testing of every child determined to be at high risk. Previous rules detailed only investigation and abatement requirements. The new rules, in addition to requiring investigation and abatement, establishes criteria for screening of children, as well as, specifying the frequency for and methods of testing and follow up consistent with the new Centers for Disease Control's recommendations. The regulations must be adopted by the Public Health Council before they go into effect.

The program has also provided to the physicians of New Jersey a "Revised Algorithm for Evaluation and Management of Asymptomatic Children Screened for Lead Poisoning" which is designed to be used in conjunction with the free phone consultation service that is available from physicians of the New Jersey Lead Consortium who helped prepare the Algorithm. The program developed a manual for the safe removal of lead paint and developed a brochure titled "Planning to Renovate - Beware Lead Poisoning" during the year.

Dental Health

Dental disease is probably the most common health problem in the nation and the state. Except for oral cancer, dental health issues are neither dramatic nor life threatening. As a result, the public health importance of dental disease, especially among children, is frequently not appreciated. Poor nutritional habits among children increase the amount of dental disease, and in later life leads to the loss of dentition.

National surveys conducted in 1980 on the status of the oral health of children have found that on the average a 15 year

old child will have 4.94 decayed, missing or filled permanent teeth. A special epidemiologic survey sponsored by the Dental Health Program shows that 15 year old children in New Jersey have 4.07 decayed, missing or filled permanent teeth (Table XXIIIa), which is a decrease from 1980. However, the study also showed that children from high risk areas have a larger percentage of decayed teeth and fewer filled teeth than would be expected from national or regional rates (Table XXIIIb). These findings indicate the need for both preventive interventions to reduce the number of damaged teeth, and additional access for children to primary dental care.

In the area of childhood caries prevention, the Dental Health Program has taken a major step in providing fluoride mouth rinse programs to school children in areas without fluoridated public water supplies. As can be seen in Table XXIIIb, 80,048 children in 386 schools are currently receiving services from this cost effective preventive program. Although the number of children has increased by 12,000 (7%) during the 1987-1988 year, the table shows that more still needs to be done since the percent of schools participating is small (21%) and several urban counties with children from high need areas have only very limited participation in this preventive program.

PART II

SECTION III

CHILD with SPEICAL HEALTH NEEDS

CHILDREN WITH SPECIAL HEALTH NEEDS

Overview

In 1985, 9,153 children were newly registered with Special Child Health Services as either having or being at risk for disease or disorder requiring special health care. Of the 9,153 children, 6,504 were infants under one year of age. The average number of diagnoses for children registered was 2.05 for infants and 1.98 for all children. (Table XXIV)

Of the 9,153 new registrants, 70% were children with either congenital anomalies or certain conditions originating in the perinatal period. The next highest numbers of children registered were those with a primary diagnosis of mental disorders, primarily mental retardation, and diseases of the nervous system and sense organs, a majority with hearing impairments. (Table XXIV)

A total of 769 children were newly registered with significant congenital anomalies, most of whom will require ongoing costly care; of this number, 612 were infants. 1,550 children were registered with potentially chronic diseases/disorders other than birth defects; of this number, 180 were infants. (Table XXV)

A comparison of SCHS program data for 1981 and 1985 shows that the number of infants registered with the program has increased by more than 300%, from 2,158 to 6,504. Infants with congenital anomalies account for a major portion of this increase; 431 were registered in 1981, 2,300 in 1985. Infants registered as being at risk because of conditions originating in the perinatal period have increased from 979 to 3,481. (Table

XXVI) These increases represent intensive efforts to improve reporting and provide for early identification of children in need of special health services.

Of these 9,153 children with special needs newly registered in 1985, 47.63% had private insurance, 19.36% were covered by Medicaid, 12.84 had unspecified coverage and 13.18 had no coverage; type of coverage for 6.97 as unknown. (Table XXIV)

Need for Early Intervention and Prevention Services

Newborn Screening

1. Biochemical Disorders

State law requires that all newborns be tested for phenylketonuria, hypothyroidism and galactosemia. Abnormal results are reported to the SCHS-Newborn Biochemical Screening Program which is responsible for locating and referring for treatment all infants with abnormal results. In 1987, 106,000 infants were screened for these conditions, 4 infants were diagnosed as having PKU, 28 had hypothyroidism and 3 had galactosemia. As a result of program follow-up and tracking, all infants were receiving appropriate care within 5 weeks of diagnosis.

In 1987, 172 children with PKU were receiving specialized care at one of two treatment centers partially supported with program funds. All children with PKU who are New Jersey residents are eligible to receive special formula through the treatment centers. In 1987, 90 children were being maintained on special formula. This number is expected to increase since children with PKU are now maintained on formula

for an indefinite period of time, strict dietary control of phenylalanine intake is no longer stopped at age 5 years. Legislation was enacted which amended the newborn biochemical testing mandate to include treatment for affected individuals. In addition, attempts are being made to track women with PKU who are of childbearing age to provide counseling and place them back on restricted diets to prevent mental retardation and congenital defects in their infants. A formal system for tracking of girls with PKU must be established.

2. Sickle Cell Disease

Recent clinical research indicates that early treatment of infants with sickle cell disease, particularly penicillin prophylaxis initiated during the first 2 to 3 months of life, can significantly decrease morbidity and mortality. The promising results of these studies as well as the demonstrated effectiveness of comprehensive sickle cell treatment centers in improving the quality of life of affected children has provided an impetus to institute newborn screening for sickle cell disease.

The Department of Health has elected to screen newborns for sickle cell disease, follow-up for identified cases will be in place and primary and specialized care for all affected children will be available and accessible. Since approximately 20,000 infants born in NJ each year are identified in vital records as "black", it can be estimated that when newborn screeninig is instituted, at least 75 babies with sickle cell disease (hemoglobin SS or SC) will be identified. In addition, there are approximately 700 to 800 children (0 to 21 years of

age) with sickle cell disease residing in New Jersey. An informal survey of pediatric hemotologists in the state indicated that about 250 to 300 children with sickle cell anemia are currently under the care of these specialists. Some patients may be obtaining comprehensive care in centers in neighboring states. Others may not have access to appropriate care. Clearly, New Jersey children with sickle cell disease will benefit from in-state comprehensive medical services.

3. Risk for Hearing Impairment

To reduce the incidence of developmental delay and learning disabilities due to undetected hearing loss, Special Child Health Services, in conjunction with the state's maternity hospitals, screens all newborns for conditions that may put them at risk for hearing impairment.

In 1987:

:101,000 infants were screened for risk conditions associated with hearing impairments;

:5,471 or 5.4% wre identified with risk conditions present prior to hospital discharge;

:894 or 22% (9 months reporting period) responded to the program's follow-up efforts;

:40 or 4.4% of the responders to program follow-up were identified as hearing impaired.

Based on the incidence of hearing impairment in the high risk group which responded to follow-up in 1987, the program could potentially identify, before 1 year of age, 100 hearing impaired infants annually.

High Risk Follow-up

To assist in the early identification of infants with developmental delay and who might benefit from the early intervention programs supported by the Department of Education, follow-up programs are supported at the state's designated Level III perinatal centers.

:In 1987, 4,748 infants were discharged from a Level III Neonatal Intensive Care Units;

:3,489 or 73% of infants discharged from a Level III NICU met the criteria for high risk infant follow-up service;

:2,924 or 64% of high risk infants received at least one follow-up visit;

:5,020 follow-up visits were conducted;

:6,800 children between birth and 3 years of age met the criteria for high risk infant follow-up service;

:1,645 or 36% of the children between birth and 3 years of age who met the criteria for high risk infant follow-up returned for at least one visit beyond the initial post discharge visit.

Approximately 36% of the infants who meet the high risk criteria fail to return for even one follow-up visit. Additionally, 64% of identified high risk infants do not return for follow-up services beyond the initial visit.

Birth Defects Monitoring

Rates for thirteen specific (or "sentinel") conditions, falling under seven distinct body systems, are displayed in Table XXVII. In addition to New Jersey, there are two other major reporting systems for which rates of the specific conditions are

summarized in the table. One system is the Birth Defects Monitoring Program (BDMP), a collaborative effort involving The National Institute of Child Health and Human Development, the Centers for Disease Control, the March of Dimes Foundation, and the Commission on Professional and Hospital Activities. The other system providing published rates is the Metropolitan Atlanta Congenital Defects Program, jointly directed by the Centers for Disease Control, The Georgia Mental Health Institute, and Emory University School of Medicine.

The rates reported by the BDMP are shown separately for the Northeast and the entire United States for each of two different time periods: (a) the 1970-73 base rate period; and (b) all of 1980. Rates from the Atlanta system cover the entire period from 1968 to 1979.

With two exceptions, New Jersey's rates of reporting the selected diagnoses are strikingly similar to those for the Northeast in 1980 as reported by BDMP. The two exceptions involve ventricular septal defects and patent ductus arteriosis where the rates for New Jersey are considerably lower than thse reported to the BDMP for the Northeast.

Genetic Testing and Counseling Services

In 1986, more than 8,000 families received genetic testing and counseling services, more than half (4,808) received prenatal services. The following tables show race and ethnicity of these families and types of health care coverage.

Race, Ethnicity of Families Receiving Services

	General Counseling		Prenatal Services	
Black	503	(15%)	661	(14%)
Hispanic	463	(13%)	500	(10%)
White	1,603	(46%)	2,944	(61%)
Other & Unknown	898	(26%)	703	(15%0
Total	3,467	(100%)	4,808	(100%)

Health Care Coverage

	General Counseling		Prenatal Services	
Third Party Insurance	1,944	(56%)	3,053	(63%)
Medicare, Medicaid, Service Clinic	481	(14%)	254	(5%)
SCHS Sliding Fee Scale	104	(3%)	221	(5%)
Self Pay	476	(14%)	380	(8%)
Unknown	462	(13%)	900	(19%)
	3,467	(100%)	4,808	(100%)

Specialized Treatment Services

Financial Profiles of Children with Special Needs

1. Family Incomes

Of the children served by the SCHS network in 1987, the following statistics were reported for estimated income:

:43% at or below poverty level

:15% poverty to 150% of poverty

: 7% 150% of poverty to 200%

:35% over 200% of poverty level

According to the 1980 census, 15% of the children in New Jersey were being raised in families below the poverty level. However, of the children identified in 1985 as being in need of special health services, 43% were being raised in families below the poverty level.

217X

The following Table shows national data (Hobbs, Perrin and Ireys, 1985) for children with functional disabilities compared to data on children registered in 1985:

Type of Coverage	National	SCHS Registry
Private Insurance	61%	47.63%
Public Programs	28%	19.36%
No Coverage	10%	13.18%
Unspecified	--	12.84%
Unknown	--	6.97%

It is generally assumed that the last two categories above (unspecified/unknown) are composed primarily of children with no insurance coverage. Thus, although Hobbs, et al report 10% of children without coverage, in New Jersey, as much as 30% of children with special needs may be without insurance. Children registered with SCHS are generally poorer and have less insurance coverage than one would expect based on national data.

2. Payment Sources for Children Served

The purpose of most health insurance is the protection against risk of unpredictable and episodic medical expenses rather than provision of comprehensive health care. Such insurance, which is primarily medical insurance, is not intended to cover the broad range of services often required by chronically ill/disabled children (Hobbs, et al.). This theory is supported by data on the payment sources for children served by the SCHS network:

Payment Source	%
Private Coverage	34.0
Medicaid	30.0
Self Pay	20.0
No Coverage (SCHS fee scale)	

Although children registered with SCHS tend to be poor and have less private insurance, even those children with private insurance (47.63%) do not have adequate coverage (34% covered) for required comprehensive care.

Children Requiring Ongoing Specialized Care

Based on national prevalence rates, 233,000 children in New Jersey, under 21 years of age, could be expected to have a moderate to severe handicapping condition or chronic illness requiring comprehensive quality health care services (Table XXVIII). Of this total, 23,000 could be expected to have severe asthma, 36,592 could be hearing impaired, 57,175 would be mentally retarded, 16,009 would have a congenital heart disorder, 4,117 would have diabetes mellitus, 8,004 seizure disorders and 1,029 would have neural tube defects.

Children Served by SCHS Regional Network

Special Child Health Services provides fiscal support to a statewide network composed of twenty-two agencies providing specialized health care services. These services are available and accessible to all chronically ill/handicapped children in New Jersey. There are three regional tertiary centers that provide comprehensive, pediatric subspecialty services. Comprehensive developmental and habilitation evaluation and treatment services are available at thirteen regional sites and high risk infant follow-up services are provided at nine sites throughout the state. These agencies are required to bill all third parties for services and to make services available on a sliding fee scale basis to families without health insurance.

In 1987, approximately 26,000 chronically ill/handicapped children were served by this statewide network.

Unmet Needs

233,000	children 0-20 in need of special health care
-26,000	children served by SCHS funded agencies
207,000	children unknown to the statewide network

The SCHS funded network is serving only about 11% of the estimate population in need of specialized health care. Census data reveals that 65% of all children are members of families whose incomes are less than 200% poverty. Therefore it would be expected that 151,450 children with special health needs are living below 200% of poverty. By definition, these families have very limited disposable income. A number of recent studies have documented that out-of-pocket expenses for families with chronically ill/handicapped children are overwhelming. It is assumed that many of these 151,450 children are receiving fragmented, crisis-oriented services rather than comprehensive continuous, preventive care.

Community Based Services

In an effort to assure the provision of coordinated comprehensive services for handicapped and potentially handicapped children, Special Child Health Services partially supports 21 county case management units. These units provide case management services to newly registered children, new referrals and ongoing clients. Of the more than 100,000 children, birth through 21 years of age, currently registered with the program, over 20,000 actively received case management servies in 1987, of this number more than 7,900 were newly referred cases and more than 5,500 children had individual

service plans (ISP's) developed. While an effort is made to contact each newly registered or referred case, as the above numbers indicate, this addresses only part of the total needy population. Since case management is an ongoing process for most children until age 21, the numbers of clients and demand for case management services are increasing yearly as new groups of children are added to the existing pool.

Special Child Health Services Case Management Units also provide intensive services to children on Medicaid's Model Waiver Programs and the AIDS Community Care Alternative Program (ACCAP). There are currently 95 children being followed of which 29 are on ACCAP Waivers, this number is projected to increase significantly.

Pediatric Aids

Nationally, children account for 1.6% of the total number of AIDS cases reported (908/507024); in New Jersey, 3.3% of the cases are children (129/3899), 91% of the children with AIDS in New Jersey have parents with or at risk of AIDS compared to 77% of the children in the US. Of the 129 children known in NJ in March 1988, 59% were black, 21% hispanic and 19% were white.

Table 1

Children Reported to NJ Department of Health by Racial/ Ethnic Groups, March 1988

Racial/Ethnic Group	Children US	%	NJ	%
White, Not Hispanic	207	(23)	25	(19)
Black, Not Hispanic	490	(54)	76	(59)
Hispanic	202	(22)	27	(21)
Others and Unknown	9	(1)	1	(1)
TOTAL	908	(100)	129	(100)

As with reported cases of adults with AIDS, a majority of children with AIDS are located in the northeast corner of the state, especially in Essex, Passaic and Hudson counties. In a presentation at the Fourth National Conference on Pediatric AIDS held in New Jersey, Newark (Essex County), Paterson (Passaic) and Jersey City (Hudson) were cited in the top ten cities for reported incidence of AIDS in children.

Quality Assurance and Special Studies

Newborn Screening

In June 1987, an expert panel reviewed and evaluated the New Jersey Program to Screen Newborns for Biochemical Disorders. Special Child Health Services and the Division of Public Health and Environmental Laboratories cooperatively organized this meeting. The purpose of convening the advisory panel was to obtain expert consultation from impartial, outside reviewers who have knowledge and expertise in all aspects of Newborn Biochemical Screening. Funding for three nationally recognized expert consultants was provided by the Bureau of Maternal and Child Health, HRSA, DHHS. Although the department got a positive overall review, several major recommendations were made:

1) Initiate computerization as soon as possible.
2) Timing of specimens should agree with AAP recommendations.
3) Strongly consider sickle cell/hemoglobinopathy testing.
4) Institute computerized periodic program evaluations.
5) Define and document functional end points of responsibility for laboratory, follow-up and practitioners.

The computerization of newborn screening is expected to be complete by January 1989. Also, by January 1989, testing for sickle cell will commence.

Peer Review Initiative

The Peer Review Committee composed of representatives from the funded SCHS Child Evaluation Centers/CEC's continued to work on a self evaluation document to be used by the programs.

It is anticipated that the document will be ready for distribution and feedback from all the CECs in the Autumn of 1988.

Meanwhile, the committee has developed a plan to rotate membership and will be inviting new members to participate in the committee as the year progresses.

Several future projects are being considered, including scheduling of speakers to present topics of special interest to the CEC administrators and other representatives.

Population Based Surveillance and Etiological Research of Adverse Reproductive Outcomes

In May 1986, SCHS received funding from the Centers for Disease Control to develop and apply appropriate methodology to assess relationships between environmental exposures to toxic waste and adverse reproductive outcomes in New Jersey. The objectives of this five year project are:

1) To enhance the Department of Health's capability to conduct surveillance of adverse reproductive outcomes and associated etiological research by combining information from a variety of sources to form a large, population-based system. This will be done by

223K

establishing rates for specified adverse outcomes within small, well-defined geographic units.

2) To quantify the characteristics of the environmental risks in the geographic units, specifically focusing on describing any known Superfund sites and other sources of toxic waste exposures found within them.

3) To study the correlations between these toxic waste sites and adverse reproductive outcomes through the analysis of dat gathered on geographic units.

4) To conduct detailed etiological studies of adverse reproductive outcomes, specifically focusing on possible relationships to toxic wastes and other sources of exposures to hazardous substances.

5) In collaboration with CDC, to report on the development of the surveillance system and the findings that result to the widest possible audience.

The project is a cooperative agreement between SCHS and CDC; Maternal and Child Health Service, the Division of Occupational and Environmental Health of NJDOH and the New Jersey Department of Environmental Protection (NJDEP) are also cooperating participants in the project.

224K

PART III

SECTION I

STATEMENT OF GOALS AND OBJECTIVES

GOALS AND OBJECTIVES

The specific objectives for the Maternal and Child Health Block Grant during Federal fiscal year 1989 are:

I. MATERNAL AND CHILD HEALTH SERVICES

A. Maternal and Infant Objectives

1) Reduce infant mortality so that by 1990 the state's infant mortality rate will be no more than 9 deaths per 1000 live births. In 1986 the state's infant mortality rate was 9.8 deaths per 1000 live births.

2) Reduce minority infant mortality so that by 1990 the state's non-white infant mortality rate will be no more than 12 deaths per 1000 live births. In 1986 the state's non-white infant mortality rate was 18.0 deaths per 1000 live births.

3) Reduce neonatal mortality so that by 1990 the state's overall neonatal mortality rate will be no more than 6.0 deaths per 1000 live births, and its non-white neonatal mortality rate will be no more than 9.0 deaths per 1000 live births. In 1986 the state's overall neonatal mortality rate was 6.5 deaths per 1000 live births, and for non-white infants the rate in 1986 was 11.4.

4) Reduce the low birth weight rate so that by 1990 the state's low birth weight rate will be no more than 5 percent. In 1986 the state's low birth weight rate was 6.7 percent.

226X

5) Reduce maternal mortality so that by 1990 the direct maternal mortality ratio will not exceed 5 maternal deaths per 100,000 live births. In 1986 the direct maternal mortality ratio was 8.3 deaths per 100,000 live births.

6) Reduce adolescent fertility so that by 1990 the identified target counties will have reduced their birth rates for women 10-14 and 15-19 years old by 20 percent. The target counties are: Cumberland , Atlantic, Cape May, Salem and Passaic.

Activities that will be undertaken to achieve these objectives are:

a) The Maternal and Child Health Program will support high quality prenatal care services in areas of high maternal and child health need. The areas for need have been outlined in Section I. As part of the Governor's initiative to reduce infant mortality, eight Healthy Mothers/Healthy Babies Coalitions will be maintained covering the 10 highest need cities. These coalitions will assist in identifying community needs, and developing community based perinatal services to address needs in community education and outreach, family planning, prenatal and infant care services.

b) In conjunction with HealthStart expanded services will be provided to Medicaid covered women at all funded prenatal services. The

Maternal and Infant Health Program wil initiate new prenatal services in at least two high priority areas not now covered under HealthStart.

c) Outreach and referral services will be supported to encourage early utilization of prenatal, family planning, and child care services.

d) Foster and encourage continued professional education and cooperation for those involved in the provision of perinatal care through the development of a regionalized system of perinatal services. This will be done as part of the State's health planning process, and in conjunction with the Robert Wood Johnson Foundation initiative to improve perinatal services.

e) In conjunction with the Department's Center for Health Statistics, provide information on the status of maternal and infant health, and other data related to overall reproductive health.

i) The MCH Program in conjunction with the New Jersey Medical Society will review all maternal deaths and will undertake the selected review of fetal and infant deaths on a statewide basis.

ii) Area and statewide infant and perinatal mortality rates will be monitored on an ongoing basis,especially in areas of high mortality.

iii) the process of linking infant birth and death certificates will be continued and the resulting information distributed to perinatal centers to improve perinatal care.

f) Assure that the target population for the Women, Infant and Children Supplemental Feeding Program (WIC) is effectively served. The WIC Program in conjunction with the prenatal services funded through the Maternal and Infant Health Program will make special effort to provide services to 100 percent of eligible pregnant women and infants.

g) In conjunction with the Division on AIDS and with funding from the Centers for Disease Control, implement HIV risk assessment, counseling and testing program in all of the family planning and prenatal services funded by the Department. In conjunction with the Centers for Disease Control implement a Perinatal AIDS Prevention project in Newark, Jersey City and Paterson.

B. Child Health Objectives

1) Upgrade the provision of preventive child health services so that by 1990, 50 percent of the children served in Child Health Conferences will be receiving preventive health services from an agency which can assure the provision of comprehensive child health services. Linkages will be encouraged between Child Health Conferences of local health departments and the

pediatric services of Pediatric Primary Care Centers, and Community Health Centers in those areas served by such centers.

2) Provide comprehensive pediatric services to children in areas of identified child health need. At least six sites will be funded.

3) By enhancing the services relevant Medicaid covered and other low income families with young children, improve the current level of immunization of pre-kindergarten children which is now at 93%. The immunization levels of children that enter kindergarten in the 1989-1990 school year will be greater than 95%.

4) Maintain an active Childhood Lead Poisoning Prevention Program so that at least 55,000 children are screened and at least 95% of the Class IV, 85% of the Class III and 75% of the Class II children will receive an appropriate diagnostic evaluation within the quarter they are identified.

   a) At least 85% of the children under the program's supervision because of lead toxicity will be under active pediatric management.

   b) All environmental investigations and abatement will be conducted in accordance with state law and 75% of the identified lead hazards will be reduced during the fiscal year.

5) Maintain the number of children receiving fluoride supplementation for the prevention of dental decay

by supporting voluntary fluoride rinse programs in elementary schools. By September 1989, over 350 schools will be participating in the program, and over 75,000 children will be participating.

II. SPECIAL CHILD HEALTH SERVICES

A. Provide for the early identification of infants and children with, or at risk of developing, handicapping conditions.

1. By September 1989, 95% of infants born with a birth defect diagnosed within the first year of life, will have been registered with Special Child Health Services.

2. 98% of infants identified with biochemical disorders will be under appropriate care within recommended time periods.

3. By September 1989, at least 75 newborns with sickle cell disease will be identified through the newborn screening program and referred to a comprehensive treatment center.

B. Support and develop a statewide network of services aimed at the prevention of chronic disability due to handicapping conditions.

1. Efforts of the Genetic Services Program will be focused on outreach to the poor and minority populations resulting in a 20% increase in service provided to minority populations in targeted counties.

2. At least 25,000 children with handicapping or potentially handicapping conditions will receive specialized pediatric services from agencies funded by Special Child Health Services, efforts will be targeted to children from families with incomes under 200% of poverty.
3. 80% of infants newly registered with major birth defects will be receiving comprehensive case management services including development of Individual Service Plans.
4. 80% of children under the age of 7, covered by the Supplemental Security Income Program will have Individual Service Plans developed, implemented and monitored.
5. Work cooperatively with the Department's AIDS Program to ensure that children, under 13 years of age, with AIDS or ARC have access to necessary services including case management.

C. Develop a statewide network of Pediatric HIV Treatment Centers that will promote, advocate and provide for comprehensive coordinated family focused services for children with HIV infection and their families, as designed in the SPRANS grant.

D. Provide leadership in the planning and promoting of health services for handicapped children.

1. Continue to work cooperatively with the State Department of Education in the implementation of services for preschool handicapped children 0-3

years of age.

2. Continue to work with the newly formed Division for Developmental Disabilities to coordinate community based services for developmentally disabled children and adolescents.
3. Begin to develop parental support groups through the case management units so that by September 1989, at least 8 counties will have organized parent groups.
4. In FFY 89, establish a Catastrophic Illness Program in conjunction with the Catastrophic Illness in Children Commission as per Chapter 370, NJ PL 1987.

PART III

SECTION II

PLANNED UTILIZATION OF FUNDS

PLANNED UTILIZATION OF FUNDS

ALLOCATION OF FEDERAL FUNDS BY PROGRAM AREA

Fund Source		
Direct		
	Maternal and Child Health Block FY 89 Anticipated Award	$10,506,483
Indirect		
	Inter-Block Grant Transfer	
	Low Income Energy Assistance	115,500
	Social Service Block Grant	242,000
		$10,863,983

Allocation by Program Area

	Total	PC-CM [1]	
Maternal and Child Health Services			$ 6,396,800
Office of the Director	376,050		
Accident Prevention and Poison Control Program	$1,309,550		
Dental Health Program	337,130		
Family Planning Program	678,600		
Maternal and Infant Health Program	2,734,720		
Child Health Program	960,750	$172,590	
Special Child Health Services			$ 3,562,033
Office of the Director	$ 402,200		
Birth Defects Registry	83,000		
Community Based Services	1,192,103	$295,000	
Specialized Pediatric Services	1,884,730		
Other Departmental Services			$ 67,800
Administrative Costs			$ 837,350
			$10,863,983

[1] Special Allocation for Primary Care and Case Management Services. The funds shown separately are included in the total allocation for the identified program area.

235X

PROPOSED ALLOCATION FOR LOCAL SERVICES
BY PROGRAM AREA

Program	Total Allocation	Percent of Total	Allocation for Local Services
MATERNAL AN CHILD HEALTH SERVICES			
Accident Prevention Poison Control	$ 1,309,550	12.0%	$ 1,079,000
Dental Health	337,130	3.1%	177,780
Family Planning	678,600	6.2%	627,100
Maternal and Infant Health	2,734,720	25.2%	2,125,900
Child Health	960,750	8.8%	690,400
SPECIAL CHILD HEALTH SERVICES			
Community Based Services	1,192,103	11.0%	972,103
Specialized Pediatric Services	1,884,730	17.3%	1,475,130

PROGRAM ACTIVITY SUMMARY

To carry out these activities an effort will be made to continue funding support to a network of services designed to meet the the identified priority needs. The following is information on the activities and service levels anticipated in FY 89.

MATERNAL AND CHILD HEALTH SERVICES

Family Planning FY 89 $ 678,600

This funding, plus $ 5.1 million in funds from other sources, provides educational and medical services concerning family planning as well as contraceptives to over 77,000 women through 25 local projects. Other fund sources for family planning services are Social Service Block Grant, Title X categorical grant and State funds.

Maternal & Infant Health FY 89 $ 2,734,720

In conjunction with the $1.83 million appropriated in the Governor's Healthy Mother's and Healthy Babies initiative, and in cooperation with Health Start, two these resources are directed to reduce infant mortality through improved access to quality prenatal and newborn care. The program supports a broad range of services in thirteen counties to mothers and infants before, during, and after birth to reduce infant mortality and to help assure the infants proper growth and development. It supports eight Healthy Mother Healthy Babies Coalitions which are active in developing services in the ten cities in the state with the greatest perinatal need It provides prenatal services through local clinics for about 14,000 women. A total of 45 local agencies receive funds from this program.

Child Health FY89 $ 960,750

This program supports the delivery of comprehensive pediatric care to low income infants and children through the funding of seven Pediatric Primary Care Projects which provide preventive and primary pediatric care to 14,000 medically indigent children in high need areas. The program also works with Local Health Development Services in supporting, monitoring, and providing technical assistance to child health services provided by local health departments which serve 38,280 children.

Accident Prevention and Poison Control FY 89 $1,309,550

Provides statewide public health leadership in areas of poisoning and accident prevention. The program supports projects for the prevention of childhood lead poisoning which screens 59,700 children annually, and provides appropriate medical management and environmental abatement for those children identified as having undue lead absorption. In addition to these federal funds the program receives $395,000 in state appropriated funds. The program supports services through 14 contracts with local agencies.

Dental Health FY 89 $ 337,130

Provides statewide leadership in public health dentistry. The program also provides dental services to 3,600 migrant children through funds provided by the Department of Education. It promotes preventive dental health for 75,000 school children through school based fluoride rinse and educational programs in 350 schools.

SPECIAL CHILD HEALTH SERVICES

Special Child Health Services (SCHS) utilizes approximately 8 million dollars in state and federal funds to support and develop a statewide network of special health services aimed at the prevention of chronic illnesses or physically handicapping conditions in children. A priority is to make these services available and accessible to those children who have no private resources for payment and are not covered by other governmental programs. In state fiscal year '989, more than sixty health service grants will be negotiated with various health service agencies. It is expected that more than 26,000 children will benefit from these grants.

Approximately 100,000 newborns will be screened for biochemical causes of mental retardation, sickle cell disease and risks of hearing impairment, with follow-up provided for infants with positive laboratory results. More than 7,500 families will receive genetic counseling and testing services.

It is expected that 9,000 infants and children will be newly registered with SCHS as having a diagnosis or disorder that is or may result in a physically disabling condition. Of this number, 3,600 are expected to have diagnosed birth defects.

Approximately 21,000 children will have their medical, rehabilitative, social and educational needs identified and necessary services coordinated and monitored by a case manager from one of SCHS's case management units, jointly funded with county boards of chosen freeholders.

A major indirect function of SCHS is coordination and collaboration with the Departments of Education and Human Services and other public and private agencies, so that we all use our resources most effectively and efficiently.

To carry out its role and responsibilities, SCHS is organized into four program units: the Office of the Director, Birth Defects Reporting, Specialized Pediatric Services and Pediatric Community Based Services.

Office of the Director

The Office of Director, in addition to administrative responsibilities, is also responsible for program development, quality assurance and special studies.

In FY 89, the major activities of this office will be directed toward the development of a new state funded Catastrophic Illness in Children Program, the first of its kind in the country. A catastrophic illness is defined as any illness or condition for which the medical expenses are not covered by any other state or federal program or any insurance contract and exceed 30% of the income of a family whose income is $100,000 or less per year or 40% of the income of a family whose income is over $100,000 per year. Rules and regulations for providing assistance are to be developed by a Catastrophic Illness Commission. The special program is to be established through a fund generated from a $1.00 annual surcharge per employee for all employers who are subject to the NJ Unemployment Compensation Law.

240X

A second major initiative will be the development of a statewide network of Pediatric HIV Treatment Centers to promote, advocate and provide for comprehensive coordinated, family focused services for children with HIV infection and their families.

Community Based Services

This unit is responsible for the negotiation and monitoring of twenty-one contracts with county based units providing case management services to more than 21,000 handicapped and chronically ill children. This unit also works closely with the Division of Medical Assistance and Health Services (Medicaid), Department of Human Services to implement three cooperative agreements. Community Based Services is administratively responsible and accountable for case management services provided to children on the Medicaid Community Services Waiver and the Medicaid AIDS Waiver; approximately 100 severely ill and disabled children are served each year through these waivers, both of which require detailed accounting of services before Medicaid will reimburse for case management. In addition, SCHS has an agreement with Medicaid to provide access to coverage for SCHS eligible children who need pharmaceutical assistance. Costs for services are debited and credited between Medicaid and SCHS through the Pediatric Community Based Services Unit.

This unit also manages the SCHS Fee for Service Program, a $500,000 budget used to provide partial assistance to purchase braces, prostheses and hearing aids for children who do not have adequate resources to purchase such needed devices.

A Cooperative Agreement with the newly expanded Division of Developmental Disabilities, Department of Human Services is currently being executed to coordinate case management services between these two agencies. The manager of Pediatric Community Based Services is responsible for negotiating the implementation of this agreement.

Specialized Pediatric Services

Forty of the more than sixty grants managed by SCHS are managed through this unit totaling approximately 4.0 million dollars in service funds.

This unit is responsible for the operations of the Genetic Services Program, mandated by C 26:5 B-1, and the negotiation and monitoring of thirteen grants. The Genetic Services Program is a member of the Middle Atlantic Regional Human Genetics Network, and as such works collaboratively with similar programs in the mid-atlantic states. Included within the Genetic Services Program, is the Newborn Screening Program for Biochemical Disorders including sickle cell disease, mandated by NJAC 8:43B-813(h). More than 100,000 newborns will be screened by hospital nurseries and those infants found to be presumptive positive as a result of laboratory tests will be tracked and followed by this program.

In addition to these preventive services, grants are negotiated for the development of a statewide network of services including Child Evaluation Centers, Pediatric Tertiary Centers and Craniofacial Anomalies Centers. In addition, the state mandated newborn hearing screening program (C.26:2-101) is administered from this unit as is the state mandated scoliosis

242X

screening programs (C.18A:40-4.3).

Birth Defects Reporting

The State Birth Defects Registry, as mandated by PL 1983, Chapter 291, is administered through this unit. Approximately 3,600 infants are registered annually with birth defects. In addition, at least 6,000 children are registered with problems other than birth defects, such as chronic illnesses or physically handicapping conditions. Registrations for all children other than those with minor birth defects are forwarded to the SCHS Case Management Unit located in the county of residence of the child.

Table I

1984 Population of Two Age Groups of Women By County

County	Women Age 15-44 yr.	Rank	Women Age 10-19 yr.	Rank
Atlantic	45,227	15	14,578	15
Bergen	190,348	2	56,571	2
Burlington	90,709	10	29,677	10
Camden	110,045	7	36,430	6
Cape May	17,862	20	5,789	20
Cumberland	30,969	16	11,184	16
Essex	204,178	1	67,324	1
Gloucester	49,647	13	16,962	13
Hudson	130,237	4	40,690	4
Hunterdon	22,409	18	7,524	18
Mercer	76,095	11	24,806	12
Middlesex	153,468	3	46,876	3
Monmouth	120,298	5	40,434	5
Morris	102,031	9	32,231	9
Ocean	72,656	12	24,927	11
Passaic	108,137	8	34,889	8
Salem	14,621	21	5,210	21
Somerset	49,483	14	15,220	14
Sussex	29,941	17	9,956	17
Union	114,243	6	35,370	7
Warren	20,091	19	6,900	19
State Total	1,752,694		563,545	

Table Ia

NEW JERSEY RESIDENT
LIVE BIRTHS
1946 --1986

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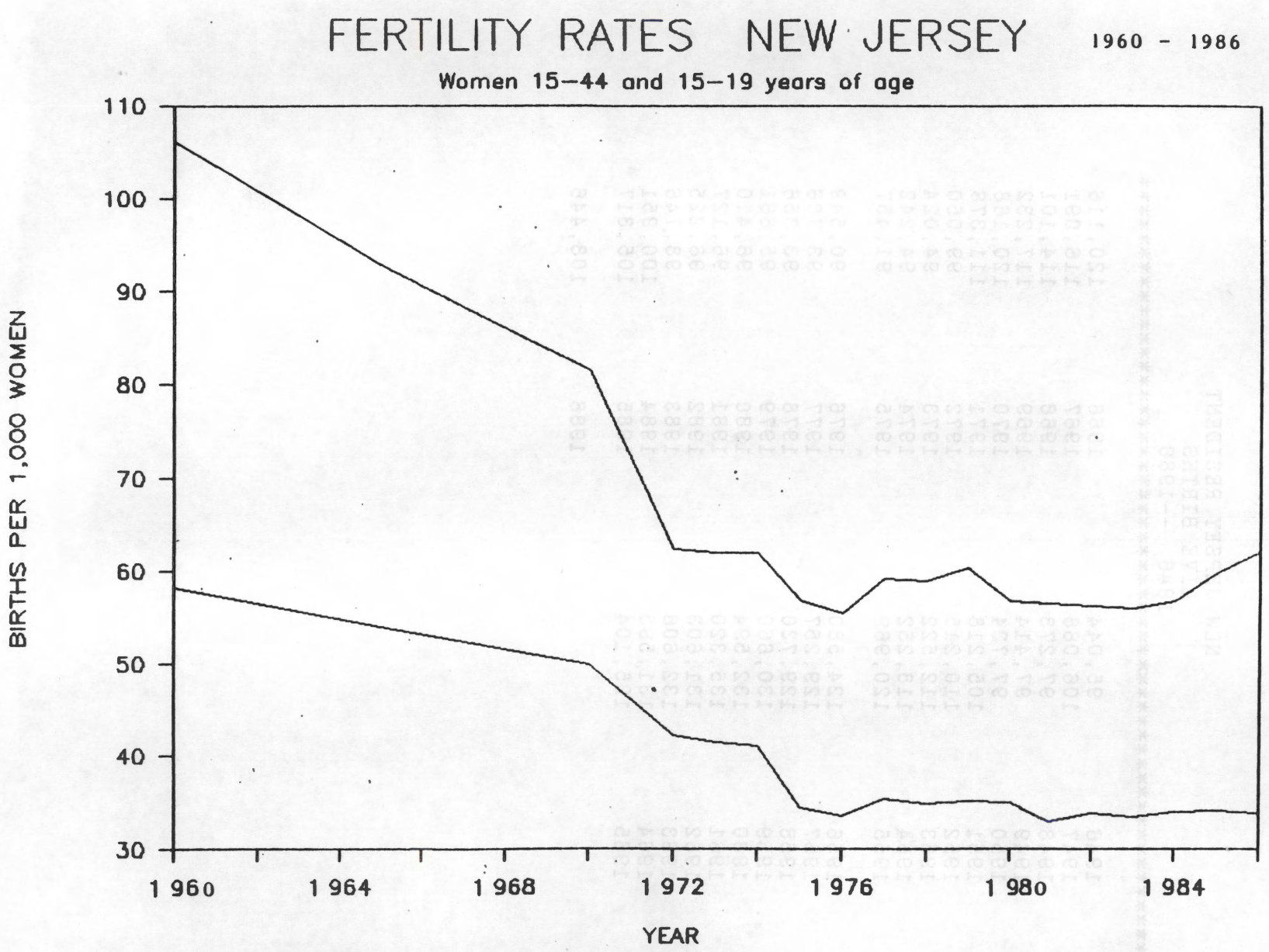
1946	95,044	1966	120,116
1947	106,086	1967	116,091
1948	97,278	1968	114,101
1949	97,414	1969	117,232
1950	97,734	1970	120,168
1951	105,218	1971	111,376
1952	110,215	1972	99,050
1953	112,522	1973	94,024
1954	118,252	1974	94,242
1955	120,969	1975	91,457
1956	124,580	1976	90,549
1957	129,257	1977	93,786
1958	129,730	1978	93,356
1959	130,660	1979	95,661
1960	132,594	1980	96,410
1961	135,320	1981	96,127
1962	131,603	1982	98,225
1963	132,606	1983	98,746
1964	131,593	1984	100,951
1965	125,104	1985	105,317
		1986	108,446

Figure I


FERTILITY RATES NEW JERSEY 1960 - 1986
Women 15–44 and 15–19 years of age
BIRTHS PER 1,000 WOMEN
110
100
90
80
70
60
50
40
30
1960
1964
1968
1972
1976
1980
1984
YEAR

Annual Report 1986

Maternity Service Report for New Jersey Hospitals Table II A

The Figures in Sections

1, 3, 4, 5, 6, 7, 8, 9 and 10 are Percentages of Mothers Delivered

The Figures in Section 2 are Percentages of Babies Born

I. PREGNANCY CENSUS		
99300	A. Total Number of Mothers Delivered	
38859	1. Primipara	39.13
60441	2. Multipara	60.87
98186	B. Single	98.88
1095	C. Twins, set(s) (equals one delivery)	1.10
19	D. Triplets and Others	0.02
100434	E. Total Number of Babies	
1612	F. No Prenatal Care	1.62
670	G. Maternal Transports	0.67
II. DELIVERIES		
62557	A. Spontaneous (Vertex)	62.29
7440	B. Low Forceps	7.41
844	C. Mid Forceps	0.84
829	D. Vacuum Extractions	0.83
16995	E. Primary Cesarean	16.92
9773	F. Repeat Cesarean	9.73
18	G. Cesarean Hysterectomy	0.02
863	H. Vaginal Delivery after Cesarean	0.86
620	I. Breech, Spontaneous/Assisted	0.62
228	J. Breech Extraction	0.23
19	K. Version and Extraction	0.02
301	L. Other	0.30
III. OTHER PROCEDURES		
532	A. Elective Induction	0.54
4805	B. Indicated Induction	4.84
28118	C. Augmentation of Labor	28.32
33703	D. Internal Electronic Fetal Monitoring	33.94
86083	E. External Electronic Fetal Monitoring	86.69
11868	F. Rh Negative Mothers	11.95
6711	G. Rhogam to Mother	56.55
6537	H. Tubal Ligation	6.58
25	I. Postpartum Hysterectomy	0.03
544	J. Postpartum D & C	0.55
13	K. Postpartum Artery Ligations	0.01
11236	L. Inhalation Anaesthesia	11.32
995	M. Caudal Anaesthesia	1.00
24859	N. Epidural Anaesthesia	25.03
53446	O. Other Anaesthesia	53.82
8370	P. No Anaesthesia	8.43
903	Q. Maternal Transfusion(s)	0.91
847	R. Other (Specify under remarks)	0.85
IV. SPECIAL MATERNAL INFORMATION (OBTAIN FROM RECORD ROOM)		
314	A. Admitted After Delivery	0.32
4450	B. Spontaneous Abortion, Complete or Incomplete	4.48
698	C. Extrauterine Pregnancy	0.70
28	D. Hydatid Mole & Choriocarcinoma	0.03
V. MATERNAL COMPLICATIONS		
5515	A. Premature Rupture of Membranes	5.55
2429	B. Membranes Ruptured (Over 24 Hours)	2.45
1989	C. Antepartum Infections	2.00
427	D. Postpartum Morbidity	0.43
1049	E. Morbidity After Cesarean Section	1.06
2696	F. Pregnancy Induced Hypertension	2.72
42	G. With Convulsions or Coma	0.04
428	H. Pre-Existing Hypertension	0.43
932	I. Essential Hypertension with Pre-Eclampsia	0.94
3873	J. Anemia	3.90
435	K. Placenta Previa	0.44
786	L. Abruptio Placenta	0.79
456	M. Uterine Atony	0.46
857	N. Postpartum Hemorrhage	0.86
312	O. Lacerations With Hemorrhage	0.31
8857	P. Lacerations Without Hemorrhage	8.92
335	Q. Heart Disease	0.34
754	R. Diabetes - Class A	0.76
361	S. Diabetes - Insulin Dependent	0.36
58	T. Isoimmunization	0.06
VI. LABOR COMPLICATIONS		
1650	A. Previous Major Uterine Surgery	1.66
5177	B. Fetal Distress	5.21
7353	C. Cord Complications	7.40
3591	D. Arrested Progress	3.62
5613	E. Fetopelvic Disproportion	5.65
2313	F. Malpresentation	2.33
17	G. Ruptured Uterus	0.02
VII. MATERNAL DEATH (Died in Hospital)		
16	Died in Hospital, Delivered or Undelivered	0.02
VIII. OTHER MATERNAL COMPLICATIONS (Specify under Comments - Page 2)		
2519		2.54

X. TOTAL BORN IN HOSPITAL

Weight and Apgar	Live Births (1)		Newborns in Need of Special Care		Fetal Deaths (Stillborn)(3)	
a. Total (a = b + c + d)	99671	99.24	10333	10.37	763	0.76
b. Less than 2501 gms.	5637	5.66	2887	51.22	579	75.88
(1) Apgar 6 or less	1095	19.43	732	25.36	X X X X X	
(2) Apgar 7 or more	4542	80.57	2155	74.64	X X X X X	
c. 2501 gms. or more	94028	94.34	7439	7.91	168	22.02
(1) Apgar 6 or less	1405	1.49	658	8.85	X X X X X	
(2) Apgar 7 or more	92623	98.51	6781	91.15	X X X X X	
d. Weight Unknown	6	0.01	7	116.7	16	2.10
(1) Apgar 6 or less	3	50.00	4	57.14	X X X X X	
(2) Apgar 7 or more	3	50.00	3	42.86	X X X X X	

XI. INFANTS NOT BORN IN HOSPITAL

Weight	No. Admitted After Birth		No. Who Died	
a. Less than 2501 gms.	68	19.60	12	75.00
b. 2501 gms. or more	272	78.39	4	25.00
c. Weight unknown	7	2.02	0	0.00

NEW JERSEY DEPARTMENT OF HEALTH AND THE NEW JERSEY MEDICAL SOCIETY

MATERNITY SERVICE REPORT
1986 ANNUAL REPORT

LEVEL I HOSPITALS

HOSPITAL CODE	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	PP MORBIDITY	PP HEMORRHAGE	FETAL DEATH	BIRTHS UNDER 2501 GM	2500 GM+ FETAL DEATHS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
050	503	40	122	0	249	1	1	2	22	2	0	2
PERCENT	99.60	61.54	24.16	0.00	49.70	0.20	0.20	0.40	4.37	0.42	0.00	9.09
075	892	60	79	27	94	1	13	14	58	3	6	18
PERCENT	98.45	54.55	8.72	3.02	10.51	0.11	1.45	1.55	6.50	0.34	0.72	31.03
077	783	69	116	0	123	1	6	10	45	3	2	2
PERCENT	98.74	65.71	14.63	0.00	15.75	0.13	0.77	1.26	5.75	0.41	0.27	4.44
097	1457	141	184	4	181	1	7	8	33	2	48	10
PERCENT	99.45	61.30	12.56	0.28	12.47	0.07	0.48	0.55	2.26	0.14	3.37	30.30
100	1113	61	268	0	167	2	2	4	79	0	7	8
PERCENT	99.64	57.01	23.99	0.00	15.05	0.18	0.18	0.36	7.10	0.00	0.68	10.13
105	674	37	76	0	72	0	2	7	54	2	50	12
PERCENT	98.97	59.68	11.16	0.00	10.64	0.00	0.30	1.03	8.01	0.32	8.06	22.22
122	1372	125	275	0	547	2	29	4	55	1	2	0
PERCENT	99.71	64.77	19.99	0.00	40.07	0.15	2.12	0.29	4.01	0.08	0.15	0.00
155	653	66	115	0	117	2	4	4	27	1	3	1
PERCENT	99.39	69.47	17.50	0.00	18.03	0.31	0.62	0.61	4.13	0.16	0.48	3.70
215	1161	93	213	0	499	3	11	5	37	0	3	3
PERCENT	99.57	55.03	18.27	0.00	42.94	0.26	0.95	0.43	3.19	0.00	0.27	8.11
249	717	52	158	4	316	0	20	4	36	2	3	12
PERCENT	99.45	62.65	21.91	0.56	44.07	0.00	2.79	0.55	5.02	0.29	0.44	33.33
275	588	66	107	5	124	0	6	6	5	1	8	2
PERCENT	98.99	67.35	18.01	0.85	21.02	0.00	1.02	1.01	0.85	0.17	1.37	40.00
290	1363	94	182	1	478	4	8	3	41	2	26	3
PERCENT	99.78	57.67	13.32	0.07	35.39	0.30	0.59	0.22	3.01	0.15	1.97	7.32
305	1052	91	169	0	138	4	13	8	28	3	1	3
PERCENT	99.25	54.82	15.94	0.00	13.13	0.38	1.24	0.75	2.66	0.29	0.10	10.71
395	801	51	177	11	143	1	8	3	13	0	2	0
PERCENT	99.63	46.79	22.01	1.37	17.83	0.12	1.00	0.37	1.62	0.00	0.25	0.00
470	990	80	187	0	75	2	5	0	19	0	2	4
PERCENT	100	64.52	18.89	0.00	7.66	0.20	0.51	0.00	1.92	0.00	0.21	21.05

NEW JERSEY DEPARTMENT OF HEALTH AND THE NEW JERSEY MEDICAL SOCIETY

MATERNITY SERVICE REPORT
1986 ANNUAL REPORT

LEVEL I HOSPITALS (cont.)

HOSPITAL CODE	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	PP MORBIDITY	PP HEMORRHAGE	FETAL DEATH	BIRTHS UNDER 2501 GM	2500 GM+ FETAL DEATHS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
490	1044	102	116	4	250	1	10	4	40	0	5	7
PERCENT	99.62	64.15	11.07	0.39	24.15	0.10	0.97	0.38	3.83	0.00	0.50	17.50
500	608	29	126	0	33	8	0	9	67	1	1	5
PERCENT	98.54	74.36	20.42	0.00	5.37	1.30	0.00	1.46	11.02	0.18	0.18	7.46
502	772	45	123	8	172	3	2	11	45	3	6	5
PERCENT	98.60	46.88	15.71	1.04	22.31	0.39	0.26	1.40	5.83	0.41	0.83	11.11
530	1216	63	197	6	119	8	3	11	42	5	32	11
PERCENT	99.10	30.14	16.06	0.49	9.79	0.66	0.25	0.90	3.45	0.43	2.73	26.19
600	967	55	147	13	194	3	0	4	31	1	5	5
PERCENT	99.59	45.83	15.14	1.35	20.19	0.31	0.00	0.41	3.21	0.11	0.53	16.13
643	1251	112	186	4	250	4	5	6	41	1	3	2
PERCENT	99.52	54.63	14.90	0.32	20.03	0.32	0.40	0.48	3.28	0.08	0.25	4.88
655	447	38	140	0	107	0	0	3	39	0	3	9
PERCENT	99.33	60.32	31.11	0.00	24.04	0.00	0.00	0.67	8.72	0.00	0.74	23.08
665	195	8	17	9	98	2	0	1	13	0	37	1
PERCENT	99.49	61.54	8.67	4.62	50.26	1.03	0.00	0.51	6.67	0.00	20.33	7.69
675	504	27	93	0	64	3	0	1	15	0	1	0
PERCENT	99.80	62.79	18.42	0.00	12.72	0.60	0.00	0.20	2.98	0.00	0.20	0.00
695	503	34	67	12	116	2	8	7	35	1	1	10
PERCENT	98.63	56.67	13.14	2.38	22.97	0.40	1.58	1.37	6.96	0.21	0.21	28.57
700	1265	99	233	0	448	8	123	7	41	2	27	17
PERCENT	99.45	35.93	18.32	0.00	35.44	0.63	9.73	0.55	3.24	0.16	2.21	41.46
885	587	44	102	2	97	4	4	4	31	1	4	3
PERCENT	99.32	47.31	17.26	0.34	16.61	0.68	0.68	0.68	5.28	0.18	0.72	9.68
887	923	75	154	1	180	0	33	6	26	0	13	7
PERCENT	99.35	65.22	16.58	0.11	19.54	0.00	3.58	0.65	2.82	0.00	1.45	26.92

NEW JERSEY DEPARTMENT OF HEALTH AND THE NEW JERSEY MEDICAL SOCIETY

MATERNITY SERVICE REPORT
1986 ANNUAL REPORT

LEVEL II AND IIA HOSPITALS

HOSPITAL CODE	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	PP MORBIDITY	PP HEMORRHAGE	FETAL DEATH	BIRTHS UNDER 2501 GM	2500 GM+ FETAL DEATHS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
025	1380	74	228	7	296	8	6	16	162	2	13	20
PERCENT	98.85	66.67	16.33	0.52	21.89	0.59	0.44	1.15	11.74	0.16	1.07	12.35
035	1288	99	236	0	424	1	11	24	104	5	13	14
PERCENT	98.17	36.25	17.99	0.00	32.74	0.08	0.85	1.83	8.07	0.42	1.10	13.46
040	941	36	189	0	115	2	0	10	72	2	35	22
PERCENT	98.95	63.45	19.87	0.00	12.21	0.21	0.00	1.05	7.65	0.23	4.03	30.56
080	2025	155	461	3	253	15	6	13	91	2	15	8
PERCENT	99.36	55.16	22.62	0.15	12.54	0.74	0.30	0.64	4.49	0.10	0.76	8.79
175	1665	115	302	0	766	7	1	11	93	3	18	10
PERCENT	99.34	61.83	18.02	0.00	46.23	0.42	0.06	0.66	5.59	0.19	1.15	10.75
180	2215	32	294	23	916	0	11	11	82	4	3	11
PERCENT	99.51	12.36	13.21	1.05	41.75	0.00	0.50	0.49	3.70	0.19	0.14	13.41
243	1517	71	197	10	339	0	9	10	32	3	17	8
PERCENT	99.35	68.93	12.99	0.66	22.38	0.00	0.59	0.65	2.11	0.20	1.14	25.00
270	2269	164	482	2	728	5	1	12	68	5	6	8
PERCENT	99.47	60.29	21.13	0.09	32.26	0.22	0.04	0.53	3.00	0.23	0.27	11.76
333	1725	140	385	4	906	5	4	11	75	3	4	4
PERCENT	99.37	57.14	22.10	0.23	52.67	0.29	0.23	0.63	4.35	0.18	0.24	5.33
385	1230	79	216	0	541	1	10	7	49	1	6	4
PERCENT	99.43	61.24	17.46	0.00	44.13	0.08	0.82	0.57	3.98	0.08	0.51	8.16
415	786	39	163	11	146	0	7	3	52	0	70	25
PERCENT	99.62	48.75	20.66	1.41	18.69	0.00	0.90	0.38	6.62	0.00	7.54	48.08
420	2751	33	436	6	585	5	4	26	245	7	26	45
PERCENT	99.06	17.19	15.70	0.22	21.37	0.18	0.15	0.94	8.91	0.20	1.04	18.37
440	2586	227	352	10	821	12	76	24	221	8	13	37
PERCENT	99.08	75.92	13.49	0.39	31.85	0.47	2.95	0.92	8.55	0.34	0.55	16.74
445	948	67	110	25	84	4	4	4	45	1	11	8
PERCENT	99.38	55.83	11.95	2.66	8.93	0.43	0.43	0.42	4.75	0.11	1.22	17.78
465	2781	246	491	21	1441	6	15	21	172	7	7	29
PERCENT	99.25	58.71	17.32	0.76	52.17	0.22	0.54	0.75	6.18	0.27	0.27	16.86
475	1878	106	217	3	873	7	5	18	121	5	14	16
PERCENT	99.05	47.53	11.45	0.16	46.68	0.37	0.27	0.95	6.44	0.28	0.80	13.22
485	1326	73	142	4	139	17	24	5	43	1	106	20
PERCENT	99.62	57.03	10.67	0.30	10.55	1.29	1.82	0.38	3.24	0.08	8.26	46.51
510	2054	136	372	5	983	0	10	15	84	1	70	39
PERCENT	99.28	53.33	17.98	0.24	48.04	0.00	0.49	0.72	4.09	0.05	3.35	46.43

NEW JERSEY DEPARTMENT OF HEALTH AND THE NEW JERSEY MEDICAL SOCIETY

MATERNITY SERVICE REPORT
1986 ANNUAL REPORT

LEVEL II AND IIA HOSPITALS (cont.)

HOSPITAL CODE	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	PP MORBIDITY	PP HEMORRHAGE	FETAL DEATH	BIRTHS UNDER 2501 GM	2500 GM+ FETAL DEATHS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
540	1119	74	180	11	415	7	3	11	71	1	21	14
PERCENT	99.03	72.55	15.93	0.98	36.95	0.62	0.27	0.97	6.34	0.10	2.00	19.72
550	910	71	145	10	143	2	7	11	29	4	20	6
PERCENT	98.81	58.20	15.74	1.09	15.65	0.22	0.77	1.19	3.19	0.45	2.27	20.69
555	1296	81	248	2	240	24	12	10	75	2	10	11
PERCENT	99.23	56.64	18.99	0.15	18.59	1.86	0.93	0.77	5.79	0.16	0.82	14.67
560	1441	114	172	0	549	1	6	5	54	2	54	7
PERCENT	99.65	69.96	11.89	0.00	38.34	0.07	0.42	0.35	3.75	0.14	3.89	12.70
570	1743	122	305	19	483	1	15	9	52	2	14	5
PERCENT	99.49	55.71	17.41	1.09	27.82	0.06	0.86	0.51	2.98	0.12	0.83	9.62
602	1988	137	315	61	794	4	3	20	79	7	8	16
PERCENT	99.00	52.49	15.69	3.07	39.96	0.20	0.15	1.00	3.97	0.37	0.42	20.25
609	1894	139	333	17	701	4	4	9	37	2	6	4
PERCENT	99.53	65.80	28.01	0.90	37.09	0.21	0.21	0.47	1.95	0.11	0.32	10.81
610	2368	221	373	15	528	10	13	11	76	3	21	10
PERCENT	99.54	66.37	15.68	0.64	22.50	0.43	0.55	0.46	3.21	0.13	0.92	13.16
640	3712	325	775	6	1373	15	50	35	191	2	29	72
PERCENT	99.07	71.43	20.68	0.16	37.13	0.41	1.35	0.93	5.15	0.06	0.82	37.70
645	984	54	168	0	165	1	5	3	68	0	3	2
PERCENT	99.70	65.85	17.02	0.00	16.87	0.10	0.51	0.30	6.91	0.00	0.33	2.94
650	604	41	87	2	109	7	18	5	24	2	5	4
PERCENT	99.18	54.94	14.29	0.33	18.08	1.16	2.99	0.82	3.97	0.34	0.86	16.67
670	763	51	160	8	240	6	53	9	41	4	13	8
PERCENT	98.83	67.11	20.73	1.05	31.50	0.79	6.96	1.17	5.37	0.55	2.08	19.51
680	1013	54	214	0	247	47	20	14	111	2	25	21
PERCENT	98.64	71.05	20.84	0.00	24.38	4.64	1.97	1.36	10.96	0.22	2.77	10.92
705	1174	94	191	5	275	11	5	2	29	0	16	3
PERCENT	99.83	64.83	16.24	0.43	23.52	0.94	0.43	0.17	2.47	0.00	1.40	10.34
800	1656	92	261	23	388	2	10	11	69	3	105	25
PERCENT	99.34	59.00	15.66	1.39	23.53	0.12	0.61	0.66	4.17	0.19	6.62	36.23
830	2888	236	597	11	544	12	28	13	110	5	3	13
PERCENT	99.55	63.27	29.50	0.38	18.93	0.42	0.97	0.45	3.81	0.18	0.11	11.82
897	1936	163	315	10	545	15	2	11	50	4	12	12
PERCENT	99.44	61.98	16.18	0.52	28.22	0.78	0.10	0.56	2.58	0.21	0.64	24.00

NEW JERSEY DEPARTMENT OF HEALTH AND THE NEW JERSEY MEDICAL SOCIETY

MATERNITY SERVICE REPORT
1986 ANNUAL REPORT

LEVEL III HOSPITALS

HOSPITAL CODE	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	PP MORBIDITY	PP HEMORRHAGE	FETAL DEATH	BIRTHS UNDER 2501 GM	10000 GM+ FETAL DEATHS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
055	2596	110	377	6	1132	58	20	26	336	14	14	58
PERCENT	99.01	90.21	14.38	0.23	43.67	2.24	0.77	0.99	12.94	0.62	0.62	17.26
115	2339	141	329	12	267	3	6	24	226	1	26	64
PERCENT	98.98	60.12	13.97	0.51	11.42	0.13	0.26	1.02	9.66	0.05	1.23	28.32
220	358	26	61	0	54	3	0	3	44	1	0	3
PERCENT	99.17	63.41	16.90	0.00	15.21	0.85	0.00	0.83	12.29	0.32	0.00	6.82
455	2544	64	408	13	678	0	12	47	234	2	175	91
PERCENT	98.19	21.77	15.75	0.51	26.54	0.00	0.47	1.81	9.20	0.07	7.58	38.87
480	820	35	118	9	95	1	18	16	136	1	14	31
PERCENT	98.09	16.28	14.11	1.09	11.53	0.12	2.18	1.91	16.59	0.15	2.05	22.79
508	2058	174	318	0	846	2	10	15	230	1	11	33
PERCENT	99.28	64.21	15.34	0.00	41.43	0.10	0.49	0.72	11.18	0.05	0.60	14.35
660	2549	81	337	21	689	13	5	32	338	3	34	96
PERCENT	98.76	36.82	13.06	0.83	27.49	0.52	0.20	1.24	13.26	0.23	1.54	16.57
685	3152	262	606	26	811	13	5	14	98	1	16	36
PERCENT	99.56	65.50	19.14	0.83	25.98	0.42	0.16	0.44	3.11	0.07	0.52	36.73

NEW JERSEY STATE DEPARTMENT OF HEALTH & THE NEW JERSEY MEDICAL SOCIETY
NEWBORN SERVICES REPORT FOR 1987

FIGURES TO THE RIGHT OF THE CATEGORIES LISTED ARE PERCENTAGES OF TOTAL BABIES ADMITTED EXCEPT:
CONGENTIAL MALFORMATIONS AND DEATHS ARE IN NUMBERS/1000 BABIES ADMITTED
DEATHS IN D.R. IS IN PERCENTAGE OF INBORN BABIES:FEED AT DISCHARGE IS IN PERCENTAGE OF BABIES DISCHARGED HOME

Total babies admitted 99,314

A. Babies admitted to nursery(s)

5901	1. 1 min Apgar 0-6	5.94
93128	2. 1 min Apgar 7-10	93.77
1266	3. 5 min Apgar 0-6	1.27
97746	4. 5 min Apgar 7-10	98.42

B. Birthweights

127	1. Total < 500 gm	0.13
214	2. Total 500-750 gm	0.22
247	3. Total 751-1000 gm	0.25
604	4. Total 1001-1500 gm	0.61
1233	5. Total 1501-2000 gm	1.24
4255	6. Total 2001-2500 gm	4.28
81781	7. Total 2501-4000 gm	82.35
10853	8. Total > 4000 gm	10.93

C. 1 Gestational age and Place of Origin

4404	a. Babies <36 weeks	4.43
2413	b. Babies >42 weeks	2.43

2 Place of Origin

98557	a. Inborn	99.24
757	Transferred in	0.76
365	b. after home birth	0.37
392	c. from another hospital	0.39

D. Delivery room

29	1. Death in D.R.	0.03
233	2. Biochemical res.	0.23
2795	3. Intubation	2.81
17776	4. O_2	17.90
2501	5. O_2 + Pos. Press	2.52

E. Admitted to

82499	1. Newborn infant nursery	83.07
12925	2. Intermediate care	13.01
2877	3. Intensive care	2.90
1013	4. Isolation	1.02

F. Course in Nursery

2020	1. Admission temp (a) 35.6°C (96°F)	2.03
509	(rectal) (b) 38.3°C (101°F)	0.51
937	2. Hematocrit (a) 40	0.94
285	(b) 70	0.29
12261	3. Bilirubin 10 mgm/dl	12.35
1637	4. Hypoglycemia glucose 40 mg/dl	1.65
357	5. Hypocalcemia	0.36
776	6. Apnea	0.78
706	7. Bradycardia	0.71

G. Special procedures

Catheterization

1329	1. Umbilical artery	1.34
455	2. Umbilical vein	0.46
407	3. Peripheral artery	0.41
5010	4. Peripheral vein	5.04
805	5. Blood transfusion	0.81
202	6. Plasma expander	0.20
113	7. Exchange transfusion	0.11

Assisted Ventilation

954	8. CPAP	0.96
1308	9. Positive pressure ventilator	1.32
1448	10. Intubation	1.46

Other

3636	11. O_2 administration	3.66
1070	12. Parenteral alimentation	1.08
4343	13. Antibiotics	4.37
5893	14. Phototherapy	5.93
432	15. Surgery	0.43

H. Diagnosis at Discharge or Transfer

	1. Normal newborn	90800	91.43
	2. Congenital malformation (total)	2408	24.25
	a. Major (Ma)	1101	11.09
	b. Minor	1307	13.16
	3. Palsy	87	0.09
	4. Proven sepsis	383	0.39
	5. RDS	1902	1.92
	6. Meconium aspiration	622	0.63
	7. Pneumothorax	308	0.31

1699	8. Hemolytic disease	1.71
1395	a. ABO	1.40
264	b. Rh	0.27
251	9. Intracranial hemorrhage	0.25
78	10. Necrotizing enterocolitis	0.08
151	11. Convulsive seizures	0.15
1663	12. Other	1.67

I. Feed at discharge

44821	1. Breast	46.42
48271	2. Formula	49.99
3468	3. Combination	3.59

J. Outcome

96560	1. Discharge home	97.23
1661	2. Transfer to other hospital	1.67
82	3. Death: 1st hour	0.83
244	4. Death: 1-24 hour	2.46
83	5. Death: 2nd-7th day	0.84
36	6. Death: 8th-28th day	0.36
31	7. Death: over 28 days	0.31

NEWBORN SERVICE REPORTS

New Jersey State Department of Health

Maternal and Child Health

Specific rates for individual hospitals derive from Newborn Service Reports

25 X

Level I Hospitals Annual Report 1987

Hosp. Code No.	Total Adm.	Under 1500 gm % of Adm.	Under 2500 gm % of Adm.	RDS % of Adm.	Meconium Aspiration % of Adm.	Congenital Malform. Major/ 1000 Adm.	5 Min. Apgar 0-6 % of Adm.	Deaths 0-7 Days/ 1000 Adm.	Transferred to Other Hospital % of Adm.	Admis. to NICU Level III % of Adm.	Deaths 8-28 Days/ 1000 Adm
050	319	0.31	5.96	1.25	1.88	15.67	0.00	0.00	4.70	0.00	0.00
075	913	1.31	7.45	1.97	2.08	17.52	1.97	4.38	4.16	0.00	0.00
077	802	0.62	6.73	0.87	0.87	19.95	1.37	8.73	2.74	0.37	0.00
097	1022	0.00	2.74	0.68	0.10	14.68	0.59	0.00	2.45	0.00	0.00
100	1141	1.05	5.78	3.24	0.00	5.26	0.96	1.75	3.68	0.00	0.00
105	861	0.46	5.92	1.86	0.23	10.45	0.81	2.32	3.48	0.00	0.00
122	1199	0.25	3.09	1.67	0.67	14.18	0.67	0.83	1.17	0.00	0.83
155	718	0.28	3.62	0.97	0.00	4.18	0.42	1.39	2.65	0.00	0.00
215	1264	0.08	2.37	0.55	0.00	12.66	0.47	0.79	0.55	0.00	0.00
249	895	0.22	4.02	1.79	1.01	26.82	0.34	3.35	3.80	0.00	0.00
275	562	0.18	1.25	0.18	0.18	8.90	0.71	3.56	0.89	0.00	0.00
290	1422	0.21	2.74	0.98	0.21	15.47	0.42	2.11	2.67	0.00	1.41
305	1074	0.28	2.23	0.74	0.37	1.86	0.65	0.93	1.68	0.00	0.00
395	858	0.12	2.33	0.47	0.23	4.66	1.05	1.17	3.73	0.00	0.00
470	1059	0.00	3.21	0.85	0.09	17.00	0.19	0.00	0.76	0.00	0.00
490	1077	0.37	5.01	1.11	0.19	13.00	0.65	1.86	1.76	3.16	0.00
500	926	1.19	9.29	1.73	0.65	6.48	1.30	2.16	2.70	0.00	0.00

New Jersey State Department of Health

Maternal and Child Health

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502	538	0.56	4.83	0.74	0.19	14.87	0.74	0.00	4.28	0.00	0.00
530	1304	0.00	3.99	0.54	0.23	1.53	0.46	0.00	2.53	0.00	0.00
600	912	0.33	10.20	0.11	0.00	2.19	0.44	0.00	2.41	0.00	0.00
643	1260	0.16	3.02	0.87	0.16	19.84	0.63	2.38	1.75	0.00	0.00
655	277	0.36	5.42	3.25	0.00	0.00	0.36	0.00	10.47	0.00	0.00
665	42	0.00	11.90	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
675	645	0.31	5.58	2.02	0.16	17.05	0.47	1.55	2.79	0.00	0.00
695	481	0.42	8.11	2.08	1.04	14.55	1.04	4.16	3.74	0.00	2.08
700	1213	0.41	3.38	0.74	0.25	4.95	0.99	4.12	2.23	0.00	0.00
885	505	0.00	5.74	1.58	0.40	1.98	0.79	1.98	3.96	0.00	0.00
887	898	0.22	2.56	1.22	2.34	7.80	0.67	2.23	2.12	0.00	0.00

NEWBORN SERVICE REPORTS

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025	1054	2.47	12.71	1.90	0.66	12.33	2.28	12.33	1.52	14.99	1.90
035	732	1.37	9.15	2.73	1.23	8.20	2.73	2.73	0.55	7.92	1.37
040	910	1.21	9.01	1.87	0.22	10.99	1.21	5.49	4.40	0.88	0.00
080	2161	0.74	6.99	0.69	0.32	5.55	0.51	0.46	2.59	0.19	0.00
175	1702	0.47	6.11	1.35	0.53	9.40	1.29	1.18	2.00	0.00	0.00
180	2378	0.29	4.71	0.00	0.17	5.05	0.50	1.68	1.60	0.00	0.00
243	804	0.12	3.98	0.87	0.12	9.95	0.75	1.24	1.24	0.00	0.00
270	2342	0.90	5.42	1.20	0.17	13.66	0.51	2.99	0.47	5.12	0.43
333	1785	0.45	4.65	0.90	0.17	11.76	0.67	2.24	2.35	0.00	0.00
385	1431	0.56	4.82	0.98	0.14	17.47	0.28	4.19	0.91	0.00	0.00
415	389	2.31	9.25	3.08	0.51	10.28	0.51	5.14	1.80	0.00	0.00
420	3041	2.86	14.07	4.14	2.30	15.13	1.41	6.58	0.30	9.31	4.93
440	2794	1.86	9.16	1.54	0.39	11.81	1.93	11.10	0.50	0.00	0.36
445	1199	0.83	5.17	1.17	0.50	0.83	1.25	7.51	2.59	0.00	0.00
465	3102	1.90	7.58	5.16	2.87	23.53	1.32	8.70	0.13	0.00	0.97
475	1450	0.34	8.83	2.48	0.69	4.14	0.48	0.00	1.52	0.00	0.00
485	1327	0.83	3.84	0.98	0.15	10.55	1.73	3.01	2.11	0.00	0.00
510	2027	0.84	5.28	0.30	0.64	5.43	1.33	1.97	0.05	5.87	2.96

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540	1129	0.62	6.64	0.89	0.00	0.89	0.71	1.77	1.33	0.00	0.00
550	1025	0.68	4.49	2.05	0.10	25.37	0.68	0.98	2.83	0.29	0.00
555	1414	0.71	5.80	1.91	0.21	7.78	1.84	7.07	2.62	6.51	0.00
560	1461	0.14	2.60	1.64	0.34	20.53	0.55	0.68	2.05	0.00	0.00
570	1853	0.38	2.75	1.51	0.27	10.25	0.86	2.16	1.73	0.00	1.08
602	1916	0.89	6.11	1.67	0.52	14.61	1.46	2.09	3.50	0.00	0.00
609	1943	0.21	4.37	1.70	1.18	9.78	0.21	0.51	2.68	1.03	0.00
610	2407	0.25	3.53	1.45	0.12	3.74	0.96	2.08	2.70	0.00	0.42
640	3030	1.16	5.15	1.32	0.17	4.29	0.50	3.96	0.23	4.32	0.33
645	1113	0.90	7.28	1.98	0.54	10.78	0.45	1.80	0.81	0.00	0.00
650	661	0.76	5.60	1.36	0.15	13.62	1.36	3.03	3.18	0.00	0.00
670	752	0.27	3.46	1.20	0.53	11.97	0.40	0.00	3.19	0.00	0.00
680	739	1.08	9.07	5.14	0.68	5.41	1.62	0.00	2.71	0.00	0.00
705	1182	0.85	4.06	1.78	0.68	16.92	1.95	3.38	1.35	0.00	0.00
800	1576	0.51	3.11	0.63	0.25	6.98	0.89	5.71	2.09	0.00	0.63
830	2782	0.50	4.31	0.72	0.32	10.78	0.61	1.80	1.73	0.04	0.00
897	2084	0.48	4.70	1.87	1.01	18.23	1.15	0.96	0.77	4.22	0.00

NEWBORN SERVICE REPORTS

New Jersey State Department of Health

Maternal and Child Health

Specific rates for individual hospitals derive
from Newborn Service Reports

Level III Hospitals Annual Report 1987

Hosp. Code No.	Total Adm.	Under 1500 gm % of Adm.	Under 2500 gm % of Adm.	RDS % of Adm.	Meconium Aspiration % of Adm.	Congenital Malform. Major/ 1000 Adm.	5 Min. Apgar 0-6 % of Amd.	Deaths 0-7 Days/ 1000 Adm.	Transferred to Other Hospital % of Adm.	Admis. to NICU Level III % of Adm.	Deaths 8-28 Days/ 1000 Adm
055	1497	3.54	13.63	4.07	0.47	10.69	2.27	10.69	1.00	9.89	3.34
115	2402	2.96	13.16	4.00	0.29	10.41	3.37	6.66	2.33	8.87	0.00
220	1393	3.23	11.99	11.20	0.43	10.77	2.66	9.33	0.57	14.57	2.15
455	812	2.34	7.88	3.33	0.37	17.24	0.62	0.00	1.35	8.25	0.00
480	2626	5.03	17.44	3.62	3.12	6.47	3.92	14.09	0.15	9.71	5.33
508	2064	3.05	10.22	2.52	0.87	6.30	1.60	9.69	1.16	9.01	0.97
660	2037	3.73	12.13	4.27	0.64	10.31	6.14	8.35	0.54	12.22	1.47
685	4601	2.61	8.95	1.17	0.28	17.60	1.89	8.26	0.20	9.43	0.43

New Jersey State Department of Health and the New Jersey Medical Society
Newborn Services Report for Transports Annual 1987

Figures to the right of the categories listed are percentages of total babies admitted except:
Congential malformations and deaths are in number/1000 babies admitted
Death in D.R. is in percentage of inborn babies:
Feed at discharge is in percentage of babies discharged home **or transferred**

Total babies admitted 1004

A. Babies admitted to nursery(s)

398	1. 1 min Apgar 0-6	39.6
567	2. 1 min Apgar 7-10	56.5
180	3. 5 min Apgar 0-6	17.9
791	4. 5 min Apgar 7-10	78.8

B. Birthweights

3	1. Total < 500 gm	0.3
22	2. Total 500-750 gm	2.2
43	3. Total 751-1000 gm	4.3
105	4. Total 1001-1500 gm	10.5
122	5. Total 1501-2000 gm	12.2
137	6. Total 2001-2500 gm	13.6
525	7. Total 2501-4000 gm	52.3
44	8. Total > 4000 gm	4.4

C. 1 Gestational age and Place of Origin

360	a. Babies < 36 weeks	35.9
20	b. Babies > 42 weeks	2.0

2 Place of Origin

___	a. Inborn	
___	Transferred in	
16	b. after home birth	1.6
988	c. from another hospital	98.4

D. Delivery room

0	1. Death in D.R.	0.0
58	2. Biochemical res.	5.8
213	3. Intubation	21.2
213	4. O_2	21.2
189	5. O_2 + Pos. Press	18.8

E. Admitted to

5	1. Newborn infant nursery	0.5
45	2. Intermediate care	4.5
952	3. Intensive care	94.8
2	4. Isolation	0.2

F. Course in Nursery

33	1. Admission temp (a) < 35.6°C (96°F)	3.3
13	(rectal) (b) > 38.3°C (101°F)	1.3
201	2. Hematocrit (a) 40	20.0
2	(b) 70	0.2
220	3. Bilirubin 10 mgm/dl	21.9
46	4. Hypoglycemia glucose 40 mg/dl	4.6
78	5. Hypocalcemia	7.8
113	6. Apnea	11.3
70	7. Bradycardia	7.0

G. Special procedures

Catheterization

287	1. Umbilical artery	28.6
131	2. Umbilical vein	13.0
150	3. Peripheral artery	14.9
425	4. Peripheral vein	42.3
279	5. Blood transfusion	27.8
114	6. Plasma expander	11.4
14	7. Exchange transfusion	1.4

Assisted Ventilation

120	8. CPAP	12.0
356	9. Positive pressure ventilator	35.5
372	10. Intubation	37.1

Other

557	11. O_2 administration	55.5
252	12. Parenteral alimentation	25.1
692	13. Antibiotics	68.9
284	14. Phototherapy	28.3
128	15. Surgery	12.7

H. Diagnosis at Discharge or Transfer

79	1. Normal newborn	7.9
167	2. Congenital malformations (total)	16.6
158	a. Major (Ma)	157.4
9	b. Minor	9.0
7	3. Palsy	0.7
67	4. Proven sepsis	6.7
253	5. RDS	25.2
50	6. Meconium aspiration	5.0
72	7. Pneumothorax	7.2
54	8. Hemolytic disease	5.4
18	a. ABO	1.8
4	b. Rh	0.4
88	9. Intracranial hemorrhage	8.8
23	10. Necrotizing enterocolitis	2.3
68	11. Convulsive seizures	6.8
56	12. Other	5.6

I. Feed at discharge

76	1. Breast	9.0
479	2. Formula	56.8
44	3. Combination	5.2

J. Outcome

546	1. Discharge home	54.4
297	2. Transfer to other hospital	29.6
1	3. Death: 1st hour	0.1
17	4. Death: 1-24 hour	1.7
30	5. Death: 2nd-7th day	3.0
13	6. Death: 8th-28th day	1.3
12	7. Death over 28 days	1.2

2602

NEWBORN SERVICE REPORTS

New Jersey State Department of Health
Maternal and Child Health

TRANSPORTS ANNUAL REPORT 1987

Specific rates for individual hospitals derived from Newborn Service Reports

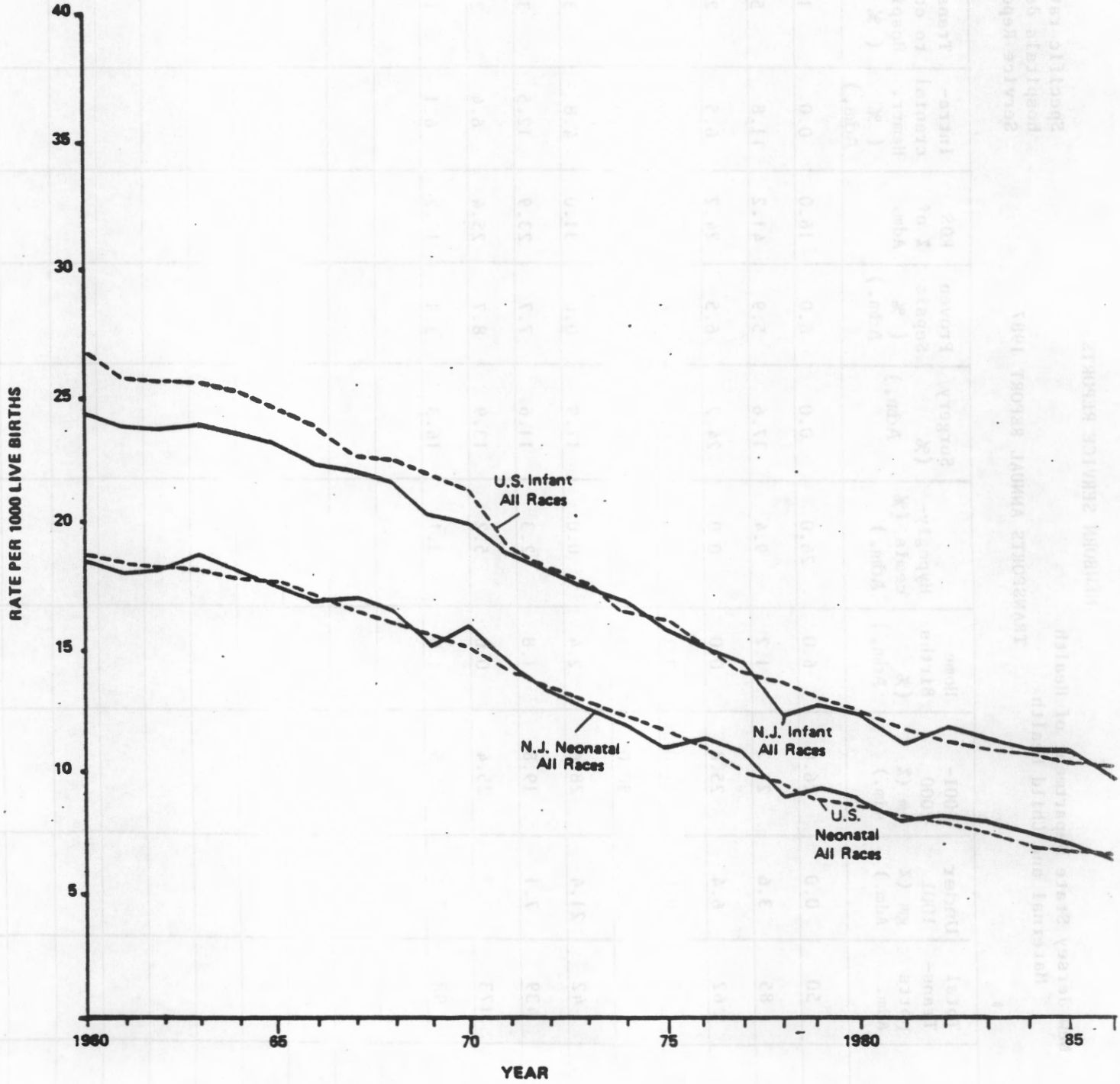
Hosp. Code No.	Total Trans-ports Adm.	Under 1001 gm (% Adm.)	1001-2000 gm (% Adm.)	Home Births (% Adm.)	Hypoglycemia (% Adm.)	Surgery (% Adm.)	Proven Sepsis (% Adm.)	RDS % of Adm.	Intracranial Hemrr. (% Adm.)	Transferr to other Hospital (% Adm.)	Deaths <28 days (per 100 babies admitt
025	50	0.0	26.0	6.0	26.0	0.0	6.0	16.0	0.0	14.0	60.0
055	85	3.6	21.2	1.2	9.4	17.6	5.9	41.2	11.8	55.3	82.3
115	62	6.4	25.8	0.0	0.0	24.2	6.5	24.2	6.5	24.2	64.5
455	47	0.0	17.0	2.1	4.3	4.3	6.4	46.8	0.0	34.0	42.6
480	8	25.0	50.0	12.5	12.5	0.0	0.0	12.5	0.0	0.0	125.0
508	42	21.4	28.6	2.4	0.0	11.9	0.0	31.0	4.8	33.3	23.8
565	439	7.1	19.8	1.8	2.3	11.6	7.7	23.9	12.5	33.0	70.6
660	173	5.7	25.4	0.0	5.2	13.9	8.7	25.4	6.4	22.0	34.7
685	98	9.2	25.5	1.0	3.1	16.3	3.1	10.2	6.1	15.3	61.2

X1980

Figure IIA

INFANT AND NEONATAL MORTALITY
RATES PER 1000 LIVE BIRTHS
1960 - 1986
NEW JERSEY AND UNITED STATES

N.J. Department of Health &
National Center for Health Statistics



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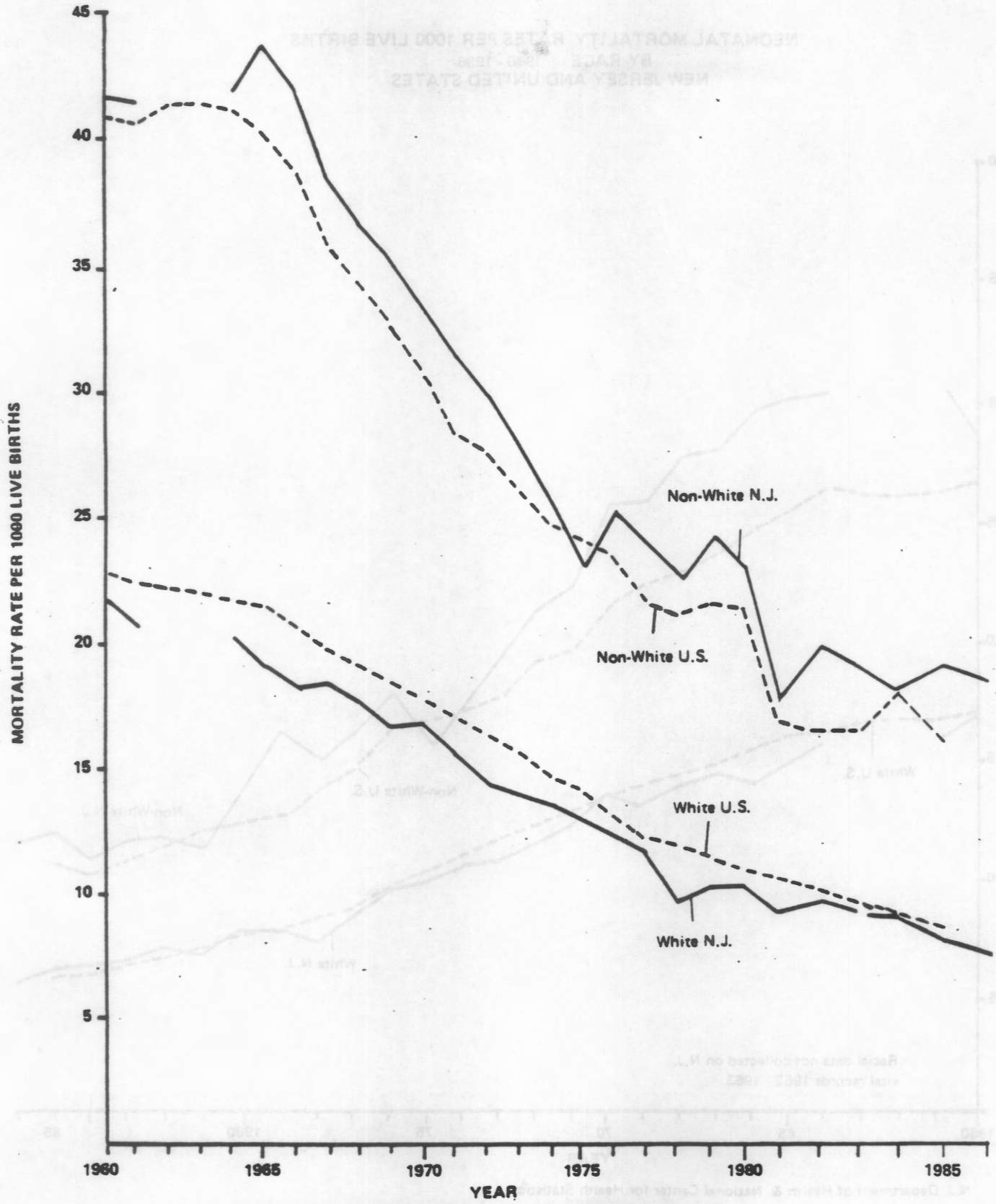
INFANT MORTALITY
UNITED STATES AND NEW JERSEY by Race

Figure IIB

1960 - 1986



NOTE: Race was not recorded in New Jersey in 1962 and 1963

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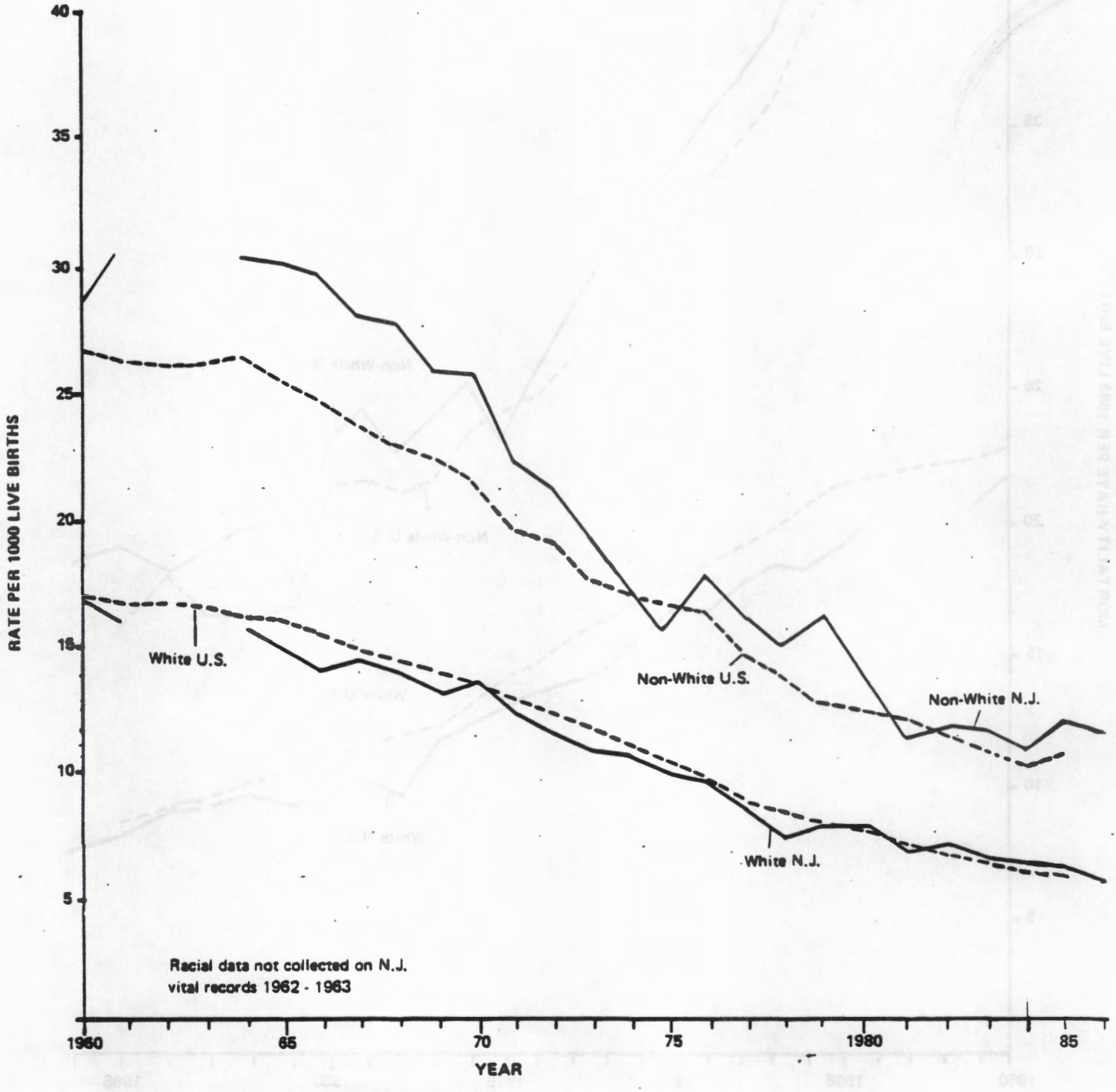
Figure IIC

NEONATAL MORTALITY RATES PER 1000 LIVE BIRTHS BY RACE 1960 - 1986 NEW JERSEY AND UNITED STATES



N.J. Department of Health & National Center for Health Statistics

264K

Table III

Non-white and White
Infant Mortality Rates (per 1,000 live births)
New Jersey 1976-1986

Year	Infant Mortality Rates Non-white	White	Ratio
1976	25.4	12.7	2.0:1
1977	24.4	12.2	2.0:1
1978	22.6	9.6	2.4:1
1979	22.5	10.5	2.1:1
1980	21.0	10.3	2.0:1
1981	19.7	9.3	2.1:1
1982	20.3	9.6	2.1:1
1983	19.3	9.2	2.1:1
1984	17.9	9.0	2.0:1
1985	18.7	8.9	2.0:1
1986	18.0	7.8	2.3:1

Table IVa

Causes of Infant Mortality
New Jersey Residents, 1986

Cause of Death (ICD-9 code)	Neonatal	Postneonatal	Infant Mortality Rate (per 100,000 live births)
Infectious diseases (001-139)	0	26	24.0
Neoplasms (140-239)	0	5	4.6
Endocrine, nutritional and metabolic diseases, immune disorders (240-278)	5	3	7.4
AIDS (279.1)	0	6	5.5
Diseases of the blood and blood-forming organs (280-289)	1	1	1.8
Meningitis and encephalitis (320-323)	1	5	5.5
Other diseases of the nervous system and sense organs (324-389)	2	14	14.8
Diseases of the circulatory system (390-459)	1	10	10.1
Pneumonia and influenza (480-487)	2	16	16.6
Other diseases of the respiratory system (460-479, 488-519)	0	15	13.8
Diseases of the digestive system (520-579)	1	8	8.3
Diseases of the genitourinary system (580-629)	0	1	0.9
Congenital anomalies (740-759)	165	65	212.1
Certain conditions arising in the perinatal period (760-779)	509	40	506.2
- Maternal causes of perinatal mortality (760-763)	29	0	26.7
- Disorders relating to short gestation and unspecified low birthweight (765)	218	4	204.7
- Birth trauma (767)	1	0	0.9
- Intrauterine hypoxia and birth asphyxia (768)	21	4	23.1
- Respiratory distress syndrome (769)	141	5	134.6
- Other respiratory conditions of fetus and newborn (770)	44	19	58.1
- Infections specific to the perinatal period (771)	19	2	19.4
- Intraventricular hemorrhage (772.1)	10	0	9.2
- Perinatal disorders of digestion (777)	7	3	9.2
- Conditions involving the integument and temperature regulation of fetus and newborn (778)	3	0	2.8
- Other and ill-defined conditions originating in the perinatal period (764, 766, 773-776, 779)	16	3	17.3
Sudden Infant Death Syndrome (798.0)	17	99	107.0
Other symptoms, signs and ill-defined conditions (780-797, 798.1-799)	2	10	11.1
Accidents (E800-E929)	1	14	13.8
Homicide (E960-E968)	2	9	10.1
Unknown	1	2	2.8
Total	710	349	976.5

Causes of Infant Mortality
New Jersey Residents, 1986
Whites

Cause of Death (ICD-9 code)	Neonatal	Postneonatal	Infant Mortality Rate (per 100,000 live births)
Infectious diseases (001-139)	0	11	13.2
Neoplasms (140-239)	0	4	4.8
Endocrine, nutritional and metabolic diseases, immune disorders (240-278)	5	3	9.6
AIDS (279.1)	0	3	3.6
Diseases of the blood and blood-forming organs (280-289)	1	0	1.2
Meningitis and encephalitis (320-323)	0	2	2.4
Other diseases of the nervous system and sense organs (324-389)	2	11	15.6
Diseases of the circulatory system (390-459)	1	7	9.6
Pneumonia and influenza (480-487)	1	9	12.0
Other diseases of the respiratory system (460-479, 488-519)	0	6	7.2
Diseases of the digestive system (520-579)	1	5	7.2
Diseases of the genitourinary system (580-629)	0	1	1.2
Congenital anomalies (740-759)	131	45	210.8
Certain conditions arising in the perinatal period (760-779)	300	22	385.6
- Maternal causes of perinatal mortality (760-763)	20	0	24.0
- Disorders relating to short gestation and unspecified low birthweight (765)	118	2	143.7
- Birth trauma (767)	1	0	1.2
- Intrauterine hypoxia and birth asphyxia (768)	12	2	16.8
- Respiratory distress syndrome (769)	88	2	107.8
- Other respiratory conditions of fetus and newborn (770)	27	10	44.3
- Infections specific to the perinatal period (771)	10	2	14.4
- Intraventricular hemorrhage (772.1)	8	0	9.6
- Perinatal disorders of digestion (777)	3	1	4.8
- Conditions involving the integument and temperature regulation of fetus and newborn (778)	1	0	1.2
- Other and ill-defined conditions originating in the perinatal period (764, 766, 773-776, 779)	12	3	18.0
Sudden Infant Death Syndrome (798.0)	8	49	68.3
Other symptoms, signs and ill-defined conditions (780-797, 798.1-799)	1	6	8.4
Accidents (E800-E929)	0	10	12.0
Homicide (E960-E968)	1	4	6.0
Unknown	0	2	2.4
Total	452	200	780.8

Causes of Infant Mortality
New Jersey Residents, 1986
Nonwhites

Cause of Death (ICD-9 code)	Neonatal	Postneonatal	Infant Mortality Rate (per 100,000 live births)
Infectious diseases (001-139)	0	15	66.2
Neoplasms (140-239)	0	1	4.4
Endocrine, nutritional and metabolic diseases, immune disorders (240-278)	0	0	---
AIDS (279.1)	0	3	13.2
Diseases of the blood and blood-forming organs (280-289)	0	1	4.4
Meningitis and encephalitis (320-323)	1	3	17.7
Other diseases of the nervous system and sense organs (324-389)	0	3	13.2
Diseases of the circulatory system (390-459)	0	3	13.2
Pneumonia and influenza (480-487)	1	7	35.3
Other diseases of the respiratory system (460-479, 488-519)	0	9	39.7
Diseases of the digestive system (520-579)	0	3	13.2
Diseases of the genitourinary system (580-629)	0	0	---
Congenital anomalies (740-759)	34	20	238.5
Certain conditions arising in the perinatal period (760-779)	209	18	1002.6
- Maternal causes of perinatal mortality (760-763)	9	0	39.7
- Disorders relating to short gestation and unspecified low birthweight (765)	100	2	450.5
- Birth trauma (767)	0	0	----
- Intrauterine hypoxia and birth asphyxia (768)	9	2	48.6
- Respiratory distress syndrome (769)	53	3	247.3
- Other respiratory conditions of fetus and newborn (770)	17	9	114.8
- Infections specific to the perinatal period (771)	9	0	39.7
- Intraventricular hemorrhage (772.1)	2	0	8.8
- Perinatal disorders of digestion (777)	4	2	26.5
- Conditions involving the integument and temperature regulation of fetus and newborn (778)	2	0	8.8
- Other and ill-defined conditions originating in the perinatal period (764, 766, 773-776, 779)	4	0	17.7
Sudden Infant Death Syndrome (798.0)	9	50	260.6
Other symptoms, signs and ill-defined conditions (780-797, 798.1-799)	1	4	22.1
Accidents (E800-E929)	1	4	22.1
Homicide (E960-E968)	1	5	26.5
Unknown	1	0	4.4
Total	258	149	1797.5

Table V a

1986 Statistics for New Jersey, Counties, and Municipalities of 30,000 or More Population

Locality	Number of Live Births	Percent White	Percent Unmarried Mothers	Percentage of Births Receiving Prenatal Care in 1st Trimester	Percentage of Births Receiving No Prenatal Care	Percentage of Live Births <=1500gm	Percentage of Live Births <=2500gm	Infant Mortality Rate	Perinatal II Mortality Rate
New Jersey State	108,446	77.0%	22.7%	78.2%	1.34%	1.25%	6.69%	9.8	14.3
ATLANTIC COUNTY (Total)	3,306	73.7%	33.5%	63.2%	2.12%	1.09%	7.20%	13.3	18.3
Atlantic City	765	33.5%	69.7%	46.5%	2.75%	1.96%	11.63%	18.3	27.1
ATLANTIC COUNTY (Remainder)	2,541	85.9%	22.7%	68.2%	1.93%	0.83%	5.86%	11.8	15.6
BERGEN COUNTY (Total)	9,443	82.9%	6.7%	82.9%	0.91%	0.66%	4.59%	6.4	9.5
Fair Lawn Borough	256	92.6%	3.1%	86.3%	0.78%	0.39%	3.52%	0.0	7.8
Fort Lee Borough	317	54.6%	2.5%	64.4%	0.63%	0.00%	2.84%	6.3	0.0
Hackensack City	482	66.6%	20.1%	78.6%	0.83%	0.62%	6.02%	8.3	12.4
Teaneck Township	451	57.0%	11.3%	70.5%	1.33%	0.67%	3.10%	11.1	11.0
BERGEN COUNTY (Remainder)	7,937	86.2%	5.9%	84.4%	0.91%	0.69%	4.69%	6.2	9.7
BURLINGTON COUNTY (Total)	5,327	82.7%	17.9%	77.2%	0.83%	1.31%	6.01%	9.8	14.0
Willingboro Township	509	45.2%	32.0%	76.0%	1.77%	2.36%	9.43%	19.6	29.1
BURLINGTON COUNTY (Remainder)	4,818	86.6%	16.4%	77.3%	0.73%	1.20%	5.65%	8.7	12.4
CAMDEN COUNTY (Total)	8,129	77.4%	31.4%	70.5%	1.97%	1.27%	7.26%	11.6	16.1
Camden City	2,328	43.9%	70.9%	52.8%	5.20%	2.10%	11.94%	16.3	19.2
Cherry Hill Township	790	93.2%	6.2%	78.1%	0.63%	0.89%	4.81%	5.1	12.6
Gloucester Township	661	94.9%	15.6%	76.1%	0.91%	0.45%	4.08%	7.6	6.0
Pennsauken Township	479	81.8%	21.5%	75.2%	1.46%	1.04%	5.43%	14.6	20.7
CAMDEN COUNTY (Remainder)	3,871	90.8%	16.8%	78.1%	0.54%	1.01%	5.71%	10.3	16.1
CAPE MAY COUNTY (Total)	1,296	89.4%	21.5%	67.1%	0.85%	1.62%	7.02%	6.2	16.8
CUMBERLAND COUNTY (Total)	2,136	75.0%	41.0%	56.4%	1.12%	1.73%	7.02%	16.4	20.9
Vineland City	799	82.2%	35.4%	65.5%	1.25%	1.38%	6.51%	13.8	15.0
CUMBERLAND COUNTY (Remainder)	1,337	70.7%	44.4%	51.0%	1.05%	1.94%	7.33%	18.0	24.4

Residents of military bases and state institutions included only in statewide data

Prepared by Maternal & Child Health Services Data Unit

2697

1986 Statistics for New Jersey, Counties, and Municipalities of 30,000 or More Population

Locality	Number of Live Births	Percent White	Percent Unmarried Mothers	Percentage of Births Receiving Prenatal Care in 1st Trimester	Percentage of Births Receiving No Prenatal Care	Percentage of Live Births <=1500gm	Percentage of Live Births <=2500gm	Infant Mortality Rate	Perinatal II Mortality Rate
ESSEX COUNTY (Total)	12,831	46.7%	42.9%	81.0%	1.32%	1.89%	9.94%	13.2	19.0
Belleville Town	460	88.5%	8.0%	84.1%	1.30%	0.22%	5.87%	2.2	15.0
Bloomfield Town	574	89.7%	6.4%	87.3%	0.70%	0.70%	6.10%	3.5	5.2
East Orange City	1,481	6.9%	59.1%	71.9%	1.82%	3.11%	12.42%	14.9	25.2
Irvington Town	1,099	26.4%	48.9%	85.5%	1.18%	1.91%	10.74%	11.8	17.2
Montclair Town	448	62.5%	16.5%	79.0%	0.67%	1.34%	6.92%	4.5	6.7
Newark City	5,782	37.5%	62.0%	79.6%	1.75%	2.06%	11.95%	18.0	22.0
Orange City	573	23.4%	45.4%	70.0%	1.40%	3.14%	6.63%	19.2	32.6
West Orange Township	474	85.2%	6.3%	88.6%	0.21%	1.05%	5.27%	12.7	14.7
ESSEX COUNTY (Remainder)	1,940	87.6%	3.5%	89.0%	0.31%	1.13%	6.49%	4.1	10.7
GLOUCESTER COUNTY (Total)	3,200	88.1%	19.3%	79.0%	0.59%	0.91%	5.31%	9.1	13.3
HUDSON COUNTY (Total)	8,580	67.9%	31.1%	70.8%	1.78%	1.43%	7.76%	12.4	15.3
Bayonne City	765	86.8%	14.4%	83.7%	0.78%	1.57%	6.80%	9.2	11.7
Hoboken City	460	61.3%	33.9%	63.0%	3.70%	1.09%	6.74%	10.9	15.1
Jersey City	4,036	50.4%	44.4%	65.3%	2.16%	1.91%	9.79%	16.6	16.5
Kearny Town	446	93.3%	9.4%	86.1%	0.45%	1.12%	5.38%	11.2	17.8
North Bergen Township	664	83.9%	13.7%	80.3%	1.20%	0.90%	4.67%	9.0	16.4
Union City	1,002	85.7%	25.8%	69.7%	1.30%	0.90%	6.09%	8.0	13.9
West New York Town	550	86.2%	22.9%	68.9%	2.18%	1.27%	6.73%	7.3	12.7
HUDSON COUNTY (Remainder)	657	82.8%	13.2%	77.8%	1.22%	0.30%	5.33%	6.1	13.6
HUNTERDON COUNTY (Total)	1,302	97.9%	7.8%	87.6%	0.23%	0.77%	3.69%	7.7	15.2
MERCER COUNTY (Total)	4,482	70.6%	30.7%	76.3%	0.94%	1.74%	7.79%	10.5	17.9
Ewing Township	371	83.0%	11.3%	85.4%	0.27%	0.54%	4.04%	5.4	5.4
Hamilton Township	1,032	91.2%	10.5%	83.2%	0.48%	0.78%	4.55%	7.8	9.7
Trenton City	1,954	47.3%	57.9%	65.6%	1.79%	3.17%	11.98%	16.9	24.7
MERCER COUNTY (Remainder)	1,125	88.1%	8.3%	85.7%	0.09%	0.53%	4.71%	3.6	17.5

270X

1986 Statistics for New Jersey, Counties, and Municipalities of 30,000 or More Population

Locality	Number of Live Births	Percent White	Percent Unmarried Mothers	Percentage of Births Receiving Prenatal Care in 1st Trimester	Percentage of Births Receiving No Prenatal Care	Percentage of Live Births <=1500gm	Percentage of Live Births <=2500gm	Infant Mortality Rate	Perinatal II Mortality Rate
MIDDLESEX COUNTY (Total)	8,898	84.3%	12.5%	81.5%	0.63%	1.21%	6.20%	8.0	11.5
East Brunswick Township	513	83.4%	4.3%	87.1%	0.00%	0.97%	5.26%	11.7	15.5
Edison Township	1,256	80.3%	5.9%	86.4%	0.48%	0.72%	6.61%	8.8	7.9
New Brunswick City	648	55.4%	42.4%	66.0%	1.54%	2.16%	9.41%	15.4	12.3
Old Bridge Township	645	89.0%	6.5%	83.1%	0.62%	0.93%	5.27%	0.0	1.5
Perth Amboy City	741	89.3%	34.0%	55.9%	1.35%	1.48%	7.02%	9.4	17.3
Piscataway Township	597	67.7%	10.7%	85.9%	0.34%	1.01%	6.03%	5.0	6.7
Woodbridge Township	1,074	89.5%	7.3%	85.2%	0.37%	1.12%	5.77%	9.3	14.8
MIDDLESEX COUNTY (Remainder)	3,424	90.5%	8.9%	85.2%	0.58%	1.31%	5.75%	7.0	12.5
MONMOUTH COUNTY (Total)	7,518	84.0%	15.8%	86.0%	0.67%	1.24%	6.09%	8.5	12.3
Middletown Township	812	94.3%	6.4%	91.5%	0.25%	0.49%	3.82%	4.9	15.8
MONMOUTH COUNTY (Remainder)	6,706	82.7%	16.9%	85.3%	0.72%	1.33%	6.37%	8.9	11.9
MORRIS COUNTY (Total)	5,354	92.2%	7.4%	90.6%	0.43%	0.75%	4.80%	7.8	11.5
Parsippany-Troy Hills	552	87.0%	5.3%	92.4%	0.18%	1.45%	5.80%	10.9	9.0
MORRIS COUNTY (Remainder)	4,802	92.8%	7.6%	90.4%	0.46%	0.67%	4.69%	7.5	11.8
OCEAN COUNTY (Total)	5,225	93.7%	13.2%	79.8%	0.59%	0.77%	5.11%	8.0	10.9
Brick Township	853	98.9%	8.3%	85.9%	0.35%	1.29%	5.86%	11.7	15.2
Dover Township	918	98.0%	12.0%	85.8%	0.54%	0.22%	4.25%	3.3	4.4
Lakewood Township	938	78.0%	17.8%	67.0%	1.39%	0.75%	4.90%	4.3	9.5
OCEAN COUNTY (Remainder)	2,516	96.1%	13.7%	80.3%	0.40%	0.79%	5.25%	9.9	12.2

1986 Statistics for New Jersey, Counties, and Municipalities of 30,000 or More Population

Locality	Number of Live Births	Percent White	Percent Unmarried Mothers	Percentage of Births Receiving Prenatal Care in 1st Trimester	Percentage of Births Receiving No Prenatal Care	Percentage of Live Births <=1500gm	Percentage of Live Births <=2500gm	Infant Mortality Rate
PASSAIC COUNTY (Total)	7,441	76.2%	29.3%	71.0%	5.43%	1.55%	7.90%	9.4
Clifton City	823	92.8%	5.7%	85.4%	1.94%	0.73%	4.98%	6.1
Passaic City	1,285	64.6%	37.0%	57.7%	2.88%	1.25%	8.56%	9.3
Paterson City	3,117	62.7%	49.1%	60.9%	9.98%	2.37%	11.04%	11.9
Wayne Township	479	94.6%	5.0%	88.5%	1.25%	1.04%	5.01%	6.3
PASSAIC COUNTY (Remainder)	1,737	96.1%	5.8%	87.2%	1.96%	0.81%	3.97%	7.5
SALEM COUNTY (Total)	859	75.6%	28.1%	70.9%	1.05%	1.40%	6.17%	16.3
SOMERSET COUNTY (Total)	2,950	88.2%	9.2%	88.2%	0.47%	0.85%	5.15%	6.8
Franklin Township	573	68.8%	16.4%	85.9%	0.70%	1.92%	7.68%	14.0
SOMERSET COUNTY (Remainder)	2,377	92.9%	7.4%	88.8%	0.42%	0.59%	4.54%	5.0
SUSSEX COUNTY (Total)	1,942	96.7%	5.9%	87.8%	0.62%	1.03%	5.05%	6.7
UNION COUNTY (Total)	6,673	72.5%	23.3%	77.4%	0.97%	1.06%	6.26%	7.9
Elizabeth City	1,916	73.0%	34.2%	65.2%	1.30%	1.10%	7.46%	8.4
Linden City	437	74.8%	21.1%	75.5%	0.92%	0.69%	5.03%	13.7
Plainfield City	937	32.1%	46.5%	71.1%	1.71%	1.49%	8.32%	11.7
Union Township	445	85.2%	8.5%	89.4%	0.67%	0.90%	4.04%	6.7
Westfield Town	354	89.5%	6.5%	89.0%	0.28%	0.85%	4.24%	2.8
UNION COUNTY (Remainder)	2,584	81.7%	12.1%	85.4%	0.62%	1.01%	5.50%	6.2
WARREN COUNTY (Total)	1,318	97.2%	15.0%	81.9%	0.46%	1.14%	4.86%	8.3

2772

Table V b

Infant Mortality Rates (per 1,000 live births)
Healthy Mothers/Healthy Babies Cities and Remainder of New Jersey
1976-1986

Year	Infant Mortality Rates HM/HB	New Jersey (Remainder)	Ratio
1976	22.9	12.9	1.8 : 1
1977	22.7	12.2	1.9 : 1
1978	21.3	9.7	2.2 : 1
1979	21.2	10.6	2.0 : 1
1980	20.2	10.4	1.9 : 1
1981	18.5	9.6	1.9 : 1
1982	18.0	10.1	1.8 : 1
1983	17.3	9.7	1.8 : 1
1984	17.5	9.1	1.9 : 1
1985	17.9	9.0	2.0 : 1
1986	16.0	8.2	2.0 : 1

Neonatal, Postneonatal and Infant Mortality Rates by Birth Weight for New Jersey Residents Born in 1985 (rates per 1,000 live births in weight group)

Weight (in grams)	Total Live Births	Neonatal Deaths		Postneonatal Deaths		Infant Deaths	
		Number	Rate	Number	Rate	Number	Rate
<500	189	167	883.6	1	5.3	168	888.9
500-999	518	255	492.3	38	73.4	293	565.6
1000-1499	616	71	115.3	26	42.2	97	157.5
1500-1999	1360	34	25.0	27	19.9	61	44.9
2000-2499	4427	55	12.4	41	9.3	96	21.7
2500-3999	84837	136	1.6	183	2.2	319	3.8
>=4000	11277	11	0.8	10	0.9	21	1.9
Unknown	2105	20	9.5	4	1.9	24	11.4
TOTAL	105329	749	7.1	330	3.1	1079	10.2

376x

Percentage of Low Birth Weight and
Very Low Birth Weight
Live Births Ranked by County of Residence
New Jersey 1986

County	Percentage of Live Births <1500 grams	Percentage of Live Births <2500 grams
Essex	1.89	9.94
Mercer	1.74	7.79
Cumberland	1.73	7.02
Cape May	1.62	7.02
Passaic	1.55	7.90
Hudson	1.43	7.76
Salem	1.40	6.17
Burlington	1.31	6.01
Camden	1.27	7.26
NEW JERSEY	**1.25**	**6.69**
Monmouth	1.24	6.09
Middlesex	1.21	6.20
Warren	1.14	4.86
Atlantic	1.09	7.20
Union	1.06	6.26
Sussex	1.03	5.05
Gloucester	0.91	5.31
Somerset	0.85	5.15
Ocean	0.77	5.11
Hunterdon	0.77	3.09
Morris	0.75	4.80
Bergen	0.66	4.59

Table VII a

Percent of Mothers Beginning Care in First Trimester and Receiving No Prenatal Care, by Age and Race Groups Resident Births 1986

Age Group	Care in First Trimester				No Prenatal Care			
	Total	White	Black	Other	Total	White	Black	Other
14 or less	37.8	43.2	35.0	0.0	7.32	9.09	6.37	0.00
15-19	52.4	52.8	52.4	44.7	3.55	3.32	3.85	2.35
20-24	71.0	74.4	63.8	73.4	2.02	1.60	3.12	3.59
25-29	83.5	87.2	72.8	81.7	0.87	0.58	2.61	1.26
30-34	85.8	89.7	77.2	85.0	0.63	0.48	1.98	0.98
35-39	82.7	87.2	76.8	86.4	0.94	0.90	1.55	1.23
40-44	75.8	82.3	72.3	81.6	1.25	0.90	3.38	2.04
45+	75.0	84.6	50.0	100.0	2.78	0.00	25.00	0.00
TOTAL	78.2	82.9	65.8	81.0	1.34	0.98	2.95	1.55

276X

Percentage of Births Which Received No Prenatal Care or Prenatal Care in First Trimester Ranked by County of Residence New Jersey 1986

County	Percentage of Births Receiving No Prenatal Care	Percentage of Births Receiving Care in First Trimester
Passaic	5.43	71.0
Atlantic	2.12	63.2
Camden	1.97	70.5
Hudson	1.78	70.8
NEW JERSEY	**1.34**	**78.1**
Essex	1.32	81.0
Cumberland	1.12	56.4
Salem	1.05	70.9
Union	0.97	77.4
Mercer	0.94	76.3
Bergen	0.91	82.9
Cape May	0.85	67.1
Burlington	0.83	77.2
Monmouth	0.67	86.0
Middlesex	0.63	81.5
Sussex	0.62	87.8
Gloucester	0.59	79.0
Ocean	0.59	79.8
Somerset	0.47	88.2
Warren	0.46	81.9
Morris	0.43	90.6
Hunterdon	0.23	87.6

Table VIII

Resident Births by Age Group, Race and Marital Status
New Jersey 1986

	All Races		White		Black		Other	
	Number of Births	% of Unmarried Mothers	Number of Births	% of Unmarried Mothers	Number of Births	% of Unmarried Mothers	Number of Births	% of Unmarried Mothers
14 or less	246	95.1	88	87.5	157	99.4	1	100.0
15-19	9,922	77.7	5,335	64.5	4,447	93.9	85	63.5
20-24	24,447	36.6	17,420	24.6	6,351	71.7	418	14.6
25-34	63,937	10.8	52,704	6.4	7,655	43.9	2,026	2.5
35-44	9,835	8.5	7,916	6.0	1,118	29.6	373	3.2
45+	36	19.4	26	15.4	4	75.0	3	0.0
Unknown age	23	39.1	15	40.0	4	75.0	0	---
TOTAL	108,446	22.7	83,504	14.0	19,736	63.7	2,906	6.2

278X

Table IXa

1986 FERTILITY RATES
(Live Births per 1,000 women)
by County

COUNTY	Ages 15-44			Ages 10-14			Ages 15-19		
	Total	White	Non-White	Total	White	Non-White	Total	White	Non-White
ATLANTIC	72.94	70.97	84.41	0.99	0.40	2.46	55.05	38.66	94.59
BERGEN	49.57	44.14	63.13	0.11	0.04	0.75	8.23	6.55	19.02
BURLINGTON	58.59	58.01	59.20	0.69	0.35	2.26	28.85	24.20	42.22
CAMDEN	73.55	68.70	72.86	1.61	0.68	4.09	55.73	37.72	89.19
CAPE MAY	72.44	77.66	90.97	0.75	0.93	0.00	39.87	38.60	84.38
CUMBERLAND	68.42	65.97	67.20	3.09	2.64	3.99	71.97	59.70	84.32
ESSEX	62.57	57.24	62.75	1.64	0.51	5.67	55.11	29.56	71.60
GLOUCESTER	64.23	61.94	72.71	0.73	0.28	4.25	31.97	26.52	76.05
HUDSON	65.73	62.97	63.14	0.73	0.73	0.74	44.08	37.50	62.82
HUNTERDON	55.83	57.74	38.30	0.00	0.00	0.00	12.44	12.20	24.10
MERCER	58.48	55.10	69.68	1.65	0.00	5.57	41.05	25.70	99.00
MIDDLESEX	57.91	56.45	67.84	0.48	0.24	2.04	19.64	17.98	44.84
MONMOUTH	62.32	59.48	72.42	0.55	0.24	2.68	25.23	14.44	78.95
MORRIS	52.44	50.59	58.82	0.19	0.14	1.09	9.73	7.89	24.97
OCEAN	71.76	72.29	62.77	0.17	0.59	2.48	27.23	23.70	56.54
PASSAIC	68.51	70.87	59.54	1.56	0.90	3.05	53.25	42.03	77.36
SALEM	58.48	52.62	67.08	1.56	1.99	0.00	39.61	25.22	85.28
SOMERSET	59.49	57.56	77.39	0.54	0.32	3.82	12.63	7.67	48.28
SUSSEX	64.86	63.41	48.05	0.00	0.00	0.00	14.07	12.82	30.30
UNION	49.62	35.12	64.85	1.08	0.63	2.38	31.69	19.92	56.72
WARREN	65.55	64.52	71.27	0.00	0.00	0.00	28.21	28.51	56.07
State	60.97	58.71	65.39	0.91	0.43	3.05	33.63	22.48	68.60

1986 Statistics for New Jersey, Counties, and Municipalities of 30,000 or More Population

Table VIA

ocality	Live Births To Women Under 15	Adolescent Fertility Rate* 10-14	Live Births To Women Aged 15-19	Adolescent Fertility Rate* 15-19	General Fertility Rate*
ew Jersey State	246	0.91	9922	33.75	61.86
TLANTIC COUNTY (Total)	7	0.99	414	55.05	73.10
tlantic City	6	4.33	173	120.56	115.14
TLANTIC COUNTY (Remainder)	1	0.18	241	39.60	65.86
ERGEN COUNTY (Total)	3	0.11	245	8.23	49.61
air Lawn Borough	0	0.00	3	2.81	39.43
ort Lee Borough	0	0.00	4	6.31	44.83
ackensack City	0	0.00	29	30.21	53.69
eaneck Township	1	0.81	9	6.02	50.17
ERGEN COUNTY (Remainder)	2	0.09	200	7.81	49.98
URLINGTON COUNTY (Total)	10	0.69	439	28.85	58.73
illingboro Township	1	0.47	67	30.45	47.07
URLINGTON COUNTY (Remainder)	9	0.73	372	28.58	60.30
AMDEN COUNTY (Total)	29	1.61	1029	55.73	73.87
amden City	27	6.95	644	164.41	152.67
herry Hill Township	1	0.34	20	6.93	50.93
loucester Township	0	0.00	40	25.24	56.44
ennsauken Township	0	0.00	59	45.67	66.71
AMDEN COUNTY (Remainder)	1	0.12	266	30.28	64.10
APE MAY COUNTY (Total)	2	0.75	125	39.87	72.56
MBERLAND COUNTY (Total)	17	3.09	409	71.97	68.97
neland City	6	2.58	146	63.20	60.91
MBERLAND COUNTY (Remainder)	11	2.00	263	78.34	74.89
SEX COUNTY (Total)	53	1.64	1934	55.11	62.84
lleville Town	0	0.00	15	12.07	53.90
loomfield Town	0	0.00	10	6.44	53.48
st Orange City	9	3.13	263	80.80	86.30
vington Town	7	3.37	183	87.77	75.25
ntclair Town	0	0.00	19	14.88	51.16
wark City	36	2.44	1347	88.07	88.99
ange City	1	0.97	73	63.92	87.28
st Orange Township	0	0.00	5	3.42	55.90
SEX COUNTY (Remainder)	0	0.00	19	2.21	17.99

Fertility rate denominators based on 1984 population estimates by NJSDH Center for Health Statistics and New Jersey Department of Labor
Prepared by the Data Unit, MCH

280X

1986 Statistics for New Jersey, Counties, and Municipalities of 30,000 or More Population

Table VIA

Locality	Live Births To Women Under 15	Adolescent Fertility Rate* 10-14	Live Births To Women Aged 15-19	Adolescent Fertility Rate* 15-19	General Fertility Rate*
GLOUCESTER COUNTY (Total)	6	0.73	280	31.97	64.46
HUDSON COUNTY (Total)	14	0.73	948	44.08	65.88
Bayonne City	2	0.99	45	19.96	54.96
Hoboken City	0	0.00	48	30.97	45.20
Jersey City	11	1.26	645	71.95	94.06
Kearny Town	0	0.00	23	16.61	55.15
North Bergen Township	1	0.77	23	14.90	62.28
Union City	0	0.00	99	41.97	74.16
West New York Town	0	0.00	36	21.43	59.46
HUDSON COUNTY (Remainder)	0	0.00	29	16.37	30.24
HUNTERDON COUNTY (Total)	0	0.00	51	12.44	58.10
MERCER COUNTY (Total)	18	1.65	570	41.05	58.90
Ewing Township	1	0.96	10	8.33	46.70
Hamilton Township	0	0.00	50	15.08	52.07
Trenton City	17	4.97	475	121.48	112.05
MERCER COUNTY (Remainder)	0	0.00	35	6.41	36.42
MIDDLESEX COUNTY (Total)	10	0.48	513	19.64	57.98
East Brunswick Township	0	0.00	13	7.94	52.76
Edison Township	1	0.39	30	10.74	68.73
New Brunswick City	3	2.96	120	130.86	128.04
Old Bridge Township	0	0.00	24	10.19	46.26
Perth Amboy City	4	3.09	104	75.36	83.74
Piscataway Township	1	0.71	26	17.31	51.90
Woodbridge Township	0	0.00	40	10.61	49.18
MIDDLESEX COUNTY (Remainder)	1	0.13	156	13.27	53.27
MONMOUTH COUNTY (Total)	11	0.55	516	25.23	62.47
MIDDLETOWN TOWNSHIP	0	0.00	31	11.45	54.51
MONMOUTH COUNTY (Remainder)	11	0.64	485	27.33	63.59
MORRIS COUNTY (Total)	3	0.19	162	9.73	52.47
Parsippany-Troy Hills	0	0.00	10	5.46	39.88
MORRIS COUNTY (Remainder)	3	0.22	152	10.26	54.45

Fertility rate denominators based on 1984 population estimates by NJSDH Center for Health Statistics and New Jersey Department of Labor

1986 Statistics for New Jersey, Counties, and Municipalities of 30,000 or More Population

Table VIA

Locality	Live Births To Women Under 15	Adolescent Fertility Rate* 10-14	Live Births To Women Aged 15-19	Adolescent Fertility Rate* 15-19	General Fertility Rate*
OCEAN COUNTY (Total)	9	0.71	334	27.23	71.91
Brick Township	0	0.00	37	18.14	67.40
Dover Township	3	1.03	46	16.66	61.11
Lakewood Township	3	2.56	84	74.01	118.11
OCEAN COUNTY (Remainder)	3	0.46	167	26.39	67.93
PASSAIC COUNTY (Total)	26	1.56	971	53.25	68.81
Clifton City	0	0.00	30	11.40	51.16
Passaic City	4	2.14	225	110.19	101.99
Paterson City	20	3.38	655	109.24	111.98
Wayne Township	1	0.52	9	4.38	43.84
PASSAIC COUNTY (Remainder)	1	0.20	52	9.44	42.69
SALEM COUNTY (Total)	4	1.56	105	39.61	58.75
SOMERSET COUNTY (Total)	4	0.54	99	12.63	59.62
Franklin Township	3	2.33	36	30.90	72.68
SOMERSET COUNTY (Remainder)	1	0.16	63	9.44	57.14
SUSSEX COUNTY (Total)	0	0.00	71	14.07	64.86
UNION COUNTY (Total)	18	1.08	592	31.69	58.41
Elizabeth City	6	1.80	260	68.06	77.30
Linden City	0	0.00	38	30.33	52.42
Plainfield City	6	3.35	152	78.67	100.42
nion Township	0	0.00	15	8.20	42.95
estfield Town	0	0.00	9	8.01	52.80
NION COUNTY (Remainder)	6	0.75	118	13.53	47.22
ARREN COUNTY (Total)	0	0.00	105	28.21	65.60

07224

Table X

CHANGE IN FERTILITY RATES - WOMEN 15 - 19 YEARS OF AGE
NEW JERSEY AND UNITED STATES 1977--1986
BY COUNTY

COUNTY	1977	1980	1981	1982	1983	1984	1985	1981-1985	1986	CHANGE
ATLANTIC	61.30	53.03	57.99	56.32	61.36	60.63	55.05	58.27	55.05	-5.53
BERGEN	9.08	9.10	7.58	8.00	8.56	7.90	7.70	7.95	8.23	3.35
BURLINGTON	30.16	29.64	27.64	28.51	27.58	28.39	30.69	28.56	28.85	1.01
CAMDEN	48.26	53.37	48.30	51.37	50.95	54.54	55.25	52.08	55.73	7.00
CAPE MAY	54.50	53.39	52.73	42.69	41.51	36.04	48.17	44.23	39.87	-9.85
CUMBERLAND	81.79	72.10	75.04	67.50	72.02	75.14	75.31	73.00	71.97	-1.41
ESSEX	57.91	58.58	52.23	53.87	53.30	56.48	57.50	54.68	55.10	0.78
GLOUCESTER	39.14	35.92	32.82	38.96	35.98	31.97	32.43	34.43	31.97	-7.15
HUDSON	51.17	51.18	48.29	49.06	48.27	47.66	43.61	47.38	44.08	-6.96
HUNTERDON	17.50	15.06	12.28	14.21	10.37	9.27	10.49	11.32	12.44	9.86
MERCER	43.66	41.76	43.37	48.83	45.10	40.61	41.48	43.88	41.05	-6.45
MIDDLESEX	21.72	19.61	21.01	23.16	22.98	18.84	19.68	21.13	19.64	-7.07
MONMOUTH	28.87	25.99	24.14	24.83	22.05	25.23	24.79	24.21	25.23	4.22
MORRIS	13.95	11.91	10.87	10.17	12.12	8.83	9.55	10.31	9.73	-5.61
OCEAN	35.61	33.31	29.50	29.24	31.84	32.94	29.27	30.56	27.23	-10.89
PASSAIC	44.27	49.28	44.72	47.84	47.44	50.67	50.50	48.23	53.25	10.40
SALEM	51.95	55.78	52.49	48.39	51.02	44.13	52.43	49.69	39.61	-20.29
SOMERSET	14.86	15.74	13.78	14.04	12.51	14.54	13.39	13.65	12.63	-7.49
SUSSEX	23.37	20.99	18.60	18.43	16.84	14.07	16.45	16.88	14.07	-16.64
UNION	27.88	28.29	28.18	28.47	29.81	28.26	31.15	29.17	31.69	8.62
WARREN	26.17	38.12	33.49	36.63	26.73	27.40	21.76	29.20	28.21	-3.40
STATE	35.30	35.00	32.84	33.81	33.39	33.93	33.99	33.59	33.63	0.11
U.S.	52.80	53.00	52.70	52.90	51.70	50.90	51.30	51.90	50.60	-2.50

REPORTED NON-PRISONER FEMAL CASES OF AIDS
BY AGE AND COUNTY
AS OF JULY 31,1988

COUNTY	TOTAL	AGE GROUP 13-19	20-29	30-39	40-49	50+
ATLANTIC	7	0	‡	‡	‡	‡
BERGEN	29	0	8	15	‡	6
BURLINGTON	8	0	‡	‡	‡	‡
CAMDEN	7	0	‡	5	‡	‡
CAPE MAY	0	0	0	0	0	0
CUMBERLAND #	1					
ESSEX	391	0	99	220	56	16
GLOUCESTER #	2					
HUDSON	156	‡	56	76	16	7
HUNTERDON #	4					
MERCER	11	0	‡	5	‡	‡
MIDDLESEX	46	0	10	28	‡	6
MONMOUTH	28	‡	7	16	‡	‡
MORRIS	15	‡	‡	9	‡	‡
OCEAN	18	0	‡	13	‡	‡
PASSAIC	98	0	36	45	13	‡
SALEM	0	0	0	0	0	0
SOMERSET	7	0	‡	‡	‡	‡
SUSSEX #	3					
UNION	85	0	26	40	13	6
WARREN #	1					
COUNTY UNKNOWN #	1					
TOTAL	918	3	265	486	108	56

/Counties with less than 5 cases show no age group break down
‡ /Age Group has less than 5 cases

Data supplied by the Division on AIDS Surveillance Unit.

Table XII

MATERNAL AND CHILD HEALTH PRIORITY RANKING
FY 1989 BLOCK GRANT

LOCALITY	SCORE 1984-1986	RANK FY1989	RANK FY1988	RANK FY1987
Camden City	15.5	1	1	4
Newark City	13.2	2	2	3
Atlantic City	12.2	3	3	1
East Orange City	11.8	4	5	6
Trenton City	9.8	5	4	2
New Brunswick City	9.0	6	6	9
Irvington	7.6	7	9	12
Jersey City	7.0	8	8	5
Paterson	6.5	9	10	8
Plainfield	6.4	10	7	7
Passaic City	4.9	11	11	14
Orange	4.9	12	12	10
Cumberland Co. (Balance)	4.2	13	14	15
Salem County (Total)	2.9	14	16	17
Perth Amboy	2.6	15	15	16
Willingboro Twp.	2.5	16	20	13
Elizabeth	2.3	17	17	18
Hoboken	2.0	18	13	11
West Orange	1.7	19	18	--
Union City	1.4	20	19	24
Franklin Twp. (Somerset)	1.1	21	25	--
Vineland	0.8	22	22	20
Atlantic Co. (Balance)	0.5	23	24	21
Cape May County (Total)	0.2	24	--	--
North Bergen Twp.	0.2	25	--	--
West New York	0.1	26	23	19
State Average	0.0			

Note: FY1989 ranking is based on data for the years 1984-1986
"--" Indicates that the municipality had a score less than 0.0 in that year and was assigned no rank

Table XIII

Population under 21 years in New Jersey

	Under 1	1-4	5-14	15-17	18-21	Totals	Percent of children
Atlantic	2,469	9,305	29,039	10,249	9,881	60,943	3
Bergen	8,542	33,427	111,427	45,739	39,786	238,921	10
Burlington	5,120	19,661	59,697	22,864	22,715	130,057	6
Camden	7,403	26,678	76,106	27,250	23,802	161,239	7
Cape May	1,065	3,671	10,528	4,067	3,951	23,282	1
Cumberland	2,020	7,553	22,780	8,078	6,610	47,041	2
Essex	12,226	45,129	134,922	48,195	43,508	283,980	12
Gloucester	3,217	14,944	33,484	11,555	11,897	75,097	3
Hudson	8,087	29,219	78,763	28,754	29,150	173,973	7
Hunterdon	1,138	4,347	14,566	5,684	4,037	29,772	1
Mercer	3,923	14,350	44,080	16,063	20,052	98,468	4
Middlesex	7,355	27,442	86,173	33,366	39,541	193,877	8
Monmouth	6,281	25,142	82,161	30,337	24,108	168,029	7
Morris	4,910	19,171	75,117	24,776	20,085	144,059	6
Ocean	4,730	18,552	51,280	16,604	13,542	104,708	4
Passaic	6,478	23,783	68,075	24,660	23,415	146,411	6
Salem	972	3,697	10,603	3,879	3,097	22,248	1
Somerset	2,333	8,755	30,660	12,564	9,710	64,022	3
Sussex	1,992	7,508	21,094	6,659	4,680	41,933	2
Union	5,945	22,138	68,525	27,269	24,540	148,417	6
Warren	1,153	4,458	13,473	4,672	4,128	27,884	1
Totals	97,359	368,930	1,122,553	413,284	382,235	2,384,361	100
Percent of children	4	16	47	17	16	100	

1982

NUMBER OF CHILDREN ELIGIBLE FOR MEDICAID
BY COUNTY
NEW JERSEY JANUARY 1988

COUNTY	UNDER 1	1-5	6-12	13-17	18-20	TOTAL
ATLANTIC	690	3,051	2,964	1,659	629	8,993
BERGEN	265	1,323	1,402	883	445	4,318
BURLINGTON	427	2,107	2,108	1,197	511	6,350
CAMDEN	2,061	10,172	10,740	5,662	2,382	31,017
CAPE MAY	176	940	964	475	196	2,751
CUMBERLAND	682	3,000	3,306	1,902	849	9,739
ESSEX	3,272	21,502	26,670	15,333	6,607	73,384
GLOUCESTER	411	1,932	1,885	885	444	5,557
HUDSON	2,062	10,722	12,609	7,270	2,872	35,535
HUNTERDON	32	206	258	138	86	720
MERCER	933	3,960	4,224	2,332	1,050	12,499
MIDDLESEX	696	3,109	3,140	1,937	919	9,801
MONMOUTH	708	3,500	3,853	2,035	884	10,980
MORRIS	124	641	721	407	206	2,099
OCEAN	449	2,216	2,318	1,227	488	6,698
PASSAIC	1,090	5,714	6,703	3,625	1,337	18,469
SALEM	201	961	1,133	614	284	3,193
SOMERSET	133	540	616	337	185	1,811
SUSSEX	85	311	324	170	88	978
UNION	948	4,498	4,923	2,579	1,094	14,042
WARREN	115	566	529	287	123	1,620
TOTAL	15,560	80,971	91,390	50,954	21,679	260,554

Table XV

Age-Specific Mortality Rates for Children
(per 100,000 population)

New Jersey
1986

Cause of Death (ICD-9 Code)	1 - 4 Years	5 - 14 Years	15 - 24 Years
Infectious Diseases (001-139)	3.1	0.8	1.8
Neoplasms (140-259)	5.7	4.3	5.7
Congenital Anomalies (740-759)	7.7	1.8	0.7
Motor Vehicle Accidents (E810-825)	3.3	6.4	23.7
Other Accidents (E800-809, 826-929)	10.5	3.4	10.0
Suicide (E950-959)	0.0	0.9	8.4
Homicide (E960-969)	1.0	0.9	9.7
Other Injuries (E890-999)	0.5	0.0	1.5
All Other Causes	14.9	5.2	14.2
TOTAL	46.8	23.6	75.7

Population estimates from N.J. Department of Labor and N.J. Center for Health Statistics (1984)

1980 Pediatric Hospitalization in New Jersey

By Age Group and Race

Age Group	Race	Number	Rate per 1000	National Rate for White and Nonwhite
1-4	White	19,524	67.6	
	Nonwhite	14,412	186.0	
	Both	34,393	94.3	86.3
5-14	White	35,768	41.2	
	Nonwhite	16,664	67.5	
	Both	53,257	47.8	49.9
15-17	White	13,795	45.3	
	Nonwhite	6,348	56.4	
	Both	20,540	49.3	67.1
Total 1-17	White	69,087	47.3	
	Nonwhite	37,424	86.0	
	Both	108,190	57.1	63.0

Pediatric Admissions by Diagnosis Category and Age Group

For each age group (1-4, 5-14, 15-17) hospitalizations were categorized into sixteen principal diagnosis categories.

Diagnosis Category	ICD-9cm Code	1 to 4 Rate per 10,000	5 to 14	15 to 17
Infections	001-139	50.8	17.7	13.8
Neoplasms	140-239	7.1	8.8	11.6
Endocrine	240-279	6.2	7.7	7.7
Hematologic	280-289	11.3	14.0	7.7
Mental Disorders	290-319	3.2	7.6	23.2
CNS & Sensory	320-389	114.1	42.4	12.7
Circulatory	390-459	11.7	3.4	4.7
Respiratory	460-519	322.8	112.9	58.5
Digestive	520-579	137.4	61.5	64.0
Genitourinary	580-629	41.2	32.6	35.7
Integumentary	680-709	16.3	11.5	13.1
Musculoskeletal	710-739	9.2	16.0	30.0
Congenital Anomalies	740-759	36.3	14.8	6.5
Perinatal Originating Conditions	760-779	.6	.1	.02
Ill Defined Conditions	780-799	56.8	20.4	14.0
Injuries & Poisonings	800-999	108.2	90.7	100.8

NUMBER OF REPORTED
SELECTED COMMUNICABLE DISEASES
NEW JERSEY 1987
BY AGE GROUP

DISEASE	AGE GROUP						
	UNDER 1	1-4	5-9	10-14	15-19	OVER 19	TOTAL
MEASLES	0	3	1	5	19	4	*39
MUMPS	0	15	32	10	11	8	76
PERTUSSIS	21	4	0	0	0	0	25
POLIO	0	0	0	0	0	0	0
RUBELLA	0	0	0	0	0	1	1

* Total does not add due to seven cases with age unspecified.

Table XIX

New Jersey
Immunization Status
Public, and Non-Public Schools
Meets all Requirements
School Year 1986-87

COUNTY	TOTAL ENROLLMENT	% Meeting Requirements in %PUBLIC	%NON-PUBLIC	%PRE-SCHOOL	%TOTAL
Atlantic	39,364	98.62	98.49	90.00	98.02
Bergen	143,200	99.16	99.14	96.75	98.95
Burlington	75,360	98.94	98.81	94.78	98.62
Camden	103,311	98.49	98.74	94.37	98.23
Cape May	14,654	98.79	95.77	91.64	97.99
Cumberland	29,510	99.37	98.77	91.53	98.87
Essex	160,394	98.63	97.63	93.48	98.06
Gloucester	43,620	99.07	97.15	89.85	98.24
Hudson	94,064	97.14	98.11	88.72	96.98
Hunterdon	18,363	99.31	84.40	94.77	98.85
Mercer	63,423	98.40	98.33	93.05	97.89
Middlesex	106,626	99.09	99.07	93.68	98.70
Monmouth	109,197	99.42	99.15	94.65	98.97
Morris	81,495	99.35	98.19	96.92	98.98
Ocean	72,160	99.39	99.00	94.32	99.00
Passaic	84,212	97.81	98.00	92.32	97.50
Salem	13,635	99.01	96.43	88.86	98.28
Somerset	41,094	99.24	98.23	95.66	98.72
State Schools	1,921	97.24	0.00	0.00	97.24
Sussex	28,427	99.10	96.96	94.17	98.51
Union	85,410	98.17	99.12	90.53	97.71
Warren	17,315	99.45	98.89	96.17	99.18
Total State	1,426,755	98.77	98.50	93.79	98.35

282X

CHILDHOOD LEAD POISONING PROGRAM SUMMARY 1987

COUNTY/MUNICIPALITY	SCREENED	CLASS II, III, IV	% POSITIVE
ATLANTIC COUNTY	40	3	7.5%
Atlantic City	15	2	13.3%
BERGEN COUNTY	265	3	1.1%
Englewood	71	1	1.4%
Hackensack	109	1	0.9%
BURLINGTON COUNTY	1281	8	0.6%
CAMDEN COUNTY	6190	60	1.0%
CAPE MAY COUNTY	110	2	1.8%
CUMBERLAND COUNTY	1696	22	1.3%
Vineland	986	5	0.5%
ESSEX COUNTY	12463	645	5.2%
Belleville	206	0	0.0%
Bloomfield	375	0	0.0%
E. Orange	4086	76	1.9%
Irvington	750	64	8.5%
Montclair	492	2	0.4%
Newark	5272	455	8.6%
Nutley	84	0	0.0%
Orange	1161	48	4.1%
GLOUCESTER COUNTY	3922	4	0.1%
HUDSON COUNTY	8423	107	1.3%
Bayonne	304	2	0.7%
Harrison	82	1	1.2%
Hoboken	214	5	2.3%
Jersey City	7575	86	1.1%
Kearny	68	1	1.5%
Union City	73	4	5.5%
W. New York	65	0	0.0%
HUNTERDON COUNTY	14	0	0.0%
MERCER COUNTY	1819	80	4.4%
Trenton	1794	80	4.5%
MIDDLESEX COUNTY	2748	32	1.2%
MONMOUTH COUNTY	6749	41	0.6%
Asbury Park	1557	20	1.3%
Freehold	293	3	1.0%
Keansbury	440	0	0.0%
Long Branch	1190	8	0.7%
Neptune	547	4	0.7%
Red Bank	390	0	0.0%
MORRIS COUNTY	93	6	6.5%
OCEAN COUNTY	48	5	10.4%
PASSAIC COUNTY	5250	180	3.4%
Passaic	84	2	2.4%
Paterson	5143	178	3.5%
SALEM COUNTY	117	2	1.7%
SOMERSET COUNTY	64	0	0.0%
SUSSEX COUNTY	0	0	

293*

Table XX

CHILDHOOD LEAD POISONING PROGRAM SUMMARY 1987

UNION COUNTY	7447	123	1.7%
Cranford	60	0	0.0%
Elizabeth	3893	83	2.1%
Hillside	442	7	1.6%
Linden	570	2	0.4%
Plainfield	1713	22	1.3%
Roselle	261	6	2.3%
Roselle Park	72	0	0.0%
WARREN COUNTY	6	1	16.7%
OUT-OF-STATE	53	8	15.1%
TOTAL	58798	1332	2.3%

DEVELOPMENTAL CENTERS

New Lisbon	120	2	1.7%
Woodbine	25	3	12.0%
Vineland	503	19	3.8%
Hunterdon	70	0	0.0%
North Jersey	130	5	3.8%
North Princeton	26	0	0.0%
TOTAL	874	29	3.3%

Table XXI

CHILDHOOD LEAD POISONING PROGRAM

Progress and Evaluation Report
CY87

OBJECTIVE	PROGRESS	EVALUATION
Total Number Children Screened	51224	E
Total Number Class IV	36	//////////
% Class IV Receiving Diagnostic Eval.	97%	E
Total Number Class III	335	//////////
% Class III Receiving Diagnostic Eval.	97%	E
Total Number Class II	758	//////////
% Class II Receiving Diagnostic Eval.	94%	E
Total Current Follow-up	1433	//////////
Total Delinquent Follow-up	231	//////////
% Current	86%	E
Number With Pb Hazard Found	1395	//////////
Number With Pb Hazard Reduced	1146	//////////
% Reduced	82%	E

* Funded Lead Programs Only

Table XXII

Childhood Lead Poisoning Prevention

Priority I Municipalities

Municipality	Number of Children at High Risk	Score	Rank
Newark City	28592	29.3484	1
Camden City	7038	26.3315	2
East Orange City	5770	25.6880	3
Asbury Park City	1308	23.6314	4
Wrightstown Borough	585	21.6026	5
Paterson City	12058	20.9343	6
Woodbine Borough	200	20.2289	7
Orange City	2192	19.9609	8
Trenton City	7056	19.4497	9
Passaic City	4361	19.4057	10
Jersey City	17314	17.9643	11
Victory Gardens Boro	93	16.9707	12
Hoboken City	3215	16.9674	13
Salem City	564	16.9084	14
Penns Grove Borough	493	16.7747	15
Atlantic City	2166	15.3495	16
Lawnside Borough	159	15.3345	17
Bridgeton City	1682	15.3186	18
Plainfield City	3374	15.2929	19
New Brunswick City	2366	14.9512	20
Pleasantville City	959	13.9340	21
Union City	3993	13.5895	22
Irvington Town	4040	13.3997	23
Chesilhurst Borough	128	12.8999	24
Paulsboro Borough	545	12.8840	25
Seaside Heights Boro	138	12.2202	26
Long Branch City	2128	12.1371	27
Pemberton Borough	89	11.9559	28
Elizabeth City	7386	11.9256	29
Hi-Nella Borough	117	11.6941	30
Fairfield Township	409	11.5948	31
New Hanover Township	677	10.5910	32
Perth Amboy City	2883	10.4456	33
East Newark Borough	125	9.6555	34
West New York Town	2250	9.4321	35
Shrewsbury Township	83	9.3751	36
Wildwood City	293	8.8400	37
Englewood City	1357	8.6418	38
Mount Holly Township	809	8.3955	39
North Hanover Township	1200	7.6495	40
Bradley Beach Borough	326	7.5989	41
Commercial Township	398	7.3837	42
Deerfield Township	176	7.2579	43
Lakewood Township	3384	7.1521	44
Burlington City	621	7.1151	45
Red Bank Borough	587	6.9260	46
Keansburg Borough	858	6.7463	47

Table XXII

Priority I Municipalities Con't.

Municipality	Number of Children at High Risk	Score	Rank
Pemberton Township	2841	6.6862	48
Burlington Township	793	6.6530	49
Weehawken Township	750	6.4487	50
Bordentown City	278	6.4369	51
Sussex Borough	199	6.3263	52
Hackensack City	1964	6.2054	53
Morristown Town	763	6.1937	54
Egg Harbor City	358	6.1754	55
Roselle Borough	1213	6.0483	56
Neptune Township	1639	5.9870	57
Clayton Borough	620	5.9495	58
Freehold Borough	730	5.9396	59
Glassboro Borough	859	5.8966	60
Lindenwold Borough	1426	5.8891	61
Hillside Township	1297	5.7852	62
Lakehurst Borough	313	5.7612	63
Swedesboro Borough	778	5.7130	64
Jamesburg Borough	362	5.6757	65
Beverly City	225	5.6133	66
Woodbury City	696	5.5403	67
National Park Borough	318	5.5218	68
Winfield Township	97	5.4576	69

DECAYED (D), MISSING (M) AND FILLED (F) PERMANENT TEETH FOR CHILDREN IN HIGH RISK AREAS

Area	#	Male	Female	Both Males & Females
1	375	4.13	5.31	4.75
2	732	5.47	6.15	5.83
3	468	4.09	4.40	4.28
4	541	3.16	4.41	3.88

DECAYED (D), MISSING (M) AND FILLED (F) PERMANENT TEETH FOR CHILDREN IN LOW RISK AREAS

Area	#	Male	Female	Both Males & Females
1	271	3.51	3.71	3.60
2	255	3.29	3.72	3.51
3	467	2.67	3.27	2.96
4	406	3.09	3.23	3.15

Table XXIII a

DECAYED (D), MISSING (M) AND FILLED (F) PERMANENT TEETH FOR CHILDREN

#	Age	Male 1707	Females 1849	Both Male & Females 3556
3556	All	3.79	4.51	4.17
6	13	5.00	3.50	4.50
502	14	3.22	3.94	3.59
1686	15	3.67	4.40	4.07
1182	16	4.03	4.81	4.43
159	17	4.72	5.58	5.09
21	18	3.64	6.00	4.43

Table XXIII b

STATE OF NEW JERSEY FLUORIDE MOUTHRINSE PROGRAM

COUNTY	# OF PUBLIC SCHOOLS	# PUBLIC SCHOOLS PARTICIPATING	% PUBLIC SCHOOLS PARTICIPATING	# NON-PUBLIC SCHOOLS PARTICIPATING	RANK BY COUNTY	# STUDENTS PARTICIPATING
Atlantic	66	21	32	4	5	5,114
Bergen	210	14	7	12	13	3,832
Burlington	102	14	14	6	11	3,917
Camden	132	51	39	11	4	15,472
Cape May	22	12	55	2	1	4,232
Cumberland	48	13	27	1	7	2,501
Essex	171	34	20	7	9	10,688
Gloucester	65	14	22	4	8	3,747
Hudson	81	9	11	10	11	2,591
Hunterdon	35	7	20	-0-	8	955
Mercer	61	1	2	5	14	551
Middlesex	138	20	14	9	10	5,786
Monmouth	130	14	11	11	11	5,785
Morris	123	3	2	-0-	14	392
Ocean	68	19	28	4	6	4,161
Passaic	98	10	10	4	12	3,418
Salem	26	11	42	2	3	1,873
Somerset	54	-0-	-0-	-0-	16	-0-
Sussex	35	4	11	-0-	11	645
Union	110	1	1	4	15	1,050
Warren	32	17	53	1	2	3,338
TOTALS	1,807	289	16.0	97		80,048

Table XXIV

SPECIAL CHILD HEALTH SERVICES

INFANTS AND TOTAL OF ALL CHILDREN UP TO AGE 21 ADDED TO THE SERVICE REGISTRY IN 1985 - BY PRIMARY DIAGNOSIS, ALL CONDITIONS, AND CONDITIONS BY TYPE OF INSURANCE COVERAGE

DIAGNOSTIC CATEGORIES		UNDUPLICATED COUNTS OF ALL REGISTRATIONS BY PRIMARY DIAGNOSIS		NUMBERS OF DIAGNOSED CONDITIONS PRESENT IN ALL REGISTRATIONS		NUMBERS AND PERCENTS OF TOTAL DIAGNOSED CONDITIONS BY TYPE OF INSURANCE COVERAGE*									
						NONE		MEDICAID		UNSPECIFIED		UNKNOWN		PRIVATE	
RANGE	DESCRIPTION	INFANTS	TOTAL	INFANTS	TOTAL	#	%	#	%	#	%	#	%	#	%
001-139	INFECTIOUS AND PARASITIC DISEASES	10	23	38	63	16	25.40	22	34.92	3	4.76	10	15.87	12	19.05
140-239	NEOPLASMS	60	151	82	183	19	10.38	20	10.93	27	14.75	9	4.92	107	58.47
240-279	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES, AND IMMUNITY DISORDERS	48	149	95	222	32	14.41	30	13.51	37	16.67	34	15.32	89	40.09
280-289	DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS	8	34	22	58	7	12.07	17	29.31	9	15.52	3	5.17	22	37.93
290-319	MENTAL DISORDERS	4	483	23	956	101	10.56	282	29.50	183	19.14	89	9.31	301	31.49
320-389	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS	28	460	117	857	135	15.75	214	24.97	148	17.27	62	7.23	296	34.54
390-459	DISEASES OF THE CIRCULATORY SYSTEM	41	68	177	247	30	12.15	38	15.38	31	12.55	18	7.29	129	52.23
460-519	DISEASES OF THE RESPIRATORY SYSTEM	7	134	31	208	47	22.60	44	21.15	30	14.42	15	7.21	72	34.62
520-579	DISEASES OF THE DIGESTIVE SYSTEM	90	110	172	215	31	14.42	55	25.58	21	9.77	16	7.44	92	42.79
580-629	DISEASES OF THE GENITOURINARY SYSTEM	8	30	50	80	19	23.75	12	15.00	4	5.00	5	6.25	40	50.00
630-676	COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM	3	4	6	7	1	14.29	0	0.00	1	14.29	0	0.00	5	71.43
680-709	DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE	53	59	68	82	11	13.41	9	10.98	13	15.85	1	1.22	48	58.54
710-739	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE	8	119	22	163	31	19.02	51	31.29	25	15.34	10	6.13	46	28.22
740-759	CONGENITAL ANOMALIES	2300	2677	3330	3936	422	10.72	657	16.69	443	11.26	282	7.16	2130	54.12
760-779	CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD	3481	3798	7360	8097	1211	14.96	1771	21.87	618	7.63	540	6.67	3953	48.82
780-799	SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS	127	431	307	862	125	14.50	235	27.26	153	17.75	51	5.92	297	34.45
800-999	INJURY AND POISONING	2	133	8	191	30	15.71	76	39.79	20	10.47	8	4.19	57	29.84
	DIAGNOSIS PENDING; OTHER	226	290	1431	1692	185	10.93	409	24.17	155	9.16	95	5.61	847	50.06
	TOTALS	6504	9153	13339	18119	2453	13.54	3942	21.76	1921	10.60	1248	6.89	8543	47.15

* Does not include twelve diagnosed conditions for two cases with other types of insurance coverage.

NUMBERS AND PERCENTS OF UNDUPLICATED COUNTS OF ALL REGISTRATIONS (N = 9153) BY TYPE OF INSURANCE COVERAGE

1206	13.18	1772	19.36	1175	12.84	638	6.97	4360	47.63

301 X

Table XXV

Children Registered With Selected Congenital Anomalies And Other Significant Conditions - 1985

Selected Congenital Anomalies	< 1 yr.	1 yr.	Total
Spina bifida with/without hydrocephalus	49	14	63
Transposition of great vessels	24	8	32
Ventricular septal defect	93	33	126
Patent ductus arteriosis	82	18	100
Cleft Palate	51	22	73
Cleft palate with cleft lip	87	14	101
Tracheo-esophageal fistula	17	2	19
Atresia/stenosis of large intestine	33	3	36
Renal agenesis	10	1	11
All limb reductions	63	3	66
Down syndrome	86	34	120
Biliary atresia	2	5	7
Hypoplastic left heart	15	0	15
Subtotals	612	157	769
Other Significant Conditions			
Cystic fibrosis	9	17	26
Asthma	6	146	152
Werdnig-Hoffman Syndrome	0	3	3
Fetal alcohol syndrome	10	3	13
Neurofibromatosis	4	7	11
PKU	11	5	16
Sickle cell	0	16	16
Cerebral palsy	9	125	134
Epilepsy	1	24	25
Scoliosis	4	73	77
Leukemia	2	27	29
Neoplasm - malignant	0	50	50
bone	0	4	4
genitourinary	0	0	0
CNS	0	10	10
Broncho pulmonary dysplasia	46	18	64
Hearing loss (all types)	12	243	255
Muscular dystrophy	1	6	7
Diabetes	4	40	44
Quadriplegia	0	9	9
Amputation - Leg-foot	0	5	5
Arm-hand	0	2	2
Spinal cord injury	0	4	4
Burns - severe	0	2	2
Head injuries	0	20	20
Arthritis - juvenile	0	8	8
other	0	5	5
Renal failure	0	17	17
Developmental delay	61	481	542
Subtotals	180	1,370	1,550
Grand Totals	792	1,527	2,319

Table XXVI

Comparison of SCHS Data
1981 and 1985
By Need Indicators

Infants ≤ 1 year of age registered by major diagnostic categories:	1981	1985
Infectious and Parasitic Diseases	36	10
Neoplasms	10	60
Endocrine, Nutritional, and Metabolic Diseases, and Immunity Disorders	23	48
Diseases of the Blood and Blood-Forming Organs	6	8
Mental Disorders	35	4
Diseases of the Nervous System and Sense Organs	50	28
Diseases of the Circulatory System	14	41
Diseases of the Respiratory System	284	7
Diseases of the Digestive System	44	90
Diseases of the Genitourinary System	6	8
Complications of Pregnancy, Childbirth, and the Puerperium	0	3
Diseases of the Skin and Subcutaneous Tissue	2	53
Diseases of the Musculoskeletal System and Connective Tissue	81	8
Congenital Anomalies	431	2,300
Certain Conditions Originating in the Perinatal Period	979	3,481
Symptoms, Signs, and Ill-Defined Conditions	45	127
Injury and Poisoning	112	2
Diagnosis Pending	-	226
Total	2,158	6,504

Table XXVII

RATES PER 1000 LIVE BIRTHS OF SELECTED DIAGNOSES AS REPORTED BY DIFFERENT BIRTH DEFECTS MONITORING SYSTEMS

ICD-9 CODES	SYSTEM AND DIAGNOSTIC DESCRIPTION	REPORTING SYSTEMS: Birth Defects Monitoring Program: 1970 - 1973 Northeast	Birth Defects Monitoring Program: 1970 - 1973 Total	Birth Defects Monitoring Program: 1980 Northeast	Birth Defects Monitoring Program: 1980 Total	Atlanta[a] 1968 - 1979	New Jersey 1985
	Central Nervous System:						
740.0 - 740.2	Anencephalus and similar anomalies	.51	.52	.37	.33	.73	.20
741.0 - 741.9	Spina bifida	.69	.72	.38	.52	.95	.53
742.3	Congenital hydrocephalus (without spina bifida)	.47	.47	.39	.40	1.00	.51
	Cardiovascular:						
745.1	Transposition of great vessels	.09	.08	.09	.08	.38	.25
745.4	Ventricular septal defect	.58	.52	1.45	1.17	1.89	.94
747.0	Patent ductus arteriosus	.46	.51	1.71	1.67	N.A.	.89
	Craniofacial:						
749.0	Cleft palate (without cleft lip)	.57	.53	.39	.49	.63	.53
749.1 - 749.2	Cleft lip (with or without cleft palate)	.92	1.00	.66	.80	1.06	.94
	Gastrointestinal:						
750.3	Tracheoesophageal fistula	.17	.16	.19	.20	.22	.18
751.2	Atresia and stenosis of large intestine, rectum, etc.	.42	.36	.41	.34	.43	.35
	Genitourinary:						
753.0	Renal agenesis and dysgenesis	.09	.08	.09	.12	N.A.	.12
	Musculoskeletal:						
755.2 - 755.4	Reduction deformities	.29	.31	.44	.38	.78	.64
	Chromosomal:						
758.0	Down's syndrome	.97	.83	.87	.73	.94	.83

[a] N.A. = Not Available

April, 1986.

304X

Table XXVIII

ESTIMATED PREVALENCE OF CHRONIC DISEASES AND CONDITIONS IN CHILDREN AGES 0 - 20 IN NEW JERSEY*

Disorder	Prevalence/1000	Estimated Total
Arthritis	2.2	5,031
Asthma	38.0	86,906
Mod. to Severe	10.0	(22,870)
CNS Injury		
Tr. Brain Inj.	.05	114
Paralysis	2.1	4,803
Cerebral Palsy	2.5	5,713
Ch. Renal Failure	.08	183
Terminal	.01	(23)
Non Term.	.07	(160)
Cleft Lip/Palate	1.5	3,430
Cong. Heart Dis.	7.0	16,009
Severe	.5	(1,144)
Cystic Fibrosis	.2	457
Diabetes Mellitus	1.8	4,117
Down Syndrome	1.1	2,516
Hearing Impairment	16.0	36,592
Deafness	.1	(229)
Leukemia		
Actue Lympho.	.11	252
Mental Retardation	25.0	57,175
Muscular Dystrophy	.06	137
Neural Tube Defect	.45	1,029
Spina Bifida	.40	(915)
Encephalocele	.05	(114)
PKU	.10	229
Sickle Cell Disease	.46	1,052
Sickle Cell Anemia	.28	(640)
Seizure Disorder	3.5	8,004
		233,749

*Based on prevalence estimates for 1980, published in Chronic Diseases in Children, the Pediatric Clinics of North America, 1984.

APPLICATION FOR ALCOHOL AND DRUG ABUSE AND MENTAL HEALTH SERVICES

BLOCK GRANT FY 1988

Submitted by:

Honorable Thomas H. Kean
GOVERNOR, STATE OF NEW JERSEY

Molly Joel Coye, M.D., M.P.H.
COMMISSIONER OF HEALTH

NEW JERSEY DEPARTMENT OF HEALTH
A BETTER STATE OF HEALTH

306x

APPLICATION FOR

ALCOHOL AND DRUG ABUSE

AND MENTAL HEALTH SERVICES

BLOCK GRANT FY 1988

NEW JERSEY STATE DEPARTMENT OF HEALTH

Contact Person:

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307X

Application for

Alcohol and Drug Abuse and Mental Health Services
Block Grant FY 1988

Table of Contents

		Page Number
Part I	A. Statement of Assurances	1
	B. Introduction	1
Part II	Alcohol	
	A. Problem Definition and Action Plan FY 88	3
	B. Alcoholism and Drug Abuse (AD) - Introduction	16
	C. Performance and Expenditure Report FY 87	17
	D. Spending Plan FY 88	28
Part III	Drug Abuse	
	A. Problem Definition and Action Plan FY 88	36
	B. Performance and Expenditure Report FY 87	47
	C. Spending Plan FY 88	51
Part IV	Mental Health	
	A. Problem Definition, Goals and Objectives FY 88	53
	B. Progress/Performance and Expenditure Report FY 87	86
	C. Action/Spending Plan FY 88	94
Part V	Attachments	110

PART I

A. STATEMENT OF ASSURANCES

Through its Administration, the State of New Jersey assures that:

(1) The State will comply with Section 1916(c) (1) through (15) of the Public Health Services Act.

(2) The Joint Budget Oversight Committee on Federal Funds of the New Jersey State Legislature formally held one (1) regional public hearing on the Federal Block Grants. The hearing was held on October 8, 1987 in Trenton, New Jersey. A transcript tape of this hearing is available.

(3) The State agrees for the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under Section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, or on the basis of race, color, or national origin under Title IV of the Civil Rights Act of 1964, programs and activities funded in whole or part with funds made available under this part are considered to be programs and activities receiving federal financial assistance.

No person shall, on the grounds of sex or religion be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity funded in whole or part with funds made available under this part.

B. INTRODUCTION

Alcoholism, drug abuse, and mental illness are major public health problems which have traditionally been addressed by both government and the private treatment system in a categorical manner. Over the past several year, given the federal leadership and that of the State-wide Health Coordinating Council (SHCC), in addition to cooperation between the New Jersey Departments of Human Services and Health, planning efforts have been directed at looking at these systems in a comprehensive manner.

The New Jersey Department of Health (DOH) will continue its designated role as the administrative agency for the ADM Block Grant (BG) monies. As such, the department has transferred, and will continue to transfer funds allocated for mental health services to the New Jersey Department of Human Services, Division of Mental Health and Hospitals (DMHH), and will allocate alcohol and drug (AD) monies to respective categorical divisions in the Department of Health, Division of Alcoholism (DOA) and the Division of Narcotic and Drug Abuse Control (DNDAC).

At this writing (6/1/87) we are anticipating that the applicable sections of the PHS Act will be reauthorized for an additional three (3) year period. We anticipate that $495,000,000 will be authorized and appropriated to the States to implement the ADM BG Program during FFY 1988. Therefore, the fiscal projections used in this application are those based on the approved program funds for ADM services for New Jersey from FFY 1987, reduced by the funds channelled thru the ADM BG from the Anti Drug Abuse Act of 1986. If Congress appropriates a different amount, required adjustments will be made as necessary.

The DOH is applying for $20,787,000 in BG funds for federal fiscal year (FFY) 1988, which it anticipates to be available through the ADM BG. In this seventh funding year, the allocation of these funds to the three (3) categorical divisions will be the same as during FFY 1987; $10,755,000 or 51.74% will be allocated to DMHH for mental health purposes, and $10,032,000 or 48.26% will be allocated for Alcoholism and Drug Abuse (AD) purposes.

Of this latter amount, $6,521,000, or 65% of the subtotal, will be assigned to the DNDAC for drug abuse services, and $3,511,000 will be assigned to the DOA for alcoholism services provision. The assignment of the AD funds maintains the same ratio utilized in allocating FFY 1987 BG funds, and earlier BG funds, as well. Attachment 1, 1-A, 1-B provide both composite and individual, categorical pie charts to illustrate the projected funding patterns.

The application includes descriptions of the alcohol, drug abuse and mental health services to be funded in FFY 1988 specifying: 1) problem definition, goals and objectives and action plan, for FY 88; 2) performance/progress and expenditure reprots for FY 87; and 3) spending plans for FY 88. The text of the application is based upon language of the federal legislation, the need for services, the effectiveness of past efforts to accomplish goals and objectives and comments of the general public and professional entities. Public comments are obtained via the Legislature sponsored public hearings referred to previously in the Assurances Section of the application.

NEW JERSEY DIVISION OF ALCOHOLISM (DOA)

PROBLEM DEFINITION

The updated problem statement submitted herein will summarize current issues of concern to the statewide alcoholism constituency. Reference will be made to several planning and resource elements completed by, or available to, the DOA since the submission of the 1987 ADM BG application.

Although the development and visibility of alcoholism services has attained greater prominence in recent years, there are still major areas of need. In August 1984, a revised estimate of alcohol abuse in New Jersey was prepared which updated the estimate contained in the 1982-1984 Behavioral Health Services Plan. The revised projection, which results from a synthesis of three (3) national models (Jellinek, Marden, Federal Funding Formula) indicates that about 442,000 people, nineteen (19) years of age and above, use alcohol to the point where treatment intervention is appropriate. This represents 6.0 percent of the total State population, and 8.6 percent of those aged 19 years and above. (A complete discussion of the results of this prevalence estimate was provided in the 1987 ADM BG application attachments).

The full extent of alcohol use and abuse by young people below age 19 is not completely known. However, in order to assess the nature and scope of both drug and alcohol abuse among New Jersey juveniles, the Attorney General authorized a third statewide study conducted by a task force within the Department of Law and Public Safety's Division of Criminal Justice. Patterned after a nationwide survey entitled, "Drug Use Among American

High School Students, 1975-1977" conducted by the Institute For Social Research at the University of Michigan, a revised survey instrument was designed and administered to high school students throughout New Jersey. The study was targetted to identify and describe the types of substances used, frequency of use, and patterns of substances abused. The study, entitled Drug and Alcohol Use Among New Jersey High School Students 1987, was conducted at 34 randomly selected high schools during mid-October 1986. It included 2,296 tenth, eleventh, and twelfth grade students. The results of the questionnaire clearly indicate that prevalence of alcohol use, either singularly or in combination with other drugs, is a widespread phenomenon of continuing concern. Among the major findings of the report are the following:

1. 89.2 percent report use of alcohol at some time in their lives and 82.9 percent report using within the past year. 61.9 percent report use of alcohol within the past month. Whites are substantially more likely than Blacks or Hispanics to have used alcohol at some time in their lives and/or in the past year.

2. 34.9 percent have used alcohol to the exclusion of all other substances during their lifetime and 41.4 percent have used alcohol exclusively in the past year.

3. 14.3 percent report regular use of alcohol (ten or more occasions within 30 days). (This includes the 2.7% who report use on 40 or more occasions within that period).

In comparison to the 1983 survey, described in earlier ADM BG applications, certain trends can be noted. With regard to alcohol, marginally significant decreases are observed in reported use on ten or more occasions in the past year among all students (54.3% in 1983, 49.5% in 1986) and also among just those students who report some use of alcohol in the past year (62.5% in 1983,

59.7% in 1986). Clearly, as this updated survey indicates, alcohol is the number one drug of choice among New Jersey high school students (within the survey classification), and it is used by a majority of a N.J. high school students. This use increases through the senior year and causes problems, as defined, for fully a third of the user population.

The network of services identified by the DOA in its treatment needs model still indicates major gaps in either availability or client access. These include: detoxification services, specialized residential treatment services for youth and the medically indigent, halfway houses (for those transferred from treatment/and or the criminal justice system) and extended care services for chronic debilitated alcoholics, who are often homeless. In most instances, the need for expanded service capacity is evident. In others, including residential care, access for medically indigent youth and adults is needed within the existing private treatment network.

During CY 1986, there were 9,333 admissions to residential alcoholism treatment facilities in New Jersey. Almost 26% percent of these were functionally medically indigent. Yet, statewide utilization of all residential programs averaged 77% percent by bed days in CY 1985 and 77% percent in CY 1986. Virtually all N.J. county alcoholism authorities have identified access to residential care for the medically indigent as a major treatment objective for SFY 1988. Moreover, with the termination of the Health Care Financing Administration (HCFA) reimbursement demonstration program in December 1985, those freestanding programs which were able to receive reimbursement through Medicare and Medicaid are now considered ineligible providers. In CY 1986 almost 11 percent of admissions for residential care were eligible

for Medicare and Medicaid, the majority of which were admitted to freestanding programs under the HCFA demonstration. Currently, many of these patients are classified as medically indigent and are unable to afford appropriate services.

To date, New Jersey has implemented five (5) private residential alcoholism treatment facilities for youth, three (3) of which are located in the southern half of the State. They account for 173 licensed and operating beds. Certificates of Need are approved for one (1) additional facility in northern New Jersey totalling 36 beds.

While the need for increased treatment service availability is an apparent one, historically a number of factors have limited the development of these client services including: (1) the funding reductions experienced in the transition from categorical to federal Block Grant funding; (2) the lack of availability in New Jersey of third party reimbursement for the aged, the disabled, the poor, and medically indigent, including both Medicare and Medicaid eligibles; and (3) New Jersey's low ranking (43rd in the nation in 1982) for the allocation of State funds for alcoholism services. A discussion of recent progress in impacting the third factor is explored below.

On January 17, 1984, New Jersey enacted P.L. 1983, Chapter 531. This law created the Alcohol Education, Rehabilitation and Enforcement Fund (AEREF), which provided for the first stable State funding base for the provision of alcoholism services. Chapter 531 provides for an increase in the State wholesale beverage tax from 6.5 percent to 7.3 percent, with the proceeds dedicated to the AEREF. During the initial year,

$200,000 of these funds were targetted for the establishment of Intoxicated Driver Resource Centers (IDRC), discussed below, for the provision of client evaluation, and when indicated, treatment referral and treatment monitoring for convicted drunk drivers. In all subsequent years, beginning in State FY 1986, funds for the AEREF will be allocated as follows:

75 percent to rehabilitation (alcoholism treatment services);

15 percent to enforcement (drunk driving initiatives);

10 percent to education (student alcoholism prevention efforts).

The above cited rehabilitation and education funds, administered by DOA, will be distributed to counties according to a formula based upon population and need, subsequent to submission and approval of an annual County Alcoholism Services Plan and grant application. The plan must address a continuum of alcoholism services including the following special categorical areas: (1) urban areas with population over 100,000 people; (2) youth; (3) drinking drivers; (4) alcoholism and women; (5) alcoholism on the job; (6) alcoholism and crime; (7) dissemination of public information on alcoholism; and (8) educational programs within school systems. Each of the twenty-one (21) counties has appointed a citizen's advisory committee on alcoholism to advise the county alcoholism authority. Each county provides 25 percent of the State award in matching funds in order to receive the AEREF allocation.

State FY 1988 marks the third full implementation year of this legislation. It is anticipated that approximately $8,499,503 in AEREF funds will be made available to the counties during

State FY 1988 in order to provide the network of services legislatively outlined. In an effort to ensure locally integrated and coordinated service delivery, the DOA has contracted the monitoring responsibilities to the county alcoholism authorities for the majority of service contracts which were formerly between the DOA and local providers. These services were purchased with both State funds and Federal Block Grant funds. The need for continued coordination between DOA and county governments is essential for the full implementation of this State/local partnership. A copy of P.L. 1983, Chapter 531 was in the 1987 ADM BG application as an attachment.

On February 9, 1984, companion legislation (P.L. 1983, Chapter 444) was signed into law for the purpose of reducing the number of automobile accidents which are caused by intoxicated drivers. This law provides for:

1. an increase in the penalties for conviction of an alcohol/drug related motor vehicle offense including fines and detention; and

2. the establishment of the aforementioned county IDRCs.

Funding for the IDRCs was initially provided for under Chapter 531, but during the third operating year. they will be largely self-sustaining from client fees. In New Jersey, over 30,000 annual drunk driving convictions are recorded, approximately half of which are committed by persons in need of alcoholism treatment services. A copy of P.L. 1983, Chapter 444, was included as an attachment in the 1987 ADM BG application.

On March 19, 1985, the Department of Health released a re-

port entitled, "How Healthy are New Jerseyans?" (HHANJ) detailing how New Jerseyans measure up to national health standards set by the U.S. Surgeon General. The following categorical areas related to alcohol consumption's impact on attaining the national health care objectives were highlighted: (1) motor vehicle accidents involving drivers with blood alcohol levels of at least 0.10 percent; (2) fatalities from other (non-motor vehicle) accidents attributable to alcohol use; (3) the cirrhosis of the liver mortality rate; (4) per capita consumption of alcohol; (5) proportion of adolescents (ages 12 to 17) abstaining from using alcohol; and (6) the proportion of problem drinkers among adults who drink. Of these six focus areas, New Jersey projects that it will meet the national objectives, except for the consumption of alcohol (#4) which has shown an increasing trend. The entire Alcoholism and Alcohol Misuse section of the HHANJ document was included as an attachment to the 1987 ADM BG application.

DOA ACTION PLAN - FY 1988

Administration

A. Planning and Coordination

The DOA proposes to further coordinate and decentralize decision making and management through implementation of the Chapter 444 and Chapter 531 legislation in partnership with county governments. The DOA will: provide technical assistance in local program service and plan development; provide coordination amongst the twenty-one (21) counties to facilitate the implementation of regionalized services; and review and approve

county alcoholism plans and grant applications for State Health Service Grants.

The DOA will continue to convene categorical statewide task forces to develop, implement and coordinate services to (1) urban populations; (2) youth; (3) women; (4) alcoholics within the criminal justice system; (5) chronic multi-substance abusers; (6) drunk drivers; and (7) employed alcoholics.

The DOA will plan, assist, and implement expansion of employee assistance programs in business, industry, unions and within local and State governments.

The DOA will coordinate the provision of standardized assessment and intervention services at the 21 county based IDRCs, targetting drunk drivers as directed by P.L. 1983, Chapter 444.

The DOA will continue to garner additional resources, assure high quality and accessible services, and incorporate alcoholism prevention, intervention, and treatment services within mental health agencies, general hospitals, and socal service agencies.

B. Quality Assurance Monitoring and Evaluation

The DOA will continue to provide required grant monitoring and evaluation services to: the twenty-one (21) county service grants funded through the AEREF; and the grants executed directly with local service providers.

The DOA will maintain the alcoholism Management Information System (MIS) for the processing of agency client intake and discharge records; a revised intake and discharge record has

been implemented to meet the dual needs of county alcoholism planners and State data processing requirements. An increased capability for matching intake and discharge records will be targetted for FY 1988.

The DOA will continue the review and recommendation of grant-in-aid applications and Certificate of need applications in conjunction with the Health Systems Agencies (HSAs), State Health Coordinating Council (SHCC) and the internal Staff Review Committee.

The Quality and Utilization Review Committee (QURC) of the New Jersey Advisory Council on Alcoholism will: (1) recommend revisions in the Manual of Standards for the Licensure of Alcoholism Treatment Facilities to facilitate separate standards for youth residential alcoholism treatment facilities; and (2) recommend revisions to the bed need methodology governing the issuance of Certificates of Need for residential alcoholism treatment facilities.

Human Resources Training

The development of new or expanded treatment services requires that manpower projections be accomplished with ongoing training for implementing personnel. Additionally, approved training opportunities for alcoholism counselor certification and recertification are needed. In an attempt to make such training programs more accessible, many of the training and education offerings will be made available regionally as will some courses offered through Trenton State College's Counselor

Education Program on Alcoholism.

Alcoholism skill development training will be offered to at least 800 treatment personnel with special emphasis on women, youth, minorities and the elderly. Training provided will qualify for counselor certification and recertification credits.

Scholarships will be provided through the Trenton State College Program and the Rutgers Summer School of Alcohol Studies to qualified alcoholism professionals. These programs are geared to ensure the provision of comprehensive training opportunities to assist prospective service personnel to attain or maintain status as Certified Alcoholism Counselors.

Treatment and Rehabilitation

The DOA will further encourage the decentralization of planning, coordination and administration of contracted services through strengthening and expansion of the State/county partnerships. During State FY 1988, many services which had been previously contracted directly to local, private providers will be administered in this manner. Counties have agreed to subcontract these funds to the current providers for comparable services at the FY 1987 funding level during FY 1988, unless prior State approval is received.

The DOA will promote the development of an appropriate and cost effective system of residential services through coordination with the county alcoholism authorities. Needed services, on a regional basis, include four (4) forty (40) bed extended care treatment facilities for the chronic debilitated alcoholic,

and four (4) halfway houses for men.

The DOA will renew funding through county governments for four (4) women's treatment initiatives, as part of the 5 percent Women's Set Aside (WSA), by executing service grants with local providers for the provision of women's halfway house services, including one program for female alcoholics with their children.

The DOA will continue to encourage the mainstreaming of outpatient alcoholism treatment services operating within both acute care medical and mental health agencies in order to fill gaps in available services.

The role of the general hospital in the provision of alcoholism treatment services will continue to be an area of discussion between the DOA and the Division of Health Planning and Resources Development within the Department of Health. Hospitals in the last several years have increasingly sought to diversify their approach to the provision of health care services. This has resulted in part from the implementation of a Diagnostic Related Groupings (DRG) reimbursement system, which in turn has effected shorter lengths of stay and reductions in overall hospital bed day utilization. As a result, hospitals in New Jersey are increasingly interested in providing the acute care aspects of alcoholism treatment. Where feasible and appropriate, the DOA will work with county governments to effect the development and implementation of these services through the utilization of the most appropriate funding/reimbursement mechanism. This initiative becomes increasingly important given: (1) the continued absence of Medicare and Medicaid reimbursement for freestanding alcoholism detoxification programs; and

(2) the increased possibility that New Jersey will become part of the national prospective rate setting system governing Medicare reimbursement. In sum, the mainstreaming of alcoholism detoxification services becomes more feasible as hospitals gain expertise in the appropriate provision of these services, including the necessary programmatic aspects, while freestanding programs struggle with reimbursement and physical plant/licensure issues.

Prevention and Education

The DOA will contract directly with the sixteen (16) county based councils on alcoholism which constitute the New Jersey Alcohol Awareness Project (NJAAP). The FY 1988 contracts will be implemented consistently with the mandate of the Federal 5 percent Women's Set Aside (WSA). They will target service provision to the special needs of women. These services will include outreach, public awareness, and education activities, information and referral, and the promotion of media events, which focus on issues impacting on women and alcoholism concerns.

The DOA will provide technical assistance to the twenty-one (21) county alcoholism authorities in the implementation of the education funding and service provision mandate of AEREF. This requires the allocation of 10 percent of the funds for the provision of education and intervention service programs targetting school age students, and inservice training programs for teachers. The DOA staff will provide consultation in the development of the educational element of the county alcoholism plans and concomitant grant applications.

The DOA Treatment, Training and Education Unit (TTE) will continue to provide regularly scheduled public information and technical training programs addressing: employee assistance; youth treatment and intervention services; alcoholism and the elderly; family counseling; and alcoholism and women, including Fetal Alcoholism Syndrome (FAS) initiatives.

Inter-divisional training programs will be provided jointly between DOA and the Division of Mental Health and Hospitals (DMH&H) to inform each others staffs of available services, and the need to combine resources for the provision of services to the multi-problemed young adults, as well. An inter-divisional agreement was signed during FY 1985 formalizing the provision of these training services. Most recently, a joint training session was conducted between DOA, DNDAC, and DMH&H on March 26, 1987, to explore the development and provision of services to the Mentally Ill Chemical Abuser (MICA).

Systems Advocacy

The decision to elect alcoholism treatment is difficult enough without the complications of lack of fiscal resources, inaccessibility, or unaccessibility caused by sexual, racial, language, age, cultural or class barriers. The DOA will work with the categorical task forces described under the Planning and Coordination Section in order to promote and facilitate access to services on behalf of all New Jersey residents in need. The categorical task forces will advise the county alcoholism authorities on issues related to plan development and service implementation, including the recommendation of objectives and action strategies for inclusion in their annual plans.

ALCOHOLISM AND DRUG ABUSE (AD) PEFORMANCE AND EXPENDITURE REPORT

INTRODUCTION

A total of $21,176,000 in 1987 ADM Block Grant funds were awarded to New Jersey for ADM services. Of this amount, $10,219,000 (48.26 percent) were allocated to the two (2) categorical divisions within the Department of Health for alcoholism and drug abuse (AD) services respectively; the Division of Alcoholism (DOA) received $3,577,000 (35 percent) of the subtotal, and the Division of Narcotic and Drug Abuse Control (DNDAC) received $6,642,000 (65 percent) of the AD subtotal. Both divisions spend these funds over two (2) state fiscal years (SFY) which begin on July 1. As we enter the final month of SFY 1987, $8,154,000 (80 percent) of the AD funds were obligated or targeted for obligation during SFY 1987. The amount of $2,065, 000 (20 percent) will be obligated during SFY 1988.

The amount of $4,124,000 (40 percent) of these AD funds was obligated or is targeted for prevention services and $6,095,000 (60 percent) wasobligated or is earmarked for treatment services. The amount of $693,000 (7.0 percent) of these AD funds was or will be allocated for administrative costs within the prevention and treatment categories. The amount of $1,101,000 of the AD funds was or will be allocated to implement AD treatment and prevention initiatives under the 5 percent Women's Set-Aside (WSA); this represented 5.2 percent of the total 1987 ADM BG award, well above the required amount. Finally, $6,172,000 (60 percent) of the total AD allocation was or will be spent for contracted services, and $4,047,000 (40 percent) has been or will be spent on program operations and administration within the two divisions.

The ensuing narratives describe the individual progress reports for DOA (p.20) and DNDAC (p.47), respectively, further describing the categorical AD expenditures. The Annual Report for the 1987 ADM BG will be submitted in early 1988 and provide additional information concerning actual categorical expenditures for DOA and DNDAC, respectively.

Division of Alcoholism (DOA) - 1987 BG Expenditure and Performance Report

INTRODUCTION

During portions of SFY 1987 and SFY 1988, the DOA will have expended or obligated $3,577,000, which representes its entire allotment of 1987 ADM Block Grant funds. Of this total, $2,701,000 (76 percent) was obligated during SFY 1987 (ending June 30, 1987) and $876,000 (24 percent) will be obligated during SYF 1988. A categorical breakdown of these subtotals by state fiscal year is contained in Table I, page 35.

Of the $2,701,000) obligated during SFY 1987 $1,991,000 was expended for treatment services and purposes, and $710,000 was spent for prevention activities. Of the $876,000 of these SFY 1987 BG funds carried over into SFY 1988, $477,000 will be expended for treatment services, and $399,000 will be obligated for prevention activities. Table I on page 35 displays these 1987 Block Grant expenditures, cited above, for the alcoholism portion of the ADM BG by state fiscal year.

The amount of $390,000 has been allocated for administrative costs within the treatment and prevention categories, $280,000 during SFY 1987

325X

and $110,000 during SFY 1988. The categorical prevention and treatment performance narratives, below, will focus on DOA activities and the progress made to date in achieving authorized purposes. These will be supplemented by a separate summary description of programs and services initiated under the 5 percent WSA which cuts across both the treatment and prevention categories.

The approach to be followed in these sections will be to provide progress information and expenditure data regarding services provided to date, and those projected during SFY 1988 with FY 1987 ADM BG funds. The Annual Report will provide a more detailed and final accounting of the total expenditures, and will be submitted in early 1988. A current (and proposed) contract list which describes the type and level of services provided with 1987 ADM BG funds is included as Attachment II, page 110.

DOA - 1987 ADM BG Prevention Expenditure and Performance Report

As indicated, $1,109,000 of the 1987 ADM BG funds have been allocated to alcoholism prevention activities. Of this total, $710,000 has been obligated during SFY 1987, and the balance of $399,000 will be carried over into SFY 1988. Of these funds, $431,000 will be utilized to implement prevention grants as described below.

During SFY 1987 the following private agencies were awarded contracts with these funds totaling $225,000: 1) Trenton State College for the provision of statewide educational programs to upgrade the knowledge and

skills of alcoholism service delivery personnel ($45,608); 2) Contact 609/Ala-Call for the provision of a statewide alcoholism services hotline to furnish information and referral services to individuals experiencing alcohol-related difficulties ($60,000); 3) Rutgers University - Center of Alcohol Studies for the provision of thirty-five (35) full and partial Scholarship awards to current and future alcoholism service personnel to attend the three week Summer School of Alcohol Studies in pursuit of counselor certification ($59,100); 4) Atlantic County Council on Alcoholism was awarded initial start-up funds for the implementation of a new county based council to join the New Jersey Alcohol Awareness Project, described below ($25,525); 5) Bergen County Council on Alcoholism for the provision of Student Awareness services to impact on drunk driving ($5,600); 6) N.J. State Police in order to continue the provision of comprehensive EAP services to facilitate early intervention on behalf of State employees and their families ($13,630); 7) Signed Help for Substance Abuse to facilitate outreach activities on behalf of hearing impaired substance abusers ($2,600); and 8) Somerset County Council on Alcoholism for the provision of comprehensive county based information and public awareness services ($13,000 supplement to the 1986 ADM BG allocation).

During SFY 1988 $206,000 will be allocated to implement two(2) major prevention initiatives: 1) Rutgers University - Center of Alcohol Studies for the provision of scholarship awards to current or potential alcoholism service personnel to attend the one (1) week Summer School of Alcoholism

327K

and Drug Abuse Studies to promote alcoholism counselor certification ($15,000) and 2) renewal of the Alcoholism Awareness Project (AAP) to be provided by sixteen (16) county or regionally based councils on alcoholism to provide comprehensive public awareness and education activities targeted to the special needs of female alcohol users and abusers ($191,000). This represents partial funding of this initiative, which will be supplemented by 1988 ADM BG funds to bring the total funding level to $400,000.

The New Jersey Alcohol Awareness Project is a statewide program which conducts alcohol awareness, public information and referral services through a network of sixteen (16) local councils of alcoholism. The county-based councils work to promote a public understanding and recognition of alcoholism/alcohol abuse and the availability of treatment for individuals and their significant others, experiencing problems with alcohol.

Contract emphasis within the AAP network of councils on alcoholism continues to be placed on: the provision of comprehensive information and referral services to the public; the promotion of media events aimed at increasing public awareness of alcohol-related issues; and the coordination of planning and promotional activities with the county alcoholism authority. The major focus of these activities will be on the issue of needs of alcohol affected women as an underserved minority population. Each council will continue a County Task Force

on Women and Alcohol, and will maintain a Minority Advisory Committee. Each of the sixteen (16) councils will receive a minimum of $25,000 during SFY 1988, approximately 50% of which will be from the 1987 ADM BG, with the remainder coming from the 1988 ADM BG.

Fourteen (14) professional clerical staff in the Training, Education and Prevention Unit (TEPU) were supported by the 1987 ADM BG from October 1, 1986 through June 30, 1987, as they will be during the first quarter of SFY 1988. These employees provide specialized training, technical assistance, and grant development and monitoring functions on behalf of local public and private providers and alcoholism constituents. In addition to salary and fringe benefit costs, funds are budgeted for operational and administrative support to the TEPU. Although part of this unit, a brief progress report of the Office on Women will be presented separtely as part of the five percent WSA progress narrative.

During CY 1986, the DOA Management Information System (MIS) reported that 59,353 individual contacts for information and referral (I & R) services were recorded by the contracted network of I & R agencies. This total includes 28,246 calls received by Ala-Call, the statewide alcoholism hotline. Table II on p.35 presents the total number of recorded client services provided by both prevention and treatment service agencies during CY 1986 and Projected for CY 1987.

<u>DOA 1987 BG Treatment and Rehabilitation Expenditure and Performance Report</u>

As indicated, <u>$2,468,000</u> of the 1987 ADM BG funds have been allocated

to alcoholism treatment and rehabilitation activities. Of this total $1,991,000 has been obligated during SFY 1987 and $477,000 will be carried forwarded into SFY 1988. These funds were expended primarily for the development, contracting, provision and monitoring of alcoholism treatment services. Funds were allocated for contracted treatment services, and operational salaries and support for DOA staff. Funds were not allocated in this category from the 1987 ADM BG for implementation of the five percent WSA. Of these funds, $729,000 have been authorized to implement treatment contracts with seven (7) county governments as described in detail below; no "carryover" funds earmarked for treatment contracts in SFY 1988 are anticipated from the 1987 ADM BG.

During SFY 1987, the DOA further implemented its plan to strengthen the state/county partnerships by supplementing the AEREF contracts, authorized under P.L. 1983, Chapter 531, with state funds and federal BG funds beginning with the 1985 and 1986 ADM BGs. In previous state fiscal years, these funds had been contracted by DOA directly to local public and private service providers. As indicated, a total of $669,000 in 1987 ADM BG funds were contracted to seven (7) county governments in order to execute subcontracts with eleven (11) local treatment providers for a variety of treatment services, ten of which had formerly been funded through contracts between the DOA and the local service providers. These eleven (11) FY 1987 county grants were earmarked to fund the following categorical treatment settings: a) four (4) inpatient detoxification services (Burlington, Bergen, Camden, and Morris Counties); b) five (5) halway houses for women

(Morris, Bergen, Burlington, Essex and Somerset Counties); c) one (1) outpatient treatment service (Burlington County); and d) one (1) residential alcoholism treatment facility (Essex County). Additionally, purchase of service subcontracts were provided to women's halfway house providers in Somerset and Burlington Counties through subcontracts with neighboring counties (Mercer and Camden Counties, respectively).

One (1) additional treatment grant was provided to the Somerset Council on Alcoholism. ($60,000). Services provided included comprehensive student assistance program services including intervention and referral services within thirteen (13) district schools.

A complete listing, to date, of alcoholism treatment grantees is provided within the 1987 ADM Contract List - DOA included as Attachment II, Page 110. A summary of type and level of treatment services is provided within the listing including (when available): agency name; grant number; 1987 ADM BG dollars award; and contract start date.

The 1987 ADM BG treatment funds were also spent on the maintenance of an average of twenty-eight (28) professional and clerical staff within the DOA, during SFY 1987, and will be continued the first quarter of SFY 1988. In addition to salary and fringe benefits, funds were expended for operations' support on behalf of these DOA employees. These staff members performed a variety of program support activities including: planning; technical assistance to county governments, local agencies, and special population constituencies; and grant management and monitoring functions.

A total of 277 service provider settings, as defined, reported admission and discharge data to the DOA MIS during calendar year 1986. These agencies provided 48,382 client admissions and 42,636 discharges during this period; 63.6 percent of these resulted in treatment completions. (Of these, 27,466 were provided by state contracted or subcontracted agencies, of which 5,789 were provided by twelve (12) provider agencies who received 1987 BG funds. This is the latest time period for which composite data is available.)

Client admissions by treatment settings for calendar year 1986 were: detoxification, 6,358; intensive treatment, 8,223; residential care, 9,333; family residential, 122; extended care, 441; outpatient, 17,981; day-evening care, 3,503; halfway house, 610; intervention and referral, 451; and counselor coordinator, 1,340.

Of the 42,636 discharges, 75.6% were reported abstinent at time of discharge; 6.4 percent decreased their alcohol consumption; 1.5 percent increased consumption; 13.5 percent remained unchanged; and 0.7 percent were unknown. Family members with no drinking problem were 2.1 percent.

Concerning employment status: 12.5 percent improved their status, whereas 1.3 percent worsened; 79.3 percent remained unchanged, and 0.8 percent were unknown.

Table II on page 35 summarizes and compares client treatment activity

332X

and projected activity for the 1986 and 1987 calendar years; and, it compares categorical expenditures and budgeted funds, as well.

DOA - 1987 ADM Block Grant Women's Set-Aside (Section 1916(c)14)Performance and Expenditure Report

As indicated $666,000 (19 percent) of the 1987 ADM BG funds allocated to the DOA were designated for the implementation of the 5 percent Women's Set-Aside (WSA). This initiative was mandated under the 1984 Amendments which were activated after the beginning of FFY 1985. In September, 1985, the FFY 1985 requirement was reduced to 3 percent for the WSA, and the language of the amendments allowed the states "to initiate and provide new or expanded alcohol and drug abuse services for women". Beginning in FFY 1986, the set-aside requirement reverted to the 5 percent level.

The cornerstone of the WSA initiatives will be the renewal of the New Jersey Alcoholism Awareness Project comprised of the sixteen (16) county-based councils on alcoholism. It represents $400,000 in state contracted services. Beginning September 1, 1987, these services will again target the special needs of both alcoholic and at-risk women who constitute a minority underserved population. Specific services provided through this network of councils will include the provision of: alcoholism public awarneness activities; public information and referral services; client outreach and advocacy services; and media presentations and events aimed at increasing public attention to alcoholism-related women's issues. Each of these activities will specifically focus on aspects of women and alcohol use, and each council will participate in a county task force on women and alcohol.

The rationale for the renewal of this activity was based on two (2) major concerns. First, women represented only 21.8 percent of the population served in formalized treatment programs in New Jersey during CY 1986. Second, the effort to provide outreach and awareness activities to increase the percentage of women in treatment was perceived as a statewide need, which the network of alcoholism councils could address in a coordinated manner. A copy of the initital contract specifications for these council contracts was included in the 1986 ADM BG application. Additional information will be included in the Annual Report after these grants, funded with 1987 ADM BG resources(and supplemented with 1988 ADM BG funds), have been executed.

Additionally, personnel and support costs totaling $147,000 were or will be incurred in order to implement elements of the WSA. Two (2) full-time DOA professional staff were assigned to the effort. They performed planning and program implementation functions. A description of major SFY 1987 activities follows.

The DOA Office on Women has been responsible for coordinating activities relevant to the issue of Fetal Alcohol Syndrome (FAS), and for coordinating and promoting statewide activities concerning women and alcohol. Assigned responsibilities included: providing staff support to the New Jersey Task Force on FAS; provision of staff support to the twenty-one (21) County Plan Review Committee on Women and Alcohol; serving as the FAS liaison to the Governor's Council on the Prevention of Mental Retardation; serving as a resource liaison to the New Jersey Task Force on

Women and Alcohol; formulating recommendations for county alcoholism coordinators on pertinent issues regarding the need for specialized women's alcoholism services; and designing, coordinating, and implementing training and education programs addressing women and alcohol use.

Activity highlights from October 1986 through June 1987 included the provision of technical assistance consistent with the above primary tasks. It also includes coordination of, or participation in, the following activities and events:

- A meeting with representatives of five major liquor trade organizations to develop a relationship and explore a cooperative public information campaign.
- Representing New Jersey's effort, by making a presentation at the National Conference on Alcohol and Birth Defects in San Diego, California on October 18-21, 1986.
- Assistance in the development of and participation in a 3-day conference on Women and Alcohol November 21-23, 1986, attended by 200 participants.
- Planning of, and participation in, a conference, "Women, Alcohol and the Criminal Justice System" held on December 10, 1086, attended by 140 participants.
- Coordination of 3 subcommittees responding to the following areas: halfway houses, data on women and alcohol and developing county task forces on women. Currently 9 counties have established task forces on women and alcohol.

335X

- Assistance to Morris and Somerset Councils on Alcoholism in the development of task forces on women and alcohol.

- Facillitation of a proclamation from Governor Kean declaring May 10-15 as "FAS Awareness Week".

- Assistance in the development of the Mid-Atlantic Conference on FAS held on May 15-17, 1987, and making a presentation on the N.J. statewide FAS initiative.

Division of Alcoholism - 1988 ADM BG Spending Plan and Statement on Intended Use

As indicated the DOA anticipates the possible availability of $3,511,000 in 1988 ADM BG funds for its use in implementing a statewide alcoholism services program. These funds will be budgeted during SFY 1988 and SFY 1989. Of this total $2,667,000 (76 percent) will be allocated for treatmemt services provision, and $944,000 (24 percent) will be allocated for prevention services. Of the total $3,295,000 (94 percent) will be budgeted for SFY 1988 and $216,000 (6 percent) for SFY 1989.

During SFY 1988 $2,451,000 will be expended for treatment services, and $844,000 for prevention services. The following year, in SFY 1989, $216,000 will be allocated for treatment services and $0 for prevention services, although this breakdown between the prevention and treatment categories is subject to revision. Table III on page 35 summarizes the DOA spending plan for the 1988 ADM BG funds, subdivided by category and state fiscal year.

A proposed contract list which identified both treatment and prevention grants is included as Attachment III, page 114. Women's services under the WSA are also separately identified.

The total of $370,000 has been allocated for administrative costs within the treatment and prevention categories, $329,000 in SFY 1988, and $41,000 in SFY 1989. This represents 10.5 percent of the total award. Administrative costs include the negotiated indirect cost rate of 29.0 percent of direct salaries of all DOA employees supported by federal Block Grant funds. It is anticipated that $1,254,000 in FY 1988 BG funds will be allocated to pay salaries and $300,000 will provide for fringe benefits for 42 professional and clerical support staff in the treatment and prevention areas. This includes two (2) staff who will continue to perform women's planning tasks, as briefly described below.

A total of $1,315,000 is planned for use in executing service grants with local private providers and county governments for the continuation of prevention and treatment services. These include grants for specialized women's alcoholism services. Of this amount, all $1,315,000 is projected for implementation of grants during SFY 1988, and no funds are projected for grant execution during the first quarter of SFY 1989.

Of the total budget figure for grants, $288,000 has been allocated to implement prevention initiatives through grants to twenty (20) providers in

the following categories: a) sixteen (16) county based councils on alcoholism, which collectively form the New Jersey Alcoholism Awareness Project; b) one (1) statewide alcoholism hotline to provide alcoholism information and referral services; c) two (2) higher educational institutions for the provision of statewide educational programs services personnel and the provision of scholarship awards to facilitate counselor certification; and d) one (1) early intervention employee assistance program on behalf of the New Jersey State Police.

The sixteen (16) council grants will continue to target alcoholism prevention for women including public awareness and education services addressing the specialized needs of alcohol abusing women. Each council will maintain a county task force on women and alcohol to assist in planning and coordination of activities. These funds will supplement funds from the 1987 ADM BG which will be used to execute these renewal grants during SFY 1988.

Also, during SFY 1988, the DOA will further implement its plan to strengthen the state/county alcoholism partnership through the execution of Health Service Grants to the twenty-one (21) counties for treatment services. These awards will succeed contracts which had been written between the DOA and local service providers through SFY 1985. The grantees will again receive their funds through contracts with the alcoholism authority in county governments, which make them more responsive to, and integrated into, local service networks. This decentralization effort will give the local alcoholism authorities greater latitude in their planning process for assessing and responding to local constituency service needs.

338X

During SFY 1988, $1,027,000 will be allocated for treatment services which will be administered in this manner with fourteen (14) county governments. The annual SFY 1988 appropriation for alcoholism services from the State Legislature, and the AEREF revenues will be granted to all twenty-one (21) New Jersey counties through the submission and approval of county alcoholism plans and applications.

As indicated, fourteen (14) counties are targeted to receive 1988 ADM BG funds, which will be earmarked to provide services to nineteen (19) local service providers in the following categories: a) Residential Alcoholism Treatment Program (1); b) Inpatient Detoxification Services (4); c) Women's Halfway Houses (5); d) Men's Halfway House (1) e) Outpatient - treatment services (8). Of these fourteen (14) counties; five (5) are in the southern part of the state (Camden, Burlington, Salem, Gloucester, Atlantic), Six (6) are in the northern part of the state (Essex, Bergen, Morris, Hudson, Passaic, Union), and three (3) are in central New Jersey (Mercer, Middlesex, Monmouth). Of the above services provided by the nineteen (19) subgrantees, at least one (1) subgrantee in ten (10) of the counties will provide unique treatment services exclusively for women alcoholics and/or their children. Funds for this latter initiative total $227,000 and form a part of the 1988 ADM BG 5 percent Women's Set-Aside.

The DOA has instituted its review process for the FY 1988 county authority grants which authorized the distribution of the Chapter 531 AEREF funds. Between March 14, 1987 and June 12, 1987, seventeen (17) of the

twenty-one (21) county applications have been formally reviewed and approved through the DOA staff review process. This includes eleven (11) of the fourteen (14) counties targeted for the 1988 ADM BG funds; the Essex and Hudson Counties application have not yet been received, and Atlantic is pending review. Copies of pertinent DOA Chapter 531 review documents were included in the 1987 ADM BG as attachments.

The total projection for the 5 percent Women's Set-Aside is $562,000, which, in addition to the already mentioned treatment and prevention contracts, includes the DOA's Office on Women. Two (2) professionals will coordinate the implementation of the major women's initiatives. An operating budget of $110,000 from the 1988 ADM BG funds will assist in the implementation of these initiatives. Major activities planned for the coming year include:

- Participation in the development of a 3-day conference on women and alcohol scheduled for November 1987.
- Sending an informational letter on FAS to 85 companies with employee assistance programs, and offering educational programs on the subject to 5 major organizations - July 1987.
- Participation in development of a conference on alcohol and domestic violence scheduled for October 18, 1987.
- Provision of staff support to the New Jersey Task Force on FAS which continues to meet every 6-8 weeks. The group recently completed developing a comprehensive set of recommendations which will be submitted to the Department of Health in July 1987 for review, comment and possible implementation.

METHODOLOGY FOR DISTRIBUTION OF 1988 ALCOHOLISM BLOCK GRANT FUNDS

As in previous years, the DOA will receive the minimum allowable 35 percent share of the AD portion of the 1988 ADM BG. The methods and criteria for its distribution will be consistent with those utilized in previous years, and will be applied to maintain the level and quality of existing services. Funds will be distributed in accordance with the Problem Definition and Action Plan described earlier in this application in order to insure the continuum of care of alcoholism services contained in published DOA guidelines.

Additionally the proposed Spending Plan will be submitted to the New Jersey Advisory Council on Alcoholism for its review and approval at their regulary scheduled meting in July, 1987. This is the statutorily mandated citizens advisory committee, with Ex-officio State Government representation, which advises the Division of Alcoholism on statewide policy matters.

The applications for Health Service Grants, including those submitted by the fourteen (14) county governments, and the sixteen (16) Councils on Alcoholism, will be reviewed internally by the Division of Alcoholism's Staff Review Committee. Subsequent recommendations will be forwarded to the Director of the Division of Alcoholism. Standard New Jersey Department of Health contracting procedures will be adhered to in executing these service grants as published in Administration of Health Service Grants.

Additional quality assurance standards are maintained through the two major monitoring protocols required by DOA through: 1) Terms and Conditons for Administration of Health Services Grant, and 2) the licensure process conducted by a separate division of the New Jersey Department of Health (DOH) utilizing the Manual of Standards for Licensure of Alcoholism Treatment Facilities. In addition, the quarterly monitoring process conducted by DOA staff assesses the utilization and performance of services delivery by grantees. The licensure process ensures adherence to comprehensive quality care standards.

Finally, subsequent to the Report on Compliance (draft) written by ADAMHA after the 1984 Block Grant audit site visits conducted in 1985, the DOH has published procedures for procedural and substantive independent state review of the failure by the state to provide block grant funds to applying entities.

TABLE I

DIVISION OF ALCOHOLISM - 1987 BG EXPENDITURES

	TOTAL	STATE FY 1987	STATE FY 1988
Prevention	$1,109,000	$ 710,000	$399,000
Treatment	2,468,000	1,991,000	477,000
TOTALS	$3,577,000	$2,701,000	$876,000

TABLE II

DOA CLIENTS/FUNDING

	1987 BG FUNDING	ADMISSIONS* CY 1986	1988 BG FUNDING	PROJECTED* ADMISSIONS CY 1987
Prevention	$1,109,000	$59,353	$1,844,000	$61,000
Treatment	2,468,000	48,382	2,667,000	51,500
Totals	3,577,000	$107,735	3,511,000	$102,500

*NOTE: These include admissions from all alcoholism service agencies reporting to the DOA MIS, regardless of funding source.

TABLE III

DIVISION OF ALCOHOLISM - 1988 BG SPENDING PLAN

	TOTAL	STATE FY 1988	STATE FY 1989
Prevention	$ 844,000	$ 844,000	$ 0
Treatment	2,667,000	2,451,000	216,000
Totals	$3,511,000	$ 3, 295,000	$216,000

NEW JERSEY DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL (DNDAC)

Problem Definition:

New Jersey's strategic location in the Northeast Corridor exposes it to some unique drug-related problems. Our highways serve as a principal conduit for the transport of illegal drugs. To drug traffickers New Jersey is known not as the Garden State, but as the "Corridor" State, a passageway for drug traffic from the South to the Northeast.

The continuing battle against drugs is a costly one. It is estimated that the drug problem costs New Jerseyans $1.5 billion each year. These costs are not limited to the price of incarcerating convicted drug pushers or of providing treatment programs for drug addicts, but also include higher medical insurance premiums, worker compensation expenses, and decreased employee productivity due to absenteeism, slow-downs, mistakes and sick leave.

Drug abuse presently affects every aspect of our society. Rich and poor, white and black, urban, suburban and rural -- no one is immune from drug abuse. Perhaps the most disturbing aspect of the drug problem is its pervasiveness among our school-age children.

In 1985, New Jersey law enforcement officers made 39,922 drug-related arrests. Approximately 75 percent (31,431) of these arrests were for possession and use of drugs, while the remaining 21 percent (8,491) were

for the sale and manufacture of drugs. Arrests for all marijuana and hashish offenses remained relatively constant while the arrests for offenses involving cocaine and related narcotic drugs increased, from approximately 6,000 in 1981 to over 11,000 in 1985. Fifty-seven percent of those arrests for drug violations were between the ages of 16 and 24.

During the first five months of 1986, the State Police Narcotics Bureau seized over 1,000 pounds of cocaine, valued at over $25,500,000. In 1984, 700 pounds of cocaine were seized; in 1985, approximately 640 pounds were seized. Seizures of methaphetamines by the Narcotics Bureau also doubled during the first five months of 1986 compared to all of 1985 and tripled compared to all of 1984.

Approximately 50 percent of all crimes prosecuted in New Jersey are drug-related. One-third of all convicted offenders were under the influence of drugs when they committed their crimes. These statistics rebut the myth, still harbored by some, that drug offenses are "victimless" crimes. The drug problem is, in fact, the root cause of an untold number of violent street crimes, including murders, rapes, robberies, burglaries and thefts.

In addition, the danger posed by illegal drugs has dramatically risen with the increased use of highly potent and addictive substances such as cocaine and its easily affordable derivative -"crack". For example, from 1983 to 1984, cocaine related deaths increased 77 percent and emergency room visits 51 percent. "Crack" is more likely to cause lung damage, brain seizures and heart attack than nasal cocaine use.

DRUG ABUSE ACTION PLAN FY 1988

ADMINISTRATION

A. PLANNING AND COORDINATION

DNDAC planning and coordination processes will continue to provide analytic, technical and policy input into the development and improvement of substance abuse prevention, treatment and rehabilitation, drug control and client advocacy. Specific areas to be targeted include:

(1) maintaining, improving and monitoring intervention, treatment and rehabilitation services for substance abusers;

(2) developing and coordinating prevention and education services and programs, and by offering a comprehensive training program;

(3) controlling drug diversion by monitoring and regulating the purchasing, dispensing, and prescription writing patterns of professionals and to ensure drug quality standards by inspecting and monitoring drug manufacturers and wholesalers;

(4) advocating appropriate care for substance abusers through reviewing, planning and developing services for the underserved and inappropriately served populations;

(5) compiling, disseminating, and promoting the use of knowledge that supports alcohol and other substance use reduction and regulation activities among the general public, professional communities, and management of the Alcohol, Narcotic and Drug Abuse Unit; and

(6) maintaining a regular process of planning, policy analysis, and program development between the Divisions of Alcoholism and Narcotic and Drug Abuse Control, and with related health, mental health, justice and social service care systems.

B. Quality Assurance, Monitoring and Evaluation

As in the 1987 program year, DNDAC will cooperate with the Department of Health, Division of General Services, in their conduct of an independent fiscal audit of Block Grant expenditures. In 1988 the Department of Health will implement a system of grant awards in an effort to promote efficiency in awarding and monitoring quality services. DNDAC has developed a systemic framework for promoting quality of services.

C. Manpower Development and Training

DNDAC will continue to provide technical, consultative and training services on family systems to an association of private clinics; this association was formed subsequent to the conversion of the State operated clinics to private facilities in June, 1984.

DNDAC has been a cooperating State agency with the New Jersey State Department of Civil Services's training program for development of a cadre of Certified Public Managers, and will continue to nominate a selected number of management trainees to complete the six part training course. This training program is designed to enhance the skills of managers in an effort to promote efficient and effective State government.

TREATMENT AND REHABILITATION

During calendar year 1986 the number of admissions to drug treatment programs increased by 685 from 13,077 (end of State calendar year 1985) to 13,762 (end of State calendar year 1986). This increase in admissions continues an upturn noted in 1985.

The DNDAC Treatment Unit will direct its action agenda in 1988 to:

(1) Continuing the examination of program priorities and reallocation of the limited resources accordingly;

(2) Implementing treatment modalities, such as those providing formal use of family systems therapy for certain selected client populations;

(3) Increasing program accountabilility by requiring quarterly aggregate client status reports on drug use, criminality, employability and employment from all Statewide treatment service grantees.

(4) Continuing to support the services by drug abuse counselors in community hospitals. Ten counselors have been placed in hospitals to advise and train staff to work with patients having substance abuse problems.

(5) Continuing the Mutual Agreement Program to enable incarcerated individuals with drug problems to be released to residential treatment centers. Forty-five individuals participated in this program during 1986; the continuation of this effort is dependent upon continued State funding.

(6) Promoting efforts to address the disease of AIDS and related problems. Efforts to address these problems include the following:

(a) supporting the placement of AIDS Coordinators in drug treatment facilities to provide education and training to communities, staff and patients;

(b) establishing an AIDS Correctional Educational Program in 1987 for the purpose of educating inmates prior to parole regarding prevention and other AIDS related issues. The educational program will also provide education for all inmates in eight adult correctional facilities and seven juvenile facilities comprising a population of approximately 4,000.

PREVENTION AND EDUCATION

The Office of Prevention, Training and Education will continue to pursue its goal of reducing the incidence of substance abuse by providing and coordinating substance abuse prevention and educational programming and a comprehensive training program to the public at large, to communities, to high risk groups, and to the staff of public and private agencies throughout New Jersey.

A. The priority initiative of the Office of Prevention, Training and Education is the Statewide Community Organization Program (SCOP). The SCOP model focuses on the development of community services and activities through:

1. The recruitment, organizing and training of community leaders on the local level;

2. The imparting of information about substance abuse and AIDS and skill devlopment in needs identification and program development to address local needs;

3. Post-training technical assistance and follow-up training;

4. Coordination of community organizations and projects through inter-community information sharing;

5. Encouragment to communities to function as a prevention network to elicit political power support and to develop alternative community regional and State funding and resources.

In FY 1988, the Office of Prevention, Training and Education plans to conduct eight 3-day training sessions with one follow-up day for approximately 40 community based teams.

B. The Office of Prevention, Training and Education will also implement the following categorical objectives:

1. Primary prevention services such as education, information and training will be provided during FY 1988 by the awarding of approximately 49 grants to AIDS and substance abuse prevention service providers. Recipients of the awards include drug and alcohol treatment agencies and other community-based service providers.

2. Primary prevention and early intervention counseling services will be provided by the grantees to approximately 38,800 people. Services will also include: 1) information, referrals; 2) education/training; 3) counseling; 4) vocational assessment, training and job placement; and 5) socio-cultural and recreational activities.

3. Prevention services to school districts will be provided through a Memorandum of Agreement with the New Jersey Department of Education. These services will include curriculum development, teacher training, peer leadership and student assistance programs and general technical assistance.

4. More than 65 certified courses and seminars in substance abuse are planned for FY 1988. These trainings in AIDS and drug abuse prevention and education will be offered to human service providers, drug treatment providers, those working toward alcohol and/or drug counselor certification and other health related professionals.

5. Information dissemination for the public concerned about substance use and abuse will be maintained and the information will be provided upon request by citizens or organizations at conferences, conventions and seminars.

6. Special projects, consultant services and support services in the areas of public education, training, seminars and conferences will be conducted for a variety of target groups including adolescents, inner-city minorities, senior citizens, licensed impaired health professionals, medical personnel, law enforcement and family court systems personnel, at risk groups, etc., in substance abuse.

7. Statewide drug abuse hotlines will continue to be provided.

CLIENT AND SYSTEMS ADVOCACY

Under the general supervision of the Office of Client and Systems Advocacy, advocacy for special population, including Blacks, Hispanics and women has been integrated into activities of either the prevention or treatment and rehabilitation services where appropriate. The initiatives for advocacy of such services for these constituencies will remain in the Office of Client and Systems Advocacy.

The Women's Unit in the Office of Client and Systems Advocacy has undertaken a major assignment in its mission of promoting and fostering behavioral health for all women in New Jersey. Among the priority action agenda for the 1988 program year are:

1. participating in a network of agencies and groups planning and promoting behavioral health among women;

2. maintaining an information center and conducting training courses and events for agency service and volunteer staff regarding the nature of prevention and treatment issues for women with behavioral health problems;

3. continuing needs assessment studies on the prevalence and incidence of behavioral health problems among women and on the needs for resources and manpower;

4. visiting programs to insure that the five percent Block Grant set aside for new or expanded initiatives for women is being utilized in an appropriate manner.

The Hispanic Unit in the Office of Client and Systems Advocacy is undertaking major assignments in the following areas:

1. participating in a network task force regarding treatment and prevention in Hispanic communities;

2. conducting training courses and informational literature for task forces regarding the nature of treatment and prevention issues for the Hispanic population;

3. conducting needs assessment studies on the prevalence and incidence of behavioral health problems among Hispanics and the need for resources and manpower.

DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL (DNDAC) - 1987 BG EXPENDITURE AND PERFORMANCE REPORT

The total FY 1987 Block Grant award was $6,642,000. During State FY 1987, $5,453,000 was expended. Of the $5,453,000, $4,276,000 was expended for contractual services ($1,837,000 for prevention and $2,439,000 for treatment). Included in the contract total was $502,000 to meet the five percent Women's Set Aside. Administrative costs of $218,000 were expended in State FY 1987 which included an indirect cost of 27.5 percent. A total of $1,189,000 will be carried over into State FY 1988; $880,000 will be designated for prevention and $309,000 for treatment services.

DNDAC 1987 TREATMENT AND REHABILITATION EXPENDITURE AND PERFORMANCE REPORT

During State FY 1987 (July 1, 1986 to June 30, 1987), $3,319,000 of the total Block Grant was expended on treatment and rehabilitation services. A total of $2,439,000 was expended for treatment contracts.

Year	Number of Cocaine Admissions	% Cocaine Admissions of total Admissions
1982	603	4%
1983	917	8%
1984	1,464	13%
1985	1,993	15%
1986	3,092	22%

These figures are reflective of a nationwide increase in the use of cocaine. Recognizing the necessity to be responsive to changes in drug use patterns, the DNDAC finds itself hampered by limited monetary resources in a changing arena of drug use. Nevertheless, efforts have been made to identify appropriate models to address these changing treatment needs while maintaining maximal levels of quality services.

The number of discharges increased from 12,292 in calendar year 1985 to 12,861 in 1986 and the retention rate (or time in treatment which significantly correlates with beneficial client outcomes) decreased from 69 percent for one month or longer, in calendar year 1985 to 68 percent in calendar year 1986. The highest retention period extending from one month to nine months was 51 percent in 1985 and 49 percent in 1986. The rate of completion of treatment increased from 20 percent in 1985 to 22 percent in 1986.

Of special interest, the number of clients employed at the time of admission and upon discharge increased from 40 percent of the total discharges in calendar year 1985 to 41 percent in calendar year 1986. In both 1985 and 1986, 49 percent of the discharges were unemployed at admission and remained unemployed at discharge.

In 1985, four percent were employed at admission but were unemployed at discharge. In 1986, three percent were employed at admission and unemployed at discharge. In 1985, eight percent were unemployed at the

time of admission and were employed at discharge; in 1986, seven percent who were unemployed at admission were employed at discharge.

It should be noted that while treatment services have focused on the adult population, the problem of drug abuse among youth is increasing and drug treatment is lacking in New Jersey for this population. The lack of treatment resources for youth is further aggravated by the need for insurance coverage for drug abuse; youth are sent out of State for treatment to such states as Pennsylvania and Minnesota. Legislation for establishing an adolescent residential treatment facility has been introduced into the New Jersey Legislature. DNDAC will continue to explore avenues for addressing the needs of youth with reference to drug abuse.

DNDAC 1987 PREVENTION EXPENDITURE AND PERFORMANCE REPORT

During State FY 1987 (July 1, 1986 to June 30, 1987), $2,135,000 of the total Block Grant was expended for prevention activities. $1,837,000 was awarded to 34 contractors affording prevention services and activities to a total of 13,164 persons. Included in this amount was a portion of the $502,000 to provide women's prevention activities as part of the five percent Women's Set Aside. Twenty-one (21) drug treatment agencies were awarded Prevention slots for Intervention Services; 11 non-treatment agencies were awarded general contracts, and 43 drug treatment agencies were awarded outpatient drug free slots. $880,000 will be carried over to State FY 1988.

METHODOLOGY IN DISTRIBUTION OF DRUG ABUSE BLOCK FUNDS

The policy of DNDAC on methods and criteria for distribution of funds is historically based on the NIDA funding criteria and federal/state regulations. These were incorporated in the New Jersey State Licensure Regulations. Special conditions were established as part of the contracts between the grant applicant agencies and the Single State Agency, the prime contractor of the federal and State appppropriated funds.

In recent years, however, because of fiscal constraints, funding decisions were neither primarily based upon prevalence and incidence of problems nor upon demonstrated shortage of resources to provide added services, but upon the need to reduce the current resources and services targeted to meet established program priorities.

The determination of priorities was further based upon: (a) utilization of treatment slots; (b) identification and treatment of drug abusers with greatest medical and social costs; (c) compliance to licensing standards and contractual considerations and conditions through regional program review and monitoring process; and (d) renegotiation of specific contract issues especially the quality treatment criteria for vocational and family services through monthly meetings between DNDAC and representatives from the contracting community service agencies.

DNDAC - 1988 ADM BLOCK GRANT STATEMENT ON INTENDED USE AND SPENDING PLAN

The 1988 Block Grant award is approximated at $6,521,000. Of this total, $4,056,000 will be expended or allocated for treatment services and $2,465,000 will be expended or allocated for prevention services. $5,558,000 of the total will be expended in State FY 1988 as follows: $3,973,000 for treatment services and 1,585,000 for prevention services.

The total amount of $3,973,000 to be expended for treatment services in State FY 1988 will be apportioned as follows: $3,039,000 for treatment grants and $934,000 for other operating costs. The total amount of $1,585,000 to be expended for prevention services in State FY 1988 will be apportioned as follows: $1,160,000 for prevention grants and $425,000 for other operating costs.

The five percent Women's Set Aside will be continued with $372,000 of 1988 Block Grant funds. A total of $339,000 will be expended in State FY 1988. These funds will be allocated for grants to programs in order to provide treatment and prevention services, and utilized for other operating expenses related to women's programming in State FY 1988. The remaining $33,000 is expected to be allocated to other operating costs for women's programming in State FY 1989.

DNDAC costs for administration are expected to be $307,000, a total of $253,000 allocated for State FY 19 88 and $54,000 allocated for State FY 1989.

DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL

1987 BLOCK GRANT EXPENDITURES

	TOTAL	STATE FY 1987	STATE FY 1988
Prevention	3,015,000	2,135,000	880,000
Treatment	3,627,000	3,318,000	309,000
TOTALS	6,642,000	5,453,000	1,189,000

DNDAC FUNDING/ADMISSIONS

	FUNDING FY 87 BG	ADMISSIONS CAL YR 86
Prevention	3,015,000	5,272
Treatment	3,627,000	8,490*
TOTALS	6,642,000	13,762

*Total admissions regardless of funding source

DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL

1988 PROJECTED BLOCK GRANT EXPENDITURES

	TOTAL	STATE FY 1988	STATE FY 1989
Prevention	2,465,000	1,585,000	880,000
Treatment	4,056,000	3,973,000	83,000
TOTALS	6,521,000	5,558,000	963,000

360X

NEW JERSEY DIVISION OF MENTAL HEALTH AND HOSPITALS

A. BACKGROUND

It is the Division's goal to plan for the provision of mental health care in New Jersey within the context of a comprehensive community mental health services system and to acknowledge the interdependence between the mental health and health care systems and the "public-private" partnership in the provision of care. State mental health policy must be developed in consideration of these interrelationships. What has, historically, been viewed as the private sector, is, increasingly supported by public funds (Medicaid, Medicare, State and local allocations to non-profit agencies). Furthermore, private sector marketing strategies and targeted clientele are often determined by severity of illness and payer status. Without adequate recognition of the context of mental health care within a total systems perspective, the "private" mental health patient becomes a "public" client over time as financial and family supports are drained by this often "catastrophic" illness.

The Division's mission to serve the most needy and vulnerable residents of the State in quality programs in the community and in the State hospitals, is reflected in its commitment to ensure that both have adequate resources to treat a diverse and severely disabled population.

Following a decade of focus on persons with extensive histories of hospitalization, New Jersey is now confronting the problems of planning for the seriously mentally ill with relatively no history of hospitalization. The mental health system of the 1990's must respond to the needs of the emerging "never institutionalized" at-risk and program resistant clients. At the same time, support for long-term rehabilitative inpatient care cannot be abandoned.

Responses to consumer preference, public policy and legal remedies which have insisted upon local community networks for those in need have led to the end of an era where all of the needs of the seriously mentally ill, particularly those without financial means, are provided within large institutions. In fulfilling its mission, the Division of Mental Health and Hospitals must oversee the development of a mental health system which ensures the provision of a wide variety of local services to meet the diverse needs of consumers. Concurrently, the Department of Human Services must advocate with the larger health and social services networks for access to necessary services by mental health consumers.

The Division of Mental Health and Hospitals serves as the primary service provider in 7 State psychiatric and specialty hospitals and contracts with approximately 120 private non-profit agencies for the provision of community-based ambulatory care programs. The role of the State Mental Health Authority is shifting from one of being the primary service provider, to architect, provider and regulator of a complex decentralized system of care. Over the last decade the Division has expanded the range of community mental health programs by using public funds to purchase direct and support services from private, non-profit community agencies. Similarly, State hospitals entered into contract with private companies for certain support services (e.g., housekeeping, laundry, pharmacy) which the hospitals traditionally provided.

The once clear distinction between the public and private sectors will continue to disappear. The Division of Mental Health and Hospitals will have an increasing role in over-seeing, funding and regulating the services it formerly provided.

The **mission** of the New Jersey Division of Mental Health and Hospitals is to:

- Promote mental health
- Assure that all the citizens of New Jersey receive the mental health services they require
- Enable adults and children with mental health problems to function at their highest possible level
- Assure that services are tailored to individual consumers' needs
- Ensure that appropriate and quality services are provided in both public and private sectors at reasonable and affordable costs to the consumers and taxpayers of the State
- Promote an organized, comprehensive system of care in which consumers are served in their respective communities

As the designated State Mental Health Authority, the Division of Mental Health and Hospitals:

- Establishes policy regarding the delivery of mental health services
- Determines need and allocates resources
- Coordinates county and consumer involvement in planning
- Operates seven State hospitals
- Contracts with 120 community mental health providers
- Provides technical assistance and recommendations to the Department of Health and the SHCC regarding Certificate of Need and licensure standards
- Reviews programs for Medicaid certification
- Monitors the provision of services in accordance with Departmental and national standards
- Advocates for New Jersey's program, funding and legislative needs at the Federal level

The Problem Definition section which follows, highlights the major driving forces to which the Division must respond and which must be considered in planning for services and maximizing State and Federal allocations. Major issues which are likely to evolve from these external driving forces and their implications for the State are summarized.

B. PROBLEM DEFINITION

A limited pool of resources presently exists to address the needs of the mentally ill citizenry who rely upon the publically supported system of care. The system's ability "to do more" with existing resources has peaked, as evidenced by an analysis of community expenditures over a ten year period. Community programs now serve more clients with the same resources. The sole strategy of shifting resources from State hospitals to community programs within the mental health system is not an effective way to meet all existing or future needs. The mental health dollar has already been stretched to its limit requiring an investment of new resources to meet even existing needs.

The continual pressure exerted on State hospital and community providers to respond to the demands of emerging groups with specialized needs without additional resources has resulted in a serious weakening of the mental health system's infrastructure. "New" resources have been utilized to develop additional services while basic mental health support services and administrative functions have been necessarily neglected. As a result, past critical deficits in the areas of manpower and capitalization have surfaced and can no longer be ignored. If left uncorrected, these will result in the system's inability to provide even the most basic services to those in need.

In addition, the clinical mix and complexity of disabilities of clients served in both hospital and community programs reflects increased severity and impairment. The growing population in need of mental health services is younger, with more complex and varied problems than the institutionalized population of 10 years ago. In spite of the advances made in current psychiatric technology, there still remain those who are seriously disabled for whom long term inpatient care is appropriate and necessary. Therefore, there is a continuing role for State hospitals which must be adequately supported to provide quality care.

There is a growing public demand for a comprehensive array of quality and accessible treatment alternatives in the community. However, a corresponding increase in resources to meet this demand is lacking. The rational and orderly development of a comprehensive community support system must continue so as to eliminate "forced choices" in balancing the needs of existing populations with those of new populations. Public policy initiatives must be directed at assuring that current and future consumers will not be pitted against one another in a "disability competition".

For example, the crisis in children's services resulted in the development of a systems plan for the reorganization of children's services which brought with it a commitment for new State community care dollars. While this action has been lauded by child advocates, consumers and family members of equally underserved groups are growing increasingly impatient with the lack of resources for essential services. The reaction of the mental health community to the consequences of these forced choices was consistently reinforced at each of the public hearings conducted by the Department of Human Services in 1987.

State Hospitals are intended to provide long term psychiatric care but have, historically, provided other levels of care in the absence of community based

363X

treatment alternatives. The Division will continue with its commitment to improve the quality of care in its institutions, but efforts to fulfill this goal are stymied when these institutions continue to be called upon to fill the many gaps in the continuum of acute inpatient psychiatric care which are best provided in treatment facilities in the community.

Increased admissions and rising census at Marlboro State Hospital provides another clear example of how the lack of adequate community resources results in dangerous overcrowding in State facilities. The absence of essential community services continues to result in inappropriate over-utilization of psychiatric inpatient care, in all settings.

With the limited expansion of community programs it has been possible to decrease the size of the State hospital system by closing antiquated and unsafe buildings and investing capital dollars in facilities which were structurally sound and suitable for safe and humane care. The 1980's have witnessed an increased demand for psychiatric care in the public and private sectors. This increased demand certainly could not be met in the existing State-supported system without a massive infusion of tax dollars for ambulatory services or for any new State hospital beds which would be needed should the community system fail to respond to this emerging need.

In the face of increasing demands and limited funds, State policy must discourage what has become an unhealthy competition between community and hospital programs for fixed resources in order to maintain a balanced system of care. Continued reallocation of a fixed pool of resources can provide only short term solutions to crisis situations. Thus, the Division, in cooperation with the Department of Health and the State Health Coordinating Council (SHCC), will continue to promote the rational and orderly development of an adequately funded, accessible system of community based care to meet the mental health needs of the citizens of the State of New Jersey.

Provision of appropriate and accessible care within local community settings has been recognized as a primary goal of the mental health care system. Since 1975, public policy has recast the foundation of the State's mental health system into one which relies on community agencies for the care of the mentally ill rather than State institutions. In the decade following 1975, institutions shrank by more than half, while community-based care has nearly doubled. In 1975, admissions to State hospitals totaled 12,000 persons compared to 5,000 in 1985, a decrease of more than 55 percent. At the same time, the 74,000 persons served by community agencies in 1975 mushroomed to nearly 140,000 (unduplicated) persons in 1985, an increase of over 85 percent.

During the past decade, the population served in both hospital and community programs has changed dramatically. Individuals served in all sectors are increasingly more disabled. These changes are represented in Figure 2 in the section on Trends in Mental Health Care. The growing population in need of mental health services is not only younger, it has more complex and more varied problems than did the institutionalized population of ten years ago. Thus, the challenge to the mental health system is to continue to evolve to meet new demands. Caring for the mentally ill is further complicated by the special and unique needs of the emerging population groups. The role of the State hospital has changed as has that of the community system. More responsive and effective community-based services will prevent or reduce initial hospitalizations. More effective aftercare, and increased

housing options prevent and reduce the number of readmissions. Under optimal conditions, the State hospitals will become even smaller, with a greater ability to provide quality long-term inpatient treatment for persons who require that level of care.

There is an acceptance and rising expectation by the citizens of the State of New Jersey for the most comprehensive array of treatment alternatives in the community. This is, in large part, attributable to the Division's implementation of State and Federal mandates to reform the mental health system. As detailed in the following narrative, the growing demand for services far exceeds capacity of the existing community services systems. The emerging populations are severely disabled and, therefore, are at risk of hospitalization without appropriate community-based treatment intervention. Simply put, ten years ago, most of these individuals would have been directly referred to State hospitals for extended periods of time.

It is expected that without a substantial infusion of State funding to expand the community-based system of care, public attention will refocus on the State hospital system as the means to fulfill the mandate to serve these individuals. In short, there will be a push towards "reinstitutionalization". It should be emphasized that inappropriate use of the State hospital system due to lack of community treatment alternatives is quite costly in terms of actual health care expenditures to say nothing of the disruption to individual and family functioning.

A sizeable proportion of State facilities are unusable due to problems in the area of life safety and antiquated design and have been vacated. Thus, clearly, the Division cannot accommodate any unanticipated increase in admissions to State hospitals, if only due to the lack of useable space. Additional constraints, such as staffing requirements and legal considerations, further diminish the feasiblity of this "solution" as a response to lack of adequate community care. To illustrate this point, construction of each new hospital bed would cost approximately $160,000 (in 1986). Therefore, even a "minor" addition of 200 beds would require a capital investment, alone, of $32,000,000. Furthermore, any substantial increase in the current State hospital census would severely compromise quality of care and jeopardize the accreditation and certification required to draw down Federal reimbursement (estimated at $27.7 million for FY'85).

Thus, planning must remain consistent with established State policy, and recognize that there will be an impact on health care costs in order to assure that the needs of the citizens of New Jersey will be met in their local communities. At the same time, funding decisions must be made in the context that psychiatric systems comprise less than 2 percent of the total hospital system.

It is the Division's policy that the major focus must be the development of comprehensive community support systems with the fiscal resources to provide adequate mental health and support services to the most needy and vulnerable residents of the State. Community care providers have clearly demonstrated a willingness and ability to successfully serve the most needy and disabled mentally ill clients in their programs, even with inadequate resources. However, the problems caused by less than "true" inflationary increases on both federal and State allocations are compounded each year and have begun to seriously affect the ability of community agencies to provide basic supervision and quality care to the chronically mentally ill and at-risk populations.

In summary, the New Jersey Mental Health System has reached a delicate balance between hospital and community programs. The immediate problem is that federal cuts and new requirements in the face of increased demand, continually threaten to disrupt this delicate balance. Community programs have been stretching resources for over ten years to provide services to more clients without accompanying funds. The State has been forced to make up the difference so that essential programs could be maintained. This has only been possible because of the positive economic climate within the State and the continued and tireless efforts of mental health advocates, and the support of the State Legislature and the Governor.

Given these limited resources, it has been the Division's policy to allocate community funding based on need and to support ambulatory care programs which divert persons from all inpatient psychiatric care and permit shorter term hospitalizations.

The section which follows highlights the major driving forces to which the mental health and health care systems must respond, and, which must be considered in planning for services and maximizing State and federal allocations. Major issues which are likely to evolve from these external driving forces and their implications for the State are summarized.

C. TRENDS IN MENTAL HEALTH CARE AND ACTION PLAN

Overview

It has been demonstrated that an effective and responsible partnership between government and private non-profit contract agencies maximizes the resources available to both. For example, over the last decade the Division has expanded the range of community mental health services by purchasing these services from private non-profit community agencies. This public/private partnership is enhanced when there is a coordination of effort among government agencies. Significant systemic changes have occurred as a result of this cooperation. Factors facilitating the development of community-based, non-public service settings include:

- Department of Health reimbursement regulations for psychiatric DRG's (adult and child) and indigent care, shifting the locus of acute inpatient care, appropriately, to community hospitals
- Revisions to the State Medicaid plan to expand eligible services and increase reimbursement for mental health care
- Development of new licensing categories for adult and children's inpatient psychiatric beds
- Dedication of nursing home and Residential Health Care beds to discharged psychiatric hospital patients requiring that level of care through the Department of Health Certificate of Need process

The Division, in cooperation with the Department of Health, to fulfill its mission, must oversee the development of a mental health system which ensures the provision of a wide variety of mental health services to meet the diverse needs of

mental health consumers. At the same time, the Division must advocate with the larger health and human services networks for access to necessary services by mental health consumers.

Environmental Trends

There are a number of environmental trends which must be considered in assessing need and planning for mental health services over the next five years. Highlights of these trends and issues which are likely to evolve from these trends are summarized below:

1. **Eroding Funding Base**

   The financial base of the health care and human services delivery systems has been seriously eroding. Consumers of mental health services depend upon the health care system, generic human services and public entitlements to succeed in community living.

   Prior to the passage of the Federal Omnibus Budget Reconciliation Act of 1981, the federal government played a primary role in setting policy for and funding categorial human services programs. It was assumed that annual increases for these programs would continue, indefinitely.

   The inception of the block grants forced state governments to reevaluate their reliance on the federal system. With increased state flexibility in administering federal funds, there also came reduced federal financial participation. In assuming this new role, states were required to either cut programs or substitute state funds to cover federal cutbacks.

   In New Jersey, the Division successfully minimized the loss of federal funds to community mental health centers through administrative changes and reallocation of funds to centers in high need areas serving unserved or underserved target populations. Thus, a $4.3 million loss in federal funds for community mental health centers was absorbed by the State, minimizing adverse affects on seriously ill mental health consumers.

   During this same time period, providers of community mental health services have struggled to maintain services in the face of the following additional adverse conditions:

   - When adjusted for inflation, the total funding for community mental health services remained unchanged since 1975 (see Figure 1);
   - Medicaid rates for outpatient mental health services have not increased since 1977;
   - Client fees and grant funds (e.g. United Way) have remained stable;
   - Decreasing contributions in support of mental health programs from municipal government sources;
   - Disincentives inherent in the current State contracting system;

367x

- Inadequate inflationary increases to contract providers;

- Lack of New Jersey Medicaid coverage for case management and outreach services most needed by the chronically mentally ill;

- Limited third party coverage for mental health treatment and support services;

- Staff turnover and a diminishing manpower pool due to factors detailed in Trend C.

In the coming years it is expected that the issues noted above will be exacerbated by the following additional factors:

- Threats to the New Jersey Federal DRG Medicare Waiver

- Dwindling State budget surpluses

- Federal Block Grant formulae which penalize New Jersey due to size and per capita income

- Proposed "Gramm-Rudman" cuts

Impact on the New Jersey Mental Health Delivery System:

As described earlier, the New Jersey Mental Health System has reached a delicate balance between hospital and community programs. Any further reductions in federal funding, coupled with other factors highlighted above will result in sharp reductions in the levels and ranges of community mental health services.

Furthermore, there will be an increased demand for mental health support services as economic conditions which impact upon needy and vulnerable populations change. With expanding demands and fixed resources for mental health services, contention among needy populations will increase, creating a disability competition (as supported by indication of future demand detailed in Trend B).

These threats to the community-based system, if left unresolved, will result in an increased reliance on institutional care. Clearly, the Division's mandate to contain and consolidate State facilities remains unchanged. Thus, planning must remain consistent with established State policy, and developed in full recognition that there will be an impact on the State budget and health care costs in order to assure that the needs of the mentally ill will be met in their local communities.

Action Plan:

In response to the increased demand for community mental health services and the continued erosion of the financial base, the Division will redouble its efforts to develop alternative funding strategies. These issues will be closely examined by the Governor's Council on Mental Health, supported by the grant from the National Institute of Mental Health (NIMH) to focus on maximizing existing

reimbursement mechanisms and examine innovative approaches to refinancing the mental health system. Thus, there will be a public airing of the issues and input into the development of solutions to the issues identified.

Several areas requiring immediate attention have been identified. These include: expanded third party coverage for mental health services (e.g. Medicaid, Blue Cross, HMO, and commercial insurers) and reimbursement for indigent care provided by general hospitals. These efforts require the cooperation and assistance of the Departments of Health and Insurance whose primary role is to set public policy in these areas. Mental health advocacy groups, like the New Jersey Mental Health Association, support the need for this expanded coverage.

County government provides a substantial financial contribution to the mental health system. Traditionally, these funds have been, primarily, directed towards institutional care for county residents. As resident populations in State hospitals have declined, many counties have redirected their funds to community care programs. Through the County Mental Health Boards, the Division will continue to advocate for additional county funding for essential services. The Division's efforts in this area will be enhanced through activities under the NIMH Planning Grant and county mental health board training efforts.

In addition to working towards systemic reforms, the Division has successfully advocated for substantial new State funding for community initiatives, such as expansion of community services in the northern region of the State and a statewide expansion of children's mental health services. While the Division and mental health constituency groups will continue to advocate for increased State allocations for community programs, it is the longer term broader changes in the reimbursement structure and the partnership with the private sector described earlier which will assure an adequate and consistent funding base for the mental health care system.

ERODING FUNDING BASE

FIGURE 1

New Jersey's community mental health programs were marginal to non-existent ten years ago. Resources were initially injected through numerous sources as the State hospitals were reduced in size. New Federal sources of funding included Title XX contracts for the severely disabled and for multi-purpose Community Mental Health Centers (P.L. 94-63). State resources were introduced in 1975 through targeted Community Services Contracts for the severely disabled and increased general purpose Grant-in-Aid funds to each county. The contract residences and day programs primarily served the most disabled in supervised settings as alternatives to State hospitalization.

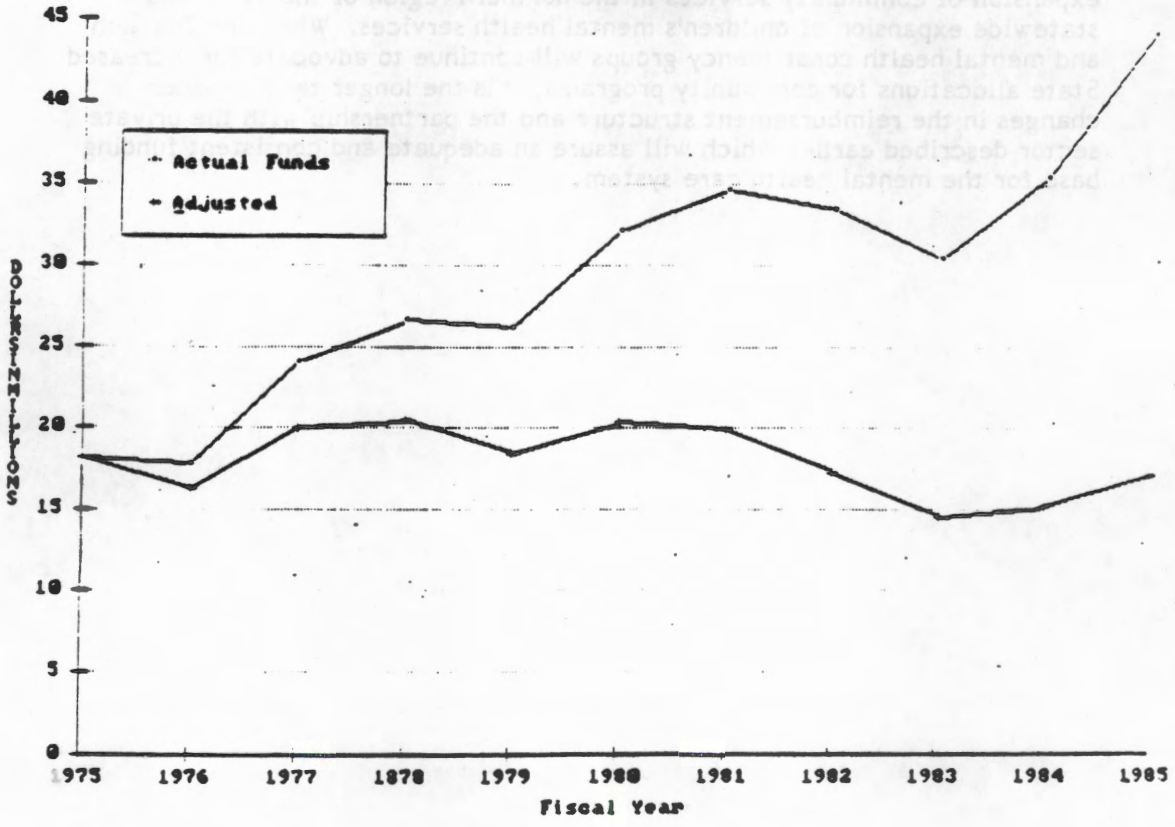
However, when adjusted for inflation, the total funding for community mental health services remained unchanged since 1975 (See Figure 1 below). Moreover, beginning in 1983, Federal subsidies diminished by more than 30 percent with the advent of block grants. The increasing Community Contract dollars were only sufficient to permit the programs to keep pace with increasing costs or to compensate for caps on federal Block Grant and Grant-in-Aid monies.

Figure 1

COMMUNITY PROGRAMS FUNDS

ACTUAL AND ADJUSTED FOR MEDICAL INFLATION

1975 - 1985



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2. Increasing Demand for Community Services

The mental health care system must remain responsive to demographic and epidemiological factors in the population-at-large. Over the last decade the mental health system has witnessed the acceptance and rising expectations by the public for appropriate treatment alternatives within their communities. The growing demand for these alternatives has underscored a need which far exceeds current capacity.

The demand for community services has been increasing over the past ten years for many reasons. There is an increased awareness that less restrictive treatment which is delivered close to or in the client's community is preferable. The growing acceptance of this "standard" is further illustrated by the recent passage of the Screening Law which revises the commitment procedures to State hospitals and fosters provision of involuntary acute care in general hospitals. Also, guarantees of civil rights for mental health clients have resulted in growing numbers of ex-hospital patients entering the community when they are no longer dangerous to themselves or others. Many of these individuals have chronic, severe mental handicaps which require intensive psychosocial rehabilitation as well as case management and support services. Evidence shows that they are better served and supported by comprehensive and coordinated community programs than in State hospitals.

As an example of the growing demand for community mental health services, there were 74,000 clients served by these community programs in 1975; it is projected that more than 155,000 will be served in FY'87. An analysis of community expenditures over a ten year period, adjusted for inflation, indicates that community programs now serve more clients with only minimal increases in resources. This pattern of "efficiency" of community services has stretched the funds provided by Federal and State sources (Figure 1). Thus, the mental health system has already been stretched to its limit requiring an investment of new resources to meet even existing needs.

As noted earlier, New Jersey is confronting the problems of planning for and developing services to an additional and new population with relatively no history of hospitalization. This change is illustrated by the increase in the numbers of 18-34 year olds being served in State, county and general hospital inpatient settings, as well as in community mental health centers. Specifically, in FY'86, more than 55 percent of all admissions to State hospitals and more than 40 percent of persons served by community agencies are comprised of this young adult population.

The growing population in need of mental health services is not only younger, it has more complex and more varied problems than did the institutionalized population of ten years ago. A high percentage of clients have histories of alcohol and drug abuse, and thus have a dual disability for which new programming and technologies must be developed. Additionally, the mental health system has been called upon to respond to the mental health needs of special populations such as the homeless, the developmentally disabled and clients with histories of criminal justice involvement. Other high risk groups with special needs include the elderly and the physically handicapped.

The demand for community mental health services has risen annually over the last three years, and all evidence indicates that this trend will continue. This conclusion is supported by the following key indicators:

Estimated Prevalence of Diagnosable Disorders

The overall prevalence of diagnosable mental disorders in the population at large is, approximately, 18 percent. By the year 1990, this would mean that 1,421,640 persons in New Jersey will have mental health problems which would require specialized mental health intervention. Furthermore, chronic mental illness has a prevalence of 1 to 2 percent of the population at large. Thus, by the year 1990, approximately 157,960 New Jersey residents will suffer from prolonged severe psychiatric disabilities.

Inpatient Psychiatric Bed Utilization

Data provided by the New Jersey Department of Health (DOH) shows a marked increase in admissions to general hospital psychiatric inpatient beds. This trend is expected to continue in view of approvals of additional psychiatric beds through the Certificate of Need process. Further indication of emerging need is supported by the recent adoption of standards which create new psychiatric bed licensing categories for children, intermediate care and special populations (such as geropsychiatric and mentally ill chemical abusers).

Mentally Ill Elderly

New Jersey statistics confirm national studies that the elderly are underrepresented as consumers of mental health services. The percentage of elderly clients enrolled in community services ranged from 3.8 percent in 1982 to 4.8 percent in FY'86. At the same time, the elderly represented 12.4 percent of New Jersey's population. It is projected that by the year 1990, this figure will rise to over 14 percent. As the general population continues to age, it is expected that there will be an increased need for services by this group.

Mentally Ill Homeless

National surveys estimate that 10-33 percent of the homeless are mentally ill. For New Jersey, the homeless population in 1986 was estimated to be approximately 25,000. This would place the estimated number of mentally ill homeless in the State at approximately 7,500 or 30 percent of the total homeless population. It is expected that as affordable housing options continue to dwindle, the number of mental health clients unable to compete successfully for affordable housing alternatives will increase.

Mentally Ill Chemical Abuser (MICA)

Approximately 30 percent of the mentally ill clients enrolled in community programs in FY'86 had either drug or alcohol problems. It is generally accepted that this percentage is an underestimation of the number of people needing specialized interventions. For example, when screening and assessment were completed by trained chemical abuse intake workers in selected mental health programs, the number of admissions with these diagnoses rose to over 50 percent.

Also, State hospital data indicate that 35 percent of the patients admitted are dually diagnosed as severely mentally ill and chemical dependent. The vast majority, or 75 percent, assessed as dually diagnosed were betweeen the ages of 18-40. As drug and alcohol abuse in the general population continues to rise, it is expected that the number of persons requiring specialized mental health and alcohol/drug intervention will also increase.

Effects of AIDS

The staggering statistics on the incidence of AIDS indicate that AIDS will have a significant impact on the mental health system. As of September, 1987, there were, 41,735 reported cases of AIDS nationally, with 2,366 in New Jersey. By 1990, it is predicted that one in 70 people will have the HIV virus in some form or stage. A secondary effect of AIDS can be severe depression and accompanying psychosis. An equally serious effect is the emotional damage to the patient and his/her relatives, with frequent occasions of serious depression and suicidal thinking. As the incidence of AIDS increases, there will be an accompanying increased demand for mental health services, especially in community programs.

Children

The 1986 Governor's Commission on Children's Services stated that recent social and economic changes affecting children and families in New Jersey are of a "magnitude unprecedented in our lifetime". Thousands of New Jersey's children are growing up in situations which are damaging to them because their families cannot provide for their basic needs. It has been established that suicide is the second leading cause of death among New Jersey's teenagers. In addition, approximately 36,000 children in New Jersey between the ages of 12 and 18 experience alcohol problems, 100,000 youngsters are involved with the courts, and 8,000 children are in out-of-home placement. The demand for inpatient psychiatric services for children has sharply increased from 1981 to 1986. For State-operated mental health facilities, the Adolescent Unit admissions doubled from 1981 to 1985 and Brisbane's admissions rose from 90 in FY'81 to 146 in FY'86. During FY'86, the Division served 23,096 children and adolescents in community programs. The demand for such services is increasing as evidenced by growing waiting lists which contribute to increased episodes of acute distress. The specific mental health needs of children are more fully discussed under Trend C.

Developmentally Disabled Mentally Ill

As a result of a parallel trend towards the deinstitutionalization of residents of State facilities for the mentally retarded, the mental health system has witnessed an unanticipated increased demand for services by this population. This may be attributable, partially, to the stresses associated with the transition to community living. It has been estimated that 5,500 formerly institutionalized retarded citizens now reside in the community. Division data indicates, that, historically, approximately 1,300 developmentally disabled/mentally retarded clients and their families need mental health treatment annually. The depopulation of State facilities for the mentally retarded, coupled with increasing demands identified by the Division of

Developmental Disabilities on its community system, will result in greater numbers of this population being referred to mental health programs and facilities. Experience, to date, has shown that to serve this population effectively, specialized intervention must be developed.

Impact on the New Jersey Mental Health Delivery System:

The New Jersey mental health service delivery system was redesigned in 1975, following a State mandate to reform its programs which was instigated by a critical comprehensive analysis of the system by the Governor's Mental Health Planning Committee in 1974. The Planning Committee's analysis dramatized the need for a complete reform of New Jersey's antiquated, fragmented, and inadequate mental health system.

In response to this mandate, major changes in the New Jersey mental health system were implemented in three areas: community reform, institutional reform, and systems reform. The thrust has been to develop community alternatives to institutionalization, and to create a comprehensive system of care in the community which is responsive to the mental health needs of the citizens of New Jersey.

Major shifts have occurred in the focus of treatment for individuals historically served in State and County hospitals. Over the last decade, the Division of Mental Health and Hospitals adopted a strategy which fostered development of community-based services to produce a dramatic decrease in the reliance on institutional care. This strategy and the Division's efforts to continue expansion of essential community services envisions a mental health system in the future which will further reduce this reliance on the massive State hospital system.

As noted above, with the expansion of community programs, there has been a decrease in the size of the State hospital system. Reduced admissions and hospital census has allowed the Division to close antiquated and unsafe buildings and invest limited capital dollars in facilities which were structurally sound and suitable for safe and humane care. This is an essential factor in understanding the implications of the system's inability to treat increasing numbers of emotionally disabled individuals in community alternatives. The beds simply are not there.

In summary, the growing demands for community services, without concomitant program development and support, threatens the very basis of the Division's mission and priorities established over a decade ago.

Action Plan:

The Division's efforts to serve the most vulnerable populations within its limited budget have resulted in a shift in the type of clients served in both hospitals and community (Figure 2). The Division has and will continue to promote greater efficiency in community programs. These programs have, already, succeeded in stretching the funds available remarkably well. The Division is also committed to maintaining accreditation and improving quality of care in its hospitals as well as promoting and supporting alternatives to

institutionalization. There is a wide variety of community mental health agencies in New Jersey supported, in part, through State contract allocations. Many provide a complete array of comprehensive community mental health services while others provide only one or two specific program elements and are complemented by other agencies within their geographic area.

However, it is the Division's position at this time that a major focus must be placed upon the development of comprehensive community support systems with the fiscal resources to provide for the mental health needs of the populations described above.

This must be done in concert with other Departments and Divisions responsible for the social/medical/specialized needs of these groups. In addition, the focus must begin with the development of core services throughout the State which includes Screening/Emergency, Case management and Short-term Acute Care Services. Further, a comprehensive commmunity support system would have to include services such as, Outpatient, Residential-Rehabilitation, Partial Care, Intensive Home Services, and Services for Special Populations (see Chart I). Implementation of this model of care is an essential step towards eliminating the following shortcomings of the current system:

- An uneven capacity to provide the full range of screening, intervention, and respite services which can prevent psychiatric hospitalization;
- A limited capacity to serve patients in need of involuntary care in commmunity general hospitals;
- A fragmented and unevenly implemented case management system with no clear responsibility to provide for support needs of the chronically mentally ill, treatment resistant and high risk clients;
- A lack of a full-range of rehabilitation and housing options throughout the State;
- A mental health service system which is not integrated with the generic social services and health care systems to ensure that all client service needs are addressed.

To address these gaps, the Division has prioritized the development of a comprehensive community support system which will emphasize the following key features:

- A single entry point (within a geographic area) through screening/emergency services. This will provide the evaluation of service needs necessary to facilitate appropriate referral and/or diversion;
- Alignment of acute mental health care with provision and financing of all acute health care;
- Short term inpatient care in local general hospitals to minimize the personal and family disruption associated with an inpatient stay. This is particularly

true of involuntary care which has, historically, been provided at regional State hospitals;

- Intensified case management services which will ensure continuity of care and ongoing support to treatment resistant and at risk clients;

- Provision of services to meet special needs within this comprehensive core model in order to reduce fragmentation.

In summary, this service model was developed in response to the increasing demands on the mental health system for intervention and support services by a diverse and severely disabled population. Ten years ago, many of these same clients would have been referred directly to State hospitals. Whereas, over the last decade the Division has planned and implemented a system of care targeted to the "deinstitutionalized" chronically mentally ill client, the mental health system of the 1990's must also respond to the needs of the "never institutionalized" at risk client.

The State Legislature, in recognition and support of the changing focus of the mental health system, has passed legislation to revise existing statutes governing the care of the mentally ill. This change reflects clinical and legal developments in the field of mental health care.

The Division has established the conceptual service model to implement these changes. However, it is not the Division's intention to promulgate a specific implementation strategy. The Division will define the basic service elements and target populations to be included in local need assessment, planning, and program development efforts.

The Division will also facilitate ongoing discussions and negotiations with sister Divisions (e.g., Medicaid, Division of Youth and Family Services, Division of Public Welfare) and other Departments (e.g., Health, Insurance, Community Affairs) to foster coordinated services which are adequately reimbursed.

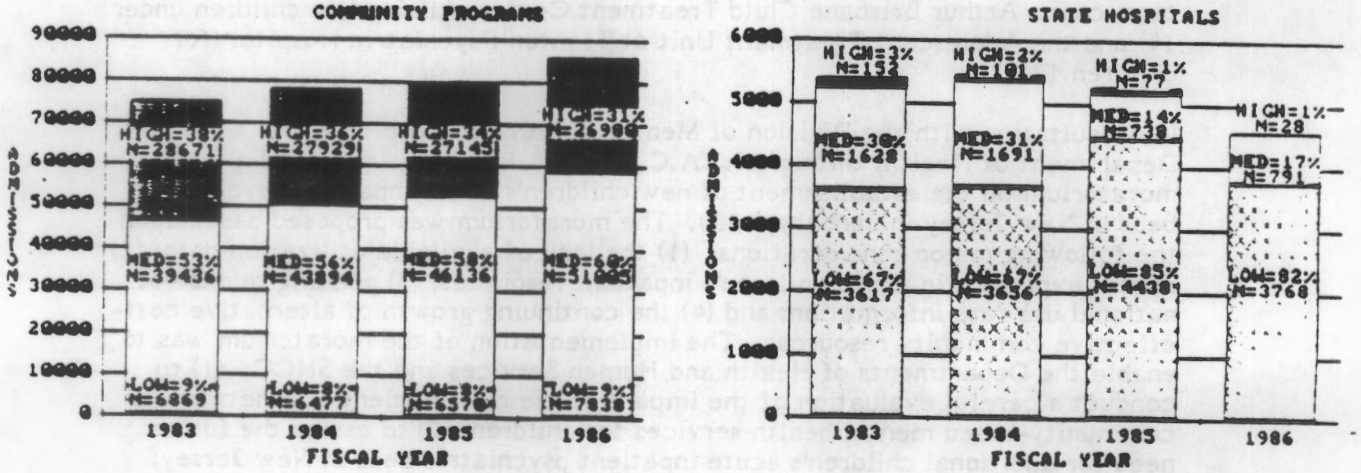
INCREASING DEMAND FOR COMMUNITY SERVICES

FIGURE 2

Ratings of the functional levels for clients admitted to hospitals and community agencies were collected in 1983, 1984, 1985 and 1986 as part of every client's registration in the mental health system. The findings show there have been slight changes over time. The clients of both hospital and community programs have become more disabled.

Over time, State hospital admissions policies have made it increasingly difficult to admit inappropriate higher functioning clients; those who are still admitted are usually court-remanded for evaluation or have no treatment alternatives. To a degree, this permitted reductions in the State hospital census. The composition of the population of admitted patients has changed from 67 percent severely disabled in 1983 to 82 percent in 1986 (Figure 3). At the same time, the Division worked closely with community agencies to assure that the severely disabled were adequately served outside the hospitals. In 1983, approximately 60 percent of clients admitted to community programs were assessed to be either severely or moderately disabled. By 1986, about 70 percent fell into these categories.

Figure 2



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3. Crisis in Children's Services

There is a growing population of emotionally disturbed children in New Jersey with very complex and diverse service needs who require the coordination of services across several systems. Community hospital inpatient units continue to be utilized at or above capacity; State facilities continue to experience serious overcrowding.

Recognition of the growing number of troubled young children in the State can be attributed not only to the emergence of children with service needs who fall between several systems, but to the general recognition that services to children with multiple needs tend to be fragmented and uncoordinated. The implementation of the Family Court Act in January, 1984 and the institution of Family Crisis Intervention Units, along with the work of service advocacy groups (e.g., the Mental Health Association of New Jersey, the Association of Children of New Jersey and the Governor's Committee on Children's Services Planning) have resulted in an increased demand for services and the requirement that these services be rendered in the least restrictive setting.

The Division began the development of a community-based mental health network for children in 1979. This communty focus started with the establishment of the following four regional children's crisis intervention centers:

-Elizabeth General Hospital Community Mental Health Center, Elizabeth
-Rutgers Community Mental Health Center, Piscataway
-St. Clare's Community Mental Health Center, Denville
-TRIS Children's Crisis Intervention Services, Sicklerville

Two Statewide inpatient services were maintained for children who could not be treated in one of the community-based regional centers and who needed longer term care: Arthur Brisbane Child Treatment Center, Allaire (for children under 14) and the Adolescent Treatment Unit at Trenton Psychiatric Hospital (for children 14-17).

In consultation with the Division of Mental Health and Hospitals, the Department of Health, through N.J.A.C. 8:43E-4.1 et seq., instituted a moratorium on the establishment of new children's acute inpatient psychiatric beds in New Jersey in January, 1984. The moratorium was proposed based upon the following major considerations: (1) the lack of available utilization data; (2) recent expansion in acute children's inpatient resources; (3) pending release of national use rate information; and (4) the continuing growth of alternative cost-effective community resources. The implementation of the moratorium was to enable the Departments of Health and Human Services and the SHCC: (1) to conduct a careful evaluation of the impact of the development of a network of community-based mental health services for children; (2) to assess the future need for additional children's acute inpatient psychiatric beds in New Jersey; and (3) to develop an effective bed need methodology.

In spite of the efforts to create a community-based network of children's services, some components of a comprehensive service continuum do not exist

in many areas. The lack of a full continuum of children's mental health services often results in the inappropriate use of more restrictive services, a backup in the inpatient care system, and longer lengths of stay.

In May of 1986, following serious overcrowding at the State psychiatric facilities for children and adolescents, and in direct response to the Public Advocate's lawsuit concerning these conditions, the Department of Human Services convened a panel of experts to provide input and recommendations on short term corrective action at the Trenton Adolescent Unit. In recognition of the broader conditions which contributed to the overcrowding experienced by both State and general hospital inpatient settings, the panel was also charged with investigating the larger planning and program implementation needs of the children's service delivery system. The work of this panel resulted in "The Plan for the Establishment of Regional Psychiatric Programs for Seriously Mentally Ill Children and Adolescents", released in February of 1987. This Plan recommends the reorganization of children's mental health services and provides estimates on the types of services needed. The Plan also emphasizes the need to coordinate programs in other systems which are necessary to provide specialized services to children and to do so closer to their homes.

A critical service gap identified in the Plan is the unmet need for acute inpatient care for children and adolescents. This need was also recognized by the Department of Health which convened a SHCC Children's Psychiatric Bed Task Force, with Division representation, and lifted the moratorium by establishing standards for the development of these beds.

Despite the Division's efforts to create a community based network of children's services, some components of the present continuum do not exist in many service areas for a variety of reasons including: limited resources, lack of clear policy which specifies responsibility for diverse service needs, and the moratorium on the development of inpatient beds.

In addition, many gaps remain in the required continuum of care for children which would include emergency services, in-home support services, outpatient services, respite care, inpatient care, case management and liaison services, advocacy, and residential care. The lack of a full continuum of children's mental health services has resulted in the inappropriate use of the most restrictive services and a backup in inpatient, residential and correctional facilities resulting in youngsters staying longer than needed. Existing resources have been strained beyond capacity. All evidence indicates that the demand for community mental health treatment alternatives will continue to exceed capacity. This conclusion is supported by the following data:

- Suicide is the second leading cause of death among New Jersey adolescents. Projections based on the most recent data from the New Jersey Department of Health and the National Center for Health Statistics indicate that suicide rates among children and adolescents in the State will continue to rise.

- While the actual number of children is decreasing, this population is placing increasing demands on the mental health system. This demand has been increasing at a rate averaging 2 percent anually. Many children and families seeking outpatient care are placed on waiting lists and some community

mental health agencies must cancel regularly scheduled sessions in order to do crisis intervention with families in acute stress. While it is difficult to estimate the number of other children who fall between service gaps or who never receive adequate care, it can be inferred that the number of untreated cases are increasing based upon the magnitude of the trends noted above.

- Children served in mental health programs are increasingly the more disabled. A survey of children served by the Children's Crisis Intervention Services (CCIS) reinforced the emergence of a population with serious behavioral problems and clinical conditions. For example, 100 percent of the children under 13 years of age exhibited one or more of the following behaviors: explosive, uncontrolled behavior; suicide attempt/ideation; homicidal or injurious behavior. Eighty percent of the children in the older age group had primary presenting problems of suicide attempt/ideation; explosive, uncontrolled behavior; and drug or alcohol abuse.

- The Division of Youth and Family Services reports that it has experienced an increasing number of adolescents needing services and has observed an increase in the severity of the problems these youths manifest. Given the increasing incidence of child abuse and neglect, adolescent drug and alcohol abuse, teenage pregnancy, homelessness and single parent households, the need for children's mental health services is anticipated to increase significantly.

Impact on the New Jersey Mental Health Delivery System:

The overcrowding in State psychiatric inpatient units, the fact that community hospital inpatient children's programs are at maximum capacity, and the difficulty some children have in returning to the community because of a lack of appropriate community alternatives are clear indications of crisis in children's New Jersey's mental health services. The State must move beyond short term responses to this crisis. The Division's commitment to implementing the "Plan for the Establishment of Regional Psychiatric Programs for Seriously Mentally Ill Children and Adolescents" has intensified the focus and activity on the development of a comprehensive system of mental health care for children.

In consideration of the above identified priority, the Division recognizes its responsibility, in concert with DYFS, to prioritize the reduction in admissions to children's inpatient units, to prevent the unnecessary hospitalization of children who could be diverted to more appropriate and less restrictive treatment resources, to increase the availability of and accessibility to short-term inpatient acute care services in the community and to assure better service coordination for youth involved in multiple systems.

Action Plan:

Since 1979, the Division has designated children and youth as a priority population. Consistent with this designation, and in compliance with the Block Grant "set aside" requirement, the Division reallocated a portion of its grant in 1984-85 for new and expanded programs in this area. It must be noted that, with no new money for New Jersey under the Block Grant, this had only minimal impact relative to the need. In lieu of additional Federal dollars, relief

must be sought through a State budgetary process which must also consider other impending cutbacks. Nonetheless, given the unmet need, the Division will continue to advocate for expansion of children's services through the following activities:

The Division will coordinate its efforts with the Department's Regional Plan in the area of children's services. In June, 1986, the Department established a special work group currently headed by the Deputy Commissioner of Human Services to coordinate all activities and planning for the improvement and expansion of children's mental health services. This Departmental leadership was essential since children's mental health services span several Divisions and Departments of State government. Within the Department, DYFS is responsible for all children's residential services and many of the children receiving mental health ambulatory services are DYFS clients.

The Department will be responsible for developing a long range plan for children's services through a Statewide Advisory Committee established by the Plan. The Division of Mental Health and Hospitals will retain the responsibility to plan for and provide community mental health services for children and for the leadership of the Regional Advisory Committees.

The Division will be working collaboratively in this effort with the cross-system representation on the Regional Advisory Committees. It is expected that expansion in mental health services will include the following areas called for in the Plan:

- Special emphasis on working with other Divisions and Departments to improve accessibility for referrals and improve appropriate utilization of all services.

- Expansion of children's acute care services in regions of the State where such services are needed but do not exist. Through collaboration with the Department of Health, new standards for Children's CCIS programs have been developed and a need for 78 new beds has been established. These additional beds will be developed over the next several years beginning in FY'89.

- Development of treatment homes for children being discharged from State hospitals and CCIS programs. This will require extensive collaboration with the Division of Youth and Family Services since all the children will neeed to be approved for residential placement.

- Development of outreach and treatment team services. These services will provide on-site clinical interventions at detention centers and residential sites and provide consultation to DYFS Offices in the development of services for seriously emotionally disturbed children. This will require interface with DYFS, the Department of Corrections, and the Youth Services Commissions.

- Expansion of partial care programs to provide full-day services for children in treatment homes. This will require interface with the Department of Education to obtain the appropriate reimbursement for the school portion of these full-day programs.

- Establishing a lead/coordinating function in each region for all the services in the Plan to provide accountability for services to seriously emotionally disturbed children. This will enhance the ability to resolve service problems and to ensure that each child receives needed services.

- The phase-down of State-operated facilities for children from 138 beds to 40 beds.

4. Mental Health Manpower Shortage

Employee compensation practices in both the hospital and community programs have not kept pace with labor market trends. Community contract agencies have experienced excessive staff turnover and a diminishing manpower pool which adversely affects the quality and continuity of direct care. In addition, hospital salary levels, lack of advancement opportunities, and negative publicity have affected the recruitment and retention of qualified institutional personnel.

The Division of Mental Health and Hospitals is actively involved in the expansion of community mental health programs necessary to close critical gaps in the service delivery system. This expansion, particularly in the areas of case management, emergency screening, and residential services will parallel the development of acute involuntary care in general hospitals and the evolution of intermediate and transitional programming in the state psychiatric centers. In order for this to be achieved, the system must be able to maintain existing staffing levels, as well as to attract significant numbers of new clinical and administrative professionals.

This will become increasingly difficult over the next three years due to high staff turnover. Presently, both hospital and community programs are experiencing difficulty in the recruitment and retention of qualified professionals. The major factors contributing to this are low salary levels, high case loads, lack of career advancement and promotional opportunity, sparse training opportunities, and negative public image.

In FY'85/86, 118 mental health community agencies concurred that the severity of staff recruitment and retention problems seriously weakened the system's infrastructure and undermined the availability of quality services to clients. The New Jersey Association of Mental Health Agencies, Inc. (NJAMHA) conducted a survey which concluded that "... one-third of all staff leave our agencies each year", and that "... one-half of direct service staff (BA level) exit each year". The same study also showed that recruitment efforts led to an average of four months vacancy in direct service positions (or 1/3 of direct service loss to clients). An estimated $2 million per year was expended on recruitment activities and the orientation and training of new employees. Extremely low salaries was cited by the survey as a major reason for staff turnover.

Further contributing to the severity of the shortage in manpower is the decline in degrees conferred in psychology and social sciences, as confirmed by data from the New Jersey Department of Higher Education and the U.S. Department of Education. The trend is away from human service majors, suggesting a continuation of a diminishing manpower pool, particularly in the area of direct human service care.

Within the State hospitals, competition with private general hospitals seriously hampers the recruitment of nursing and medical professionals. If this problem is not corrected the mental health system will face the dilemma of expanding services with additional program requirements for a more disabled population with a dwindling work force.

Without adequate, competitive salaries, effective recruitment and retention of qualified staff across hospitals and community agencies is threatened. The goal of developing a comprehensive community-based system of mental health care cannot proceed in the absence of a capable work force.

Action Plan

The Division of Mental Health and Hospitals is addressing this critical problem through a number of initiatives in both the hospitals and the community. These include the Community Agency Development Retention and Recruitment of Employees (CADRRE) Project to focus on resource needs in mental health contracted agencies in order to build a data base to assist in predicting future work force needs. The primary goals of this effort include:

- the identification of the factors contributing to high and low staff turnover.
- the design and implementation of interventions to assist agencies in maintaining and recruiting qualified personnel.
- the identification of the consequences of turnover on organizational efficiency and consumer well-being.

In addition to this effort, the Division will continue with its commitment to upgrade the salary levels paid to workers throughout the community mental health network.

Within the institutional system, the Division of Mental Health and Hospitals is currently revising the staffing standards for the State hospitals to respond to more difficult patient needs, as well as rising public expectation and increasing demands from well organized and active consumer organizations and new requirements from regulatory agencies.

Issues such as the recruitment of qualified medical and nursing personnel are being addressed through supplemental contracts with staff placement agencies as well as through the development of shared resources between hospital and community providers. The Division intends to supplement psychiatric time across the system. Psychiatric services will be purchased through individual contracts with community mental health agencies and will provide services to both community mental health agencies and State psychiatric hospitals. Staff sharing programs between institutional and community programs will be encouraged. A stronger partnership among all mental health providers is critical for the system to respond to the issues of manpower recruitment and retention.

Adequate and intense training of personnel is necessary to assure the provision of quality services. The Division plans to provide an orientation/skill development program, referred to as the Mental Health Training Academy, for

new and existing mental health personnel throughout the State. Direct care staff will be trained in the provision of quality care. This centralized training approach is expected to combat the problem created by placing direct care staff on the job prior to adequate preparation and to assure staff awareness of the goals of the mental health system in general.

5. **Lack of Affordable Housing**

Statewide lack of affordable housing severely limits the ability of the mentally ill to compete for adequate living arrangements. Large numbers of the mentally ill find themselves in boarding homes as the only affordable housing option.

The President's Commission on Housing of 1982 found that there were over 10 million "very low-income" renting households in the nation, over 25% of them live in subsidized housing. The rest live in sub-standard housing and/or pay over 25% of their income for housing. Since that time, despite evidence of increased incidence of poverty and escalating housing costs, the federal govenment has cut back its funding for any type of subsidized housing.

While certain factors negatively affect the general public, they impact more intensely on the mentally ill given their limited financial and social resources. The following data demonstrate this point:

- Division studies conducted on clients enrolled in residential programs indicate that at any given time, 20% to 35% of these clients no longer require the level and intensity of supervision provided. Dependence upon these limited resources is prolonged due to the lack of affordable housing alternatives.

- Many people remain inappropriately hospitalized due to a lack of suitable residential alternatives. The Division's 1986 Hospital Level of Care survey showed that of the 2463 patients surveyed, 948 or approximately 38.5% were more appropriate to reside in supervised or transitional housing in the community. Many of these clients remain hospitalized under the category of being "discharged pending placement", due to the lack of appropriate community placement options.

- Due to limited funding, it is only a minority of the chronically mentally ill (CMI) who have access to Division supported community residences. There are only 1200 contract housing slots available for the CMI. While the number of the estimated 80,000 CMI in New Jersey in need of supervised housing cannot be determined, a conservative projection of even 10% underscores the dramatic unmet need.

- The number of CMI in New Jersey residing in boarding homes has been estimated at 5,000. While it cannot be categorically assumed that all of these individuals would be better served in other living arrangements, agencies working with clients in boarding homes have consistently advocated for affordable alternatives to congregate living.

- The vast majority of the CMI in New Jersey, and nationally, reside with their families. Advocacy, family and consumer groups have indicated that the CMI

return to families largely due to the lack of appropriate and affordable residential treatment options. The number of CMI in New Jersey residing with families can be estimated to be as high as 60,000.

A recent M.I.T. study predicted a 27% decrease in available low income housing and a 44% increase in those who need it in the next 16 years. Consistent with this national prediction, continued deterioration of the existing housing stock in New Jersey can also be expected over the next three years. Redevelopment plans in areas that traditionally supplied low income housing and boarding homes will continue. Major redevelopment activity in Asbury Park alone could potentially displace 400-500 CMI. Gentrification in areas such as Atlantic City and Camden has also impacted negatively on the supply of low income housing. Additionally, there is concern that the number of CMI homeless will increase without substantial new housing resources and placement alternatives as the financial and emotional strains on both families and clients increase due to the lack of appropriate and affordable housing options.

As noted earlier, while boarding homes may not be an optimal living arrangement, they are often the only viable residential option for many clients. Thus, new regulatory requirements such as the Uniform Fire Safety Code, increase costs to proprietors and threaten their ability to remain in operation.

The Code will also impact on other community living arrangements for the mentally ill as owners absorb the cost of compliance with the new requirements. This will adversely affect the mentally ill on fixed incomes as rates/rental fees increase to accommodate these costs.

Action Plan

In consideration of the above issues the Division will redesign the residential service system to include the following activities:

- Expansion of Personal Care Services to Family Care Homes and selected housing sites.
- Development of a responsive system of case management and crisis intervention services to insure that acute care needs are addressed and residents receive available services and benefits.
- Development and passage of boarding home legislation.
- Development of affordable housing options through mainstream housing systems.
- Utilization of new residential health care facility beds reserved for appropriate State hospital clients currently pending placement.
- Development of alternatives to boarding homes, such as low income housing where support and rehabilitative services are available.
- Creation of specialized residential health care facilities with the Department of Health.

- Augmentation of vocational, socialization and recreational activities to improve the quality of life and provide work opportunities to change financial status.

- Establishment, with county mental health boards, of a Residential Plan which reflects the current resources and service gaps with recommendations for future development.

- Refinement of training and technical assistance to maintain boarding homes as a supportive housing option.

- Support for the participation of consumers and family members in determining the development and evaluation of residential services.

- Expansion of technical assistance capability to increase third party revenue in residential programs.

The Division will convene a statewide residential services advisory group to assist in the articulation of the direction for residential services. A number of factors underscore the need to re-conceptualize and re-direct efforts in residential services. These factors are summarized below:

- Current residential programs, which require concentrated staff time and resources for facility prior to service initiation, serve only a small number of chronically mentally ill persons.

- Resources have not been available to expand, in any meaningful way, the high cost residential options currently funded by the Division.

- High cost residential options are functioning as low income housing for approximately 30% of the residents; significant advocacy efforts are needed to expand low income housing options.

- Transitional (time limited) residential programs have been, by default, used to meet the long-term support needs of the chronically mentally ill.

- In order to minimize the effects of prolonged dependence on the mental health system, residential programs must have an increased rehabilitative orientation which will promote an individual's independence.

Active participation by various State departments, county government, consumers, family and advocacy groups, as well as local agencies is required to respond to the housing needs of the chronically mentally ill. Housing issues will be closely examined by a subcommittee of the Governor's Advisory Council as part of their overall review of the Mental Health System.

6. **Increasing Complexity of Mental Health Needs for State Psychiatric Hospital Populations**

Although the development of community alternatives has led to a reduction in the population and physical plant of the State psychiatric hospitals, those presently admitted to and residing in State psychiatric hospitals are the most severely impaired clients in the system.

The State psychiatric hospitals maintain their responsibility to protect and care for New Jersey's most severely mentally disabled citizens in an environment which meets acceptable standards and is conducive to the provision of quality care.

Statistics indicate that patients treated in State hospitals are increasingly more disabled. Both the admission criteria and the clinical profiles of these patients show that State facilities are reserved for those patients presenting with the most severe disorders. The Division's initiatives in the development of crisis intervention and screening services, involuntary community inpatient units, and the other Division-supported components of the community care system, have effectively diverted admissions of clients who, formerly, would have been admitted directly to State hospitals.

Mental health service needs for individuals requiring care and treatment in the State psychiatric hospitals is becoming increasingly complex. While the growth in community programs and subsequent reductions in dependence on State hospitals has dramatically improved the quality of life provided to many individuals, the system must continue to expand and strengthen its capabilities in order to provide more specialized clinical and rehabilitative services to those residing in State hospitals. The growing population in need of mental health services is, in many cases, younger with presenting problems complicated by substance abuse and court involvement. The same trend applies to children. Also, as more chronically ill individuals grow older, there is an emerging need for the development of a comprehensive network of gero-psychiatric services for individuals whose condition does not warrant care in nursing home settings. These two populations represent the extreme ends of the system.

This trend is supported by the following data:

- In 1983, 67 percent of State hospital admissions were assessed as severely disabled. In 1985, this percentage jumped to 85 percent.
- State hospital data indicate that 35 percent of the patients admitted are dually diagnosed as severely mentally ill and chemical dependent.
- The vast majority, or 75 percent, assessed as dually diagnosed were between 18 and 40, reflecting a younger population requiring more intensive treatment and supervision.
- The number of clients in public psychiatric hospitals admitted with criminal justice involvement has risen significantly from 951 in FY'82 to 1,364 in FY'85.
- The same trend applies to children. Approximately 36,000 children in New Jersey between 12 and 18 experience alcohol problems, and 100,000 are involved with the courts. State operated inpatient admissions doubled from 1981 to 1985 for adolescents, and admissions of younger children mushroomed from 90 in FY'81 to 146 in FY'86.

3878

Impact on the New Jersey Mental Health Delivery System:

During the period 1983-1986, all six State psychiatric facilities eligible for accreditation were approved for full three year certification by the Joint Commission on Accreditation of Hospitals. This achievement resulted from major improvements in clinical services and capital renovations. Through adjustments in the system, it has been possible since 1980 to close 17 outmoded and inefficient old buildings at Trenton and Greystone Hospitals. As a result, hundreds of patients now reside in more appropriate settings at the hospitals and participate in more active programs for meeting their individual needs with greater opportunities for discharge into community residences. In 1975, there were 5,500 patients in State hospitals; now there are approximately 3,200.

As noted in the preceding sections, the clients of both hospitals and community programs are increasingly the more disabled. The growing population in need of mental health services is not only younger, it has more complex and more varied problems than did the institutionalized population of ten years ago. The role of the State hospital will change as the community system changes. More responsive and effective community-based services will prevent or reduce initial hospitalizations. More effective aftercare, clinical and support programs will prevent or reduce the number of readmissoins. Under optimal conditions, the hospitals will become still smaller, but with a greater ability to provide long term inpatient care for persons who are dangerous to self or others. Expanded emergency/screening services and discharge oriented service planning will also have a positive impact. The Division's initiatives, in cooperation with the Department of Health and the SHCC, which facilitate placement of public psychiatric hospital patients into community nursing homes will reduce the number of geriatric patients in State facilities who are currently awaiting such placement.

New Jersey's psychiatric hospitals will continue to serve the most severely disabled population. The State hospital system is not static, rather it is expected to respond to the pressures of a society as a whole. For example, as drug and alcohol abuse in the general population continues to rise, it is expected that the number of persons requiring specialized mental health and alcohol/drug intervention will also increase. As a result, the demand for mental health services will continue to rise. The role of the mental health system is to ensure that both hospitals and community services are provided with the resources necessary to keep pace with the changing demand.

There are several distinct levels of service which the hospital system must be prepared to provide. These include: the separation of patients with more aggressive behaviors from withdrawn or self-destructive individuals; the need for a Forensic continuum which affords accceptable services to individuals acquitted of violent crimes by reason of mental illness; the identificaton of the need for specialized medical/psychiatric units for individuals whose medical conditions warrant isolation, and who require active mental health treatment; and finally, the need to provide support in a coordinated way for families who may have children and adolescents with serious mental health problems.

Within this complex network, the role of State hospitals will change. Recent passage of the revised commitment law will provide for increased and more responsive community-based services when it becomes fully operational over

the next 3 to 5 years, and will continue to divert the number of individuals with acute problems. In the interim, the State hospitals will continue to provide this service. At the same time, the hospitals will need to develop tailored programs for intermediate and transitional care with an emphasis on psycho-social rehabilitation and vocational training as these will be the overwhelming needs of the population they will eventually serve.

Contingent upon growth in the community system, the total number of State psychiatric hospital beds may decrease. In the Northern Region and in the child/adolescent service area, this will occur as a result of existing initiatives. However, it must be recognized that the remaining facilities must comply with current standards and increased expectations for quality. To this end, the strategy of diverting resources from hospitals to community is insufficient. Some resources may continue to be shifted, but with a recognition that all service levels in the system must be adequately supported and improved.

The Division's mission to serve the most needy and vulnerable residents of the State in quality programs in the community and in the State hospitals, is reflected in its commitment to ensure that both have adequate resources to treat a diverse and severely disabled population. If the Division is to fulfill this most basic charge, it must plan for and develop strategies to successfully meet the challenges inherent in serving an increasingly diverse and needy population.

While the Division has established the need to improve and expand community services in response to increasing demand, it cannot ignore the obligation to provide quality care in its hospitals. Therefore, requests for additional resources to support State facilities is consistent with Division's mission and priorities.

Action Plan*:

In recent years, the Division has struggled to meet increasing demands with a limited pool of resources. In the face of increasing demands and limited funds, the Division must discourage what has become an unhealthy competition between community and hospital programs for fixed resources in order to maintain a balanced system of care.

The Division will continue to explore alternative funding strategies to broaden the existing funding base. However, it is evident that demand will continue to outstrip resources. While further hospital down-sizing can be accomplished through community expansion, it has become apparent that there must be a concomitant investment in State facilities and programs. Therefore, the Division must continue to advocate for adequate resources to fulfill its responsibility to provide quality programs for those most in need.

The increasing clinical demands of the population entering State facilities had led to the reassessment of hospital manpower needs. As a result, the minimum staffing levels have been revised to ensure quality care and adherence to regulatory standards. Additionally, the new staffing requirements emphasize psycho-social rehabilitation which is essential to the provision of specialized programs geared toward the younger more severely disabled patient. The

*It should be noted that Block Grant funds are not used to support administrative expenses or programs in State institutions.

implementation of these standards will provide additional clinical and support positions, opportunities for education and career advancement and competitive salaries.

Since the needs of particular individuals and groups of patients are always changing, the State hospitals must be improved by offering better and more types of clinical, support and discharge planning programs. The hospitals will be able to better perform these functions if current efforts are successful in discharging patients to nursing homes, residential health care facilities, group homes, supervised apartments and other types of community-based living arrangements.

Additionally, State hospitals still have responsibility for hundreds of patients deemed eligible for discharge, but for whom alternatives have not yet been developed or made accessible. As regional hospitals in a service system, the State psychiatric hospitals also will be expected to play a significant role in the care and treatment of persons who require inpatient services and rehabilitation for longer periods of time than can be provided in a community setting.

Hospital staffing complement and the quality of care given by the staff will be an area of great focus for the Division. The more chronic patients need intensive treatment and active intervention by a staff trained in the latest techniques.

It must be acknowledged that the direct care staff at each of the Division's facilities are the most important resource. An inability to overcome the manpower recruitment and retention issues detailed in Trend D will further diminish the Division's ability to provide appropriate care. Therefore, the Division plans to enhance the skills required to successfully work with the severely mentally disabled population. These efforts will include the development of a training academy for employees of hospital and community programs and the sharing of psychiatric manpower between the community and the hospitals which will foster continuity of care.

Also, consistent with the Governor's priority for preserving and maintaining State facilities and to ensure that programs are delivered in the most therapeutically appropriate settings, the environmental deficiencies at each facility must be addressed. The physical environment is also critical to the quality of care given at the hospitals. It is no longer good enough for the buildings to be safe but they must promote the well being of the patients. The organization of the hospitals on a level of functioning basis has also worked toward establishing a variety of settings within the hospital complex. Patients can progress from restrictive to transitional settings, seeing a change in the physical environment.

7. **Increased Need for Public Education Programs as Community Services Continue to Expand**

Consumer and family involvement in the mental health system has led to a heightened awareness of the critical need for public education to dispel social stigma and reduce public apathy to the suffering of the mentally ill. As more of the seriously mentally ill are served within their communities it has become

apparent that a public education campaign is necessary to promote understanding and gain support for the need for a comprehensive system of care.

The new commitment/screening law mandates the development of specialized and responsive community services to intervene prior to commitment to State hospitals. To avert unnecessary hospitalizations, the community must be aware of available alternatives. Education is essential for an informed public to gain access to necessary services.

Additionally, major Division initiatives such as the Northern Region Community expansion, the Children's Regional Plan and the identified need to expand community programs in the Central Region will result in increased numbers of seriously mentally ill individuals being treated within their communities. These initiatives require community support and tolerance for the establishment of new programs, as well as the acceptance of the rights of the mentally ill to reside within their respective communities.

In addition to mental health program support, mentally disabled individuals require access to generic human services, public entitlements, housing and health care resources for successful community living. Public education campaigns are needed to educate and sensitize other service systems and community resources to these needs.

Fortuitously, consumer involvement in the mental health system has been steadily increasing, and the input of these important constituency groups will continue to grow. Consumers and family support organizations are developing rapidly with some 20 self-help and 20 family support groups already operating in the State, reaching 19 of 21 counties. Additional groups are being formed creating a heightened awareness and interest in promoting more community support and combating community resistance. The consumer movement in both New Jersey and nationally has provided valuable input into mental health planning and program development and will be a major factor in combating the community resistance to providing care for mentally ill persons.

A concerted public education effort, in cooperation with the rising consumer movement, will diminish the general discrimination which limits client opportunities for housing, employment and educational opportunities required for successful community living. An organized public education program is integral to community development. It will provide the tools and forums through which support from the general public, the media and the legislature can be garnered. At the same time, community opposition and resistance must be reduced or alleviated to permit continued and expanded mental health care in the community. The sharing of information on the positive impact of early detection, prevention and innovative treatment interventions can be effective in dispelling myths concerning those who are mentally ill, and affording opportunities to develop innovative and necessary community supports.

Action Plan:

To address this trend, consumers and families will continue to be involved in the planning and development of mental health services. This will include Division support for Statewide expansion of consumer self-help and family groups.

The Division proposes to expand county mental health board and community agency board member training to enlist their support in educating the community-at-large about the client population. Additionally, the New Jersey Community Mental Health Board established a Public Education Subcommittee. This subcommittee was organized to promote public awareness of mental health, to encourage people to seek help, to provide those in need with information on mental health resources, to support the growth and improvement of mental health services, and to reduce the negative effects of the stigma associated with mental illness. The Subcommittee will develop a three year plan for community education in conjunction with family and consumer groups and Rutgers University.

The projects of the Public Education Committee will enhance and support the implementation of the Division's mission and specific objectives to expand and to improve the community mental health care system. Through a systematic program of information to the mental health community, to the media, to the general public, and to other systems, everyone will be better-informed of the purposes, benefits and results of new program developments, research findings, and the opportunities for preventing and reducing the impact of mental illness.

Also related to the Division's mission of increasing public awareness of mental health, is the training of County Mental Health Board members. These boards represent a broad spectrum of community input. Laypersons, professionals and consumers comprise these boards which are charged with the responsibility of recommending changes and improvements to the county's mental health care system. The Division recently developed a County Mental Health Board training program. Two County Mental Health Boards have been trained and the remainder of the boards will receive orientation this year. Basically, the training presents an overview of the development of the community mental health system and delineates the role and responsibility of the boards. As new members join, written training packages are made available. When new topics are identified by the boards, the Division will provide consultants and guest speakers to address them. This training will be ongoing.

Based upon preliminary surveys of interest in and commitment to the public education program, the Division projects that 100 executive directors and other leaders (from the Division, from agencies, from consumers groups, from family support groups, from advocacy and volunteer organizations) will receive intensive and useful training in the first year in developing better media information, and that the second and third workshops will result in contacts with at least 50 media representatives (newspaper, magazine, radio and television) to acquaint them with future possibilities and emerging issues of the developing community mental health care system.

Based upon previous response from radio outlets throughout the State, the Division projects that some 20 to 30 percent of the radio stations in New Jersey will carry, on a regular basis, mental health awareness and educational public service announcements.

Regional Plans for Fiscal Year 1988

The Division of Mental Health and Hospitals is organized into three Regions (see Appendix V for Regional Services map). Each Region encompasses several counties which plan for and contribute to the support of community mental health services as well as participating in the support for clients from their counties who are served by the regional State psychiatric hospitals (Ancora, Marlboro, Trenton and Greystone); and for clients in Arthur Brisbane Child Treatment Center, the Adolescent Unit at Trenton Psychiatric Hospital and the Hagedorn Center for Geriatrics. Community mental health services are administered at the State level by the Division of Mental Health and planned for, cooperatively, with county mental health boards.

Regional action plans* which identify unmet needs on a county basis are developed annually. Specific activities prioritized in these plans are developed on a county basis in consideration of the issues and trends identified throughout this document and in conjunction with local county mental health boards.

D. MENTAL HEALTH FISCAL YEAR 1988 GOALS AND OBJECTIVES

OVERVIEW

Mental Health Block Grant Funds are allocated to community-based ambulatory services which are provided, Statewide, through a network of eligible local mental health agencies. The primary responsibility for planning, funding, and supervising mental health services is assigned the Division of Mental Health and Hospitals in the Department of Human Services. Services are funded through annual appropriations from all government sources. Priority services are identified and recommended through an annual planning and program development process, directed by the Division of Mental Health and Hospitals. This process involves citizen advisory boards in each of the 21 counties (members of the county mental health boards), and professional committees in each county who represent all of the agencies who provide mental health care services and who receive public funds.

The Division of Mental Health and Hospitals has recognized the need for comprehensive long range planning at both the State and County levels. County planning is integral to Statewide goals and objectives. As noted earlier, unmet service needs for FY'88 are identified in Regional and county reports which were presented to the State Community Mental Health Citizens' Advisory Board in the Spring of 1987.

GOAL

The primary goal of the Division of Mental Health and Hospitals is to provide a unified community and institutional services system for mentally ill persons in New Jersey which maximizes each client's level of functioning to the highest potential in the most normal environment consistent with the principles of advocacy and human rights, in order for them to become self-sufficient and achieve more socially acceptable behavior.

*Regional plans for FY'88 were presented at a public meeting of the State Community Mental Health Citizens Advisory Board in the Spring of 1987 and are available from the Division upon request.

As noted earlier, the Division has been working towards this goal for the past decade. Program planning, development and implementation have proceeded accordingly. Data shows a significant increase in both numbers of clients served within community agencies and the percentage of State and Federally mandated target populations served, with a concommitant decrease of reliance on the State institutional system of care. State and local need assessments reinforce the need to continue this direction. In FY'88, the Division will move further towards full implementation of the core system of services approach based upon the results of the County/State planning process noted in the Overview and portrayed in Chart I. This conceptualization of the comprehensive community mental health system is more fully described in the Problem Definition Section (Item 2). In accordance with these considerations, the Division's primary objectives for community services in Fiscal Year 1988 are, as follows:

OBJECTIVE 1*

Maintain existing community mental health programs which provide services according to regulations in the following programs areas: emergency/screening, partial care, outpatient, residential services, systems advocacy, and case management.

OBJECTIVE 2*

Provide additional community services by the continued expansion of services to meet more of the unmet needs identified in county mental health plans and by the Division in the following programs areas: emergency/screening, partial care, outpatient, residential services, systems advocacy and case management; and targeted to the following populations: Young chronic adults, severely disturbed children and adolescents, elderly, mentally ill substance abusers, and mentally ill homeless, and screening of inmates in correctional facilities.

E. MENTAL HEALTH PROGRESS REPORT - FISCAL YEAR 1987

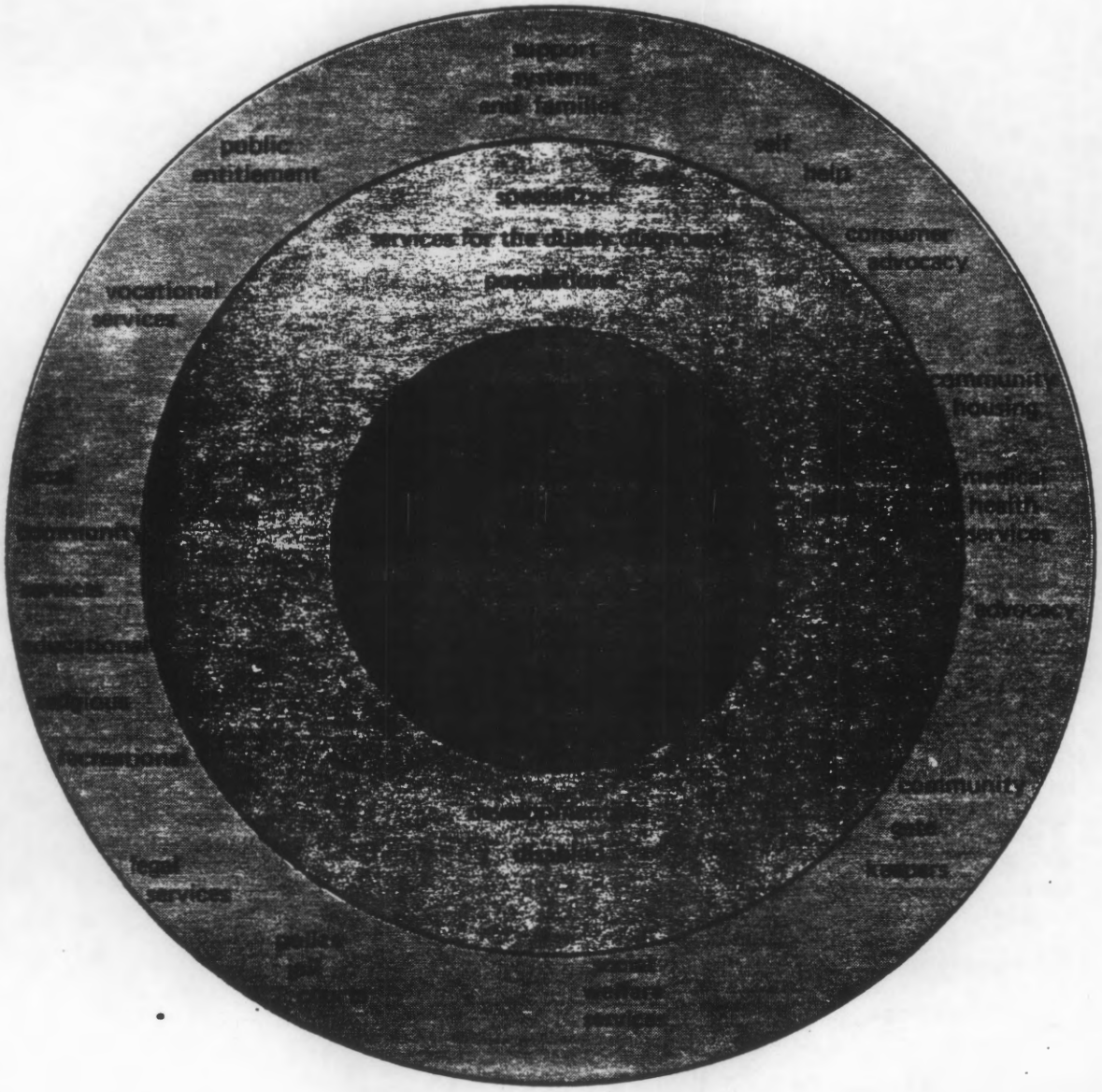
1. Compliance with 10% Block Grant Set-Aside Requirement

New Jersey has established and/or expanded programs and services in accordance with the 10% set-aside requirement. In Fiscal Years 1984 and 1985, new comprehensive community mental health programs and/or service activities funded were, primarily, for centers in high urban need and high rural need areas of the State and were selected through application of the Regional Based Planning Methodology and the county-based need assessment process, highlighted below. Other new funding was allocated to identified underserved populations (such as inmates in county jails) and populations identified as underserved in county mental health plans. New Jersey maintained this effort in Fiscal Year 1987 and will continue compliance in 1988. A full breakdown of these allocations, by center, can be found in the Spending Plan section.

Underserved areas were identified in the following manner: in FY'82, the Division of Mental Health and Hospitals, faced with impending cuts in its

*More specific goals and objectives are published in the Mental Health Plan Element of the New Jersey State Health Plan and are available from the Division upon request.

COMPREHENSIVE COMMUNITY SUPPORT SYSTEM



LEGEND

Mental Health System

- Generic Community Services
- Services for Dually Diagnosed Clients (to be provided in conjunction with other Divisions and Departments)
- Components of a Mental Health System
- Core Mental Health Services

} Comprehensive Mental Health System

STCF = Short-term Care Facility
IPU = General Hospital Inpatient Unit

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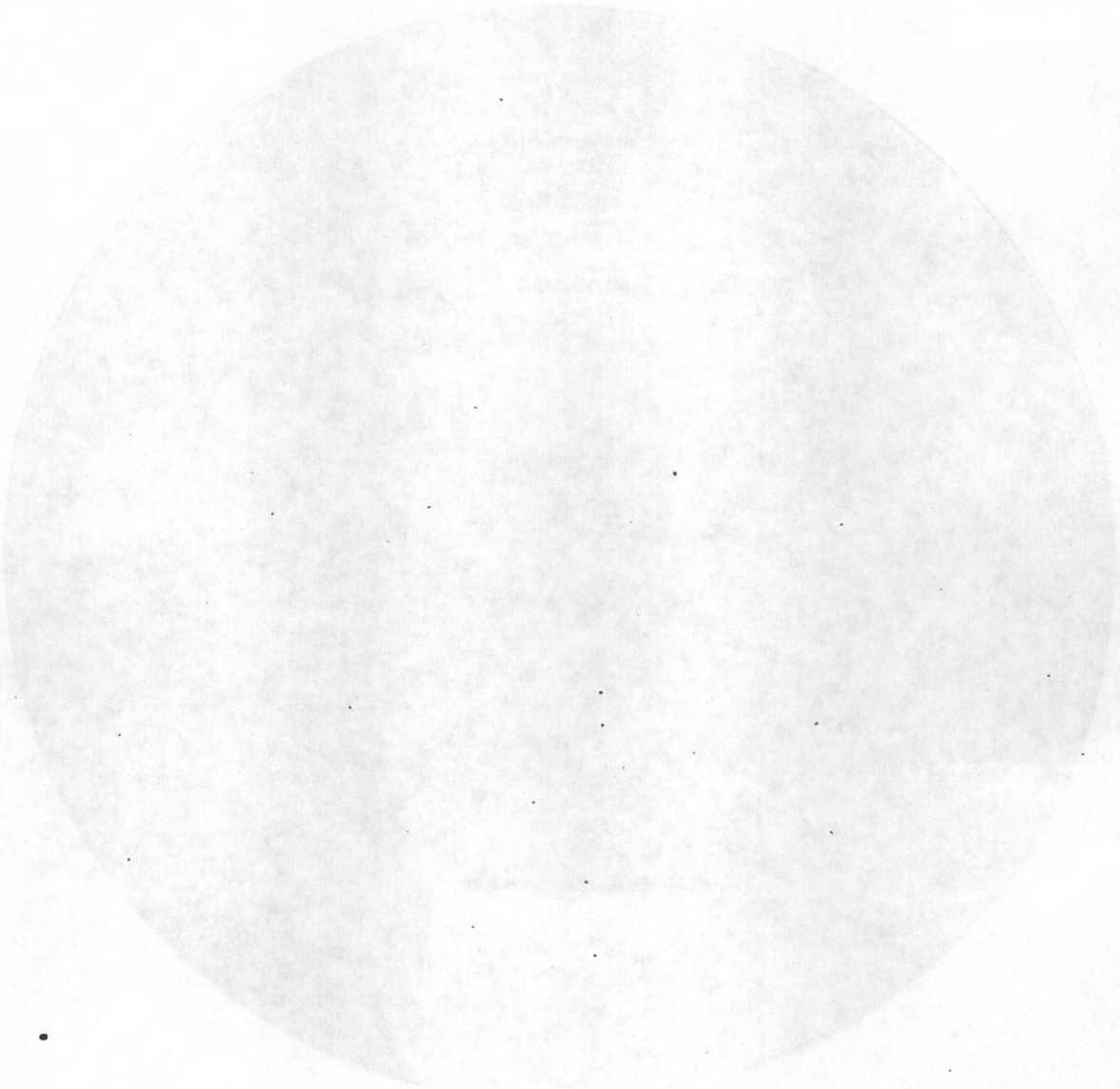

Federal funds, began to shift its community mental health funding decisions using a need-based approach. The Need-Based Plan utilized the latest available population census for each county statistically related to mental health service utilization (e.g., poverty, family disruption, unemployment, crime, etc.) material to obtain socio-demographic characteristics together with community mental health and State/county psychiatric hospital data to indicate relative mental health need among counties. These need scores were then incorporated with data on available resources and historical funding patterns to yield indices of need for mental health funding.

The results were translated into dollars to be allocated to each eligible community mental health center (CMHC). Thus, funding decisions in subsequent fiscal years for new dollars and systems development efforts were allocated essentially following this principle.

It has been the Division of Mental Health and Hospitals' stated goal to distribute new dollars based on need and not on historical patterns of funding or numbers of population, in order to assure a more equitable distribution of community mental health systems development resources.

Service needs for underserved populations and critical service gaps were identified via the County/State planning process noted under Mental Health Fiscal Year 1988 Goals and Objectives. As noted earlier, the Division of Mental Health and Hospitals has recognized the need for and initiated comprehensive long-range planning at both the State and county levels. County planning is integral to statewide goals and objectives. The results of County planning processes identify:

1) The major needs and the major gaps in the local service system for the priority target populations;

2) Specific proposals for expansion of existing or new programs to meet these needs and to fill these gaps;

3) A descriptive projection of what the county's overall mental health delivery system should look like by program element.

The major efforts in each Region during Fiscal Year 1987 focused on the development and refinement of those core services needed to operate an effective, comprehensive mental health system. Particular emphasis was placed on planning and implementation of emergency screening, case management services, and expanded involuntary inpatient care in general hospitals. Additionally, efforts were made to increase, within each county, agency capability to provide housing/residential services, medication monitoring special programs for children and family support groups.

Furthermore, in addition to specific mental health program and system development activities, emphasis was placed on enforcing accessibility of mental health clients to health and social services programs. These efforts resulted in signed affiliation agreements and joint programs developed with agencies such as, Divisions of Alcoholism, Developmental Disabilities, and Youth and Family Services at the local level, and the Departments of Health and Community Affairs at the State level.

396X

Thus, major program goals identified for FY'87 were completed during the past year. A summary* of major accomplishments, by Region, is available from the Division, upon request.

*These summaries were presented at a public meeting of the State Community Mental Health Citizens' Advisory Board in the Spring of 1987.

397X

Clients/Funding Fiscal Years 1986-1987

The table below shows apportionment of funding and clients by program element for Block Grant Centers for Fiscal Year 1986 and Fiscal Year 1987.

DIVISION OF [illegible]
STATE AND FEDERAL ALLOCATIONS TO BLOCK GRANT CENTERS BY PROGRAM ELEMENT

	FY 86 FUNDING		FY 86	FY 87 FUNDING		FY 87
PROGRAM	STATE	BLOCK GRANT	CLIENTS	STATE	BLOCK GRANT	CLIENTS
EMERGENCY/SCREENING	$3,611,362	$2,298,343	33457	$4,160,160	$2,114,838	36185
PARTIAL CARE	$3,210,379	$2,043,109	4180	$3,781,961	$1,922,580	3880
OUTPATIENT	$4,368,851	$2,780,424	41674	$5,134,750	$2,631,612	38433
RESIDENTIAL	$2,156,445	$1,378,769	774	$2,547,379	$1,305,806	508
CLINICAL CASE MANAGEMENT	$655,330	$417,046	1720	$945,491	$480,645	1950
[illegible]	$1,928,307	$1,163,923	3137	$2,160,180	$1,107,419	11376
TOTAL	$15,841,344	$10,081,686	86113	$18,730,321	$9,562,390	92332

Contract Totals Fiscal Years 1986-1987

Table I shows State and Block Grant allocations to Block Grant Centers for Fiscal Year 1986 and Fiscal Year 1987.

Table I

DIVISION OF MENTAL HEALTH AND HOSPITALS
STATE AND FEDERAL ALLOCATIONS TO BLOCK GRANT CENTERS

AGENCY	STATE FISCAL YEAR 1986 JULY 1, 1985-JUNE 30, 1986			STATE FISCAL YEAR 1987 JULY 1, 1986-JUNE 30, 1987		
	BLOCK GRANTS	STATE	TOTAL	BLOCK GRANTS	STATE	TOTAL
ADMINISTRATION	$1,104,895	$0	$1,104,895	$1,068,100	$0	$1,068,100
CAMCARE	$761,832	$951,947	$1,713,779	$623,637	$1,047,466	$1,671,103
CHILD PSY CTR	$603,706	$988,189	$1,591,895	$399,235	$937,884	$1,337,119
CHRIST HOSPITAL	$192,234	$214,080	$406,314	$178,597	$266,357	$444,954
COMM CTR FOR MH	$273,391	$459,735	$733,126	$217,922	$486,216	$704,138
CUMBERLAND GUID CTR	$366,519	$665,885	$1,032,404	$422,734	$874,643	$1,297,377
GREATER TRENTON	$1,961,513	$1,945,886	$3,907,399	$1,799,901	$2,449,499	$4,249,400
JERSEY CITY MED CTR	$103,655	$194,569	$298,224	$100,605	$228,468	$329,073
JERSEY SHORE MED CTR	$225,779	$619,383	$845,162	$225,743	$701,985	$927,728
MID BERGEN CMHC	$709,023	$1,012,425	$1,721,448	$694,119	$1,252,201	$1,946,320
MT CARMEL GUILD	$257,043	$439,053	$696,096	$220,429	$484,567	$704,996
NEWARK BETH ISREAL	$100,507	$381,267	$481,774	$110,839	$431,768	$542,607
RUTGERS MED SCHOOL	$121,134	$301,544	$422,678	$118,693	$342,647	$461,340
ST CLARE'S HOSP	$562,498	$837,562	$1,400,060	$323,708	$726,637	$1,050,345
ST MARY'S HOSP	$275,943	$467,059	$743,002	$348,500	$664,344	$1,012,844
MH CTR OF GLOUC	$270,291	$645,491	$915,782	$280,921	$758,541	$1,039,462
FAIRLAWN MH CTR	$25,853	$71,188	$97,041	$26,331	$81,286	$107,617
SO. BERGEN MH CTR	$476,285	$815,805	$1,292,090	$462,548	$971,931	$1,434,479
PROSPECT HOUSE	$229,357	$319,419	$548,776	$190,959	$352,431	$543,390
E. ORANGE GEN HOSP	$313,270	$505,054	$818,324	$280,515	$576,272	$856,787
IRVINGTON MH CTR	$63,150	$101,852	$165,002	$70,796	$135,114	$205,910
MT CARMEL GLD/JC	$259,486	$441,400	$700,886	$247,272	$520,183	$767,455
BAYONNE CMHC	$68,747	$142,471	$211,218	$83,494	$187,205	$270,699
RICHARD HALL CMHC	$128,207	$336,995	$465,202	$135,540	$393,656	$529,196
GUID CTR OF WARREN	$39,505	$121,925	$161,430	$81,660	$192,319	$273,979
RIVERVIEW HOSP	$222,924	$301,414	$524,338	$219,929	$379,044	$598,973
MH CLINIC OF OCEAN	$231,458	$645,125	$876,583	$261,287	$730,218	$991,505
GUID CTR OF CAMDEN	$379,082	$717,397	$1,096,479	$585,214	$1,129,673	$1,714,887
MH SERV CAPE MAY	$243,707	$357,495	$601,202	$231,791	$430,898	$662,689
SALEM CNTY GUID CTR	$233,110	$300,089	$533,199	$285,121	$454,434	$739,555
CLIFFWOOD MH CTR	$362,475	$559,540	$922,015	$384,860	$721,933	$1,106,793
SUB TOTAL	$10,081,684	$15,841,244	$25,922,928	$9,612,900	$18,909,820	$28,522,720
GRAND TOTAL	$11,186,579	$15,841,244	$27,027,823	$10,681,000	$18,909,820	$29,590,820

F. METHOD FOR DISTRIBUTION OF THE MENTAL HEALTH PORTION OF THE BLOCK GRANT

In 1963, Congress passed the Mental Retardation Facilities and Community Mental Health Centers Act. This Act was intended to encourage, through Federal support, the development of less restrictive (non-institutional) community alternatvies to meet the service needs of the mentally disabled. Federal funds were provided for the first eight years of operation with the possibility of post-graduation support for five additional years. These funds supported all service elements required of Federal Community Mental Health Centers. Under this Act, monies were allocated by the Federal government directly to community mental health centers, with the State retaining little control over these funds. This resulted in a fragmented funding process, since the State also allocated its own funds for a similar purpose. This confused funding system adversely affected services and resulted in a major barrier to comprehensive planning and the efficient delivery of services.

With the discretion afforded to States under the Omnibus Budget Reconcilliation Act, and, in order to minimize the impact of funding cutbacks on critical services, the Division of Mental Health and Hospitals developed a methodology for distributing Block Grant funds in an equitable fashion, according to the highest need and to those Community Mental Health Centers which provide quality service to State and locally defined target populations. To allocate these funds, a Block Grant advisory committee, consisting of major mental health groups in the State, including consumers, was developed to establish a funding formula and a process of public review. This formula gives emphasis to high priority target groups and takes into account the difference between community "need" and locally available resources. Thus, a consensus was developed on this difficult issue and funding levels could then be determined in a more systematic, rational, and equitable manner. (The 1986 Need-Based Plan for Mental Health Funding: Social Area Analysis and a description of the application of the New Jersey need-based planning data to the allocation of the Block Grant as well as definitions of New Jersey target populations was submitted in past applications and is available from the Division upon request.)

Under the Block Grant, Federal Community Mental Health Centers were integrated into the Division's existing planning and administrative process for the first time within the State Fiscal Year 1983. For example, in an effort to consolidate the administration of these funds with out State operations, a consolidated funding application was developed to allow community mental health agencies to submit one application to the State for funding beginning with Fiscal Year 1983 and continuing with Fiscal years 1984, 1985, 1986, 1987 and 1988, regardless of the source of these dollars. These applications were reviewed by County mental Health Boards as an extension of their historical role within the New Jersey State per capita funding decision-making process. During January of each preceding year, qualified Community mental Health Programs were given a planning dollar amount which included funds available under the Block Grant to include in their preparation of their Consolidated Funding Applications. These applications were then reviewed by County Mental Health Board which then submitted recommendations on total (State

and Federal) allocations to community agencies based upon priorities set within each respective County Mental Health Plan*.

Decisions on services and amount of support from the Block Grant were made in consideraton of county mental health plans and need assessments in addition to the input from the County Mental Health Boards and the State Community Mental Health Citizens' Advisory Board. Final decisions on funding also considered the ability of an agency to provide the required services. Thus, Block Grant funds were allocated directly to community agencies via the Division's existing contracting procedures and are viewed as part of the overall allocation of mental health resources within any given county.

This same process will be followed for allocation of Block Grant funds in Fiscal Year 1988. Mental health agencies submitted Consolidated Funding Applications to the Division of Mental Health and Hospitals in February 1987 for all funding. These applications were reviewed by County Mental Health Boards and the Division of Mental Health and Hospitals for eligibility and compliance with Federal, State and County mandates and requirements for the purpose of contract awards to mental health providers for the Fiscal Year beginning July 1, 1987.

G. SPENDING PLAN: NEW JERSEY DIVISION OF MENTAL HEALTH AND HOSPITALS

1. Introduction

Federal Community mental Health Centers were integrated into the Division's current planning and administrative process beginning with State Fiscal Year 1984 (July 1, 1983 - June 30, 1984) and continuing for Fiscal Years 1985, 1986, 1987 and 1988. A Consolidated Funding Application was developed in order to allow community mental health agencies to submit one application to the State for Fiscal Years 1983-1988 funding, regardless of the source of these dollars. As previously described, these applications were reviewed by County mental Health Boards as an extension of their historical role within New Jersey per capita funding decision-making process. Thus, Block Grant funds have been and will continue to be allocated directly to community agencies via the Division's current contracting procedures and are viewed as part of the overall allocation of mental health resources within any given county.

In past fiscal years, New Jersey was able to take advantage of the carry forward provision in the Block Grant Legislation. This carry forward balance (which was close to $5 million in Fiscal Year 1985), was primarily due to continued Federal commitments and funding to Centers funded under the former Community Mental Health Center's Act during Fiscal Year 1982 and which continued up to September, 1982. In previous years, this has allowed the State to minimize the impact of reduced Federal allocations as well as to provide for expansion of services to target populations. Unfortunately, in

*A detailed description of this public review process was submitted with past applications. County mental health plans are available for public review by contacting individual county mental health boards. A listing for each county mental health board is included as Appendix VI.

Fiscal Year 1986, there was only just over $400,000 available and the carry forward balance was exhausted in FY'87. No additional Federal funds have been made available to New Jersey for mental health services since the onset of the Block Grant and, indeed, the State is faced with impending cuts should the reauthorization incorporate the new "equity" formula without a hold harmless clause. However, new State funds were allocated in order to help mitigate the original reduction in Federal funding in order to maintain critical programs and to continue expansion of core services in unserved areas and for underserved populations.

2. **Allocations**

A breakdown of the Division of Mental Health and Hospitals' spending plan for Fiscal Year 1988, by Center, appears in Table II. In Table III, an estimated number of clients to be served in Fiscal Year 1988 is apportioned by funding and program element.

In Fiscal Years 1985 and 1986, over 4.1 million dollars was set aside (or approximately 40% of the Block Grant allocation) for new or expanded programs/services in Centers in high urban need and high rural need areas for services to underserved populations and for several disturbed children and adolescents. A breakdown of the total allocations to these Centers by the above noted areas appears in Table IV. Table V shows the estimated number of clients served by Block Grant recipients by Center and program element.

In all cases, allocation of Block Grant funds is made to Centers eligible to receive such funding under the requirements of the Omnibus Budget Reconciliation Act (Section 1915, subsection (c)).

It should be noted that the legislation prohibits the State from allocating Block Grant funds for provision of inpatient services, as formerly allowable, and New Jersey has complied with this provision. Approximately one million dollars was granted to Community mental Health Centers in New Jersey in Fiscal Year 1981 for inpatient services. Since that time, the hospitals affected have negotiated with the Health Department to have these cuts picked up within their reimbursement structure in accordance with State Regulations. Thus, there was minimal impact in the area of inpatient service delivery. It is important to note that, given these constraints, the Division of Mental Health and Hospitals' focus has been to reallocate funding on need to support ambulatory care programs which divert persons from all inpatient psychiatric care and permit shorter-term hospitalization.

3. **New Programs and Services Initiated in Accordance with the 10% Set Aside Requirement**

The Division of Mental Health and Hospitals will continue its compliance with the 10% set aside requirements as described below, by the allocation of Block Grant funds to Centers in high urban need and high rural need areas and for children's services. Approximately $5.1 million or 50% of the amount of the mental health portion of the Block Grant was allocated for new or expanded services, as noted above, to these Centers in Fiscal Years 1985 and 1986. Additional allocations for those programs were also granted in Fiscal Years 1987 and 1988. The methodology utilized to determine these allocations is described in the "Progress Report" section of this application.

Table II

DIVISION OF MENTAL HEALTH AND HOSPITALS
STATE AND FEDERAL ALLOCATIONS TO BLOCK GRANT CENTERS

AGENCY	STATE FISCAL YEAR 1987 JULY 1, 1986-JUNE 30, 1987			STATE FISCAL YEAR 1988 JULY 1, 1987-JUNE 30, 1988			STATE FISCAL YEAR 1989 JULY 1, 1988-JUNE 30, 1989		
	BLOCK GRANTS	STATE	TOTAL	BLOCK GRANTS	STATE	TOTAL	BLOCK GRANTS	STATE	TOTAL
ADMINISTRATION	$1,068,100	$0	$1,068,100	$1,121,222	$0	$1,121,222	$1,095,646	$0	$1,095,646
CAMCARE	$623,637	$1,047,466	$1,671,103	$666,759	$1,179,153	$1,707,912	$611,845	$1,164,383	$1,776,228
CHILD REV CTR	$299,235	$837,564	$1,137,119	$340,713	$962,542	$1,303,255	$334,946	$1,013,359	$1,348,305
CHRIST HOSPITAL	$178,597	$266,157	$444,754	$178,649	$273,458	$452,107	$173,333	$296,510	$469,843
COMM CTR FOR MH	$217,922	$468,216	$686,138	$192,352	$466,000	$658,352	$159,150	$493,153	$652,303
CUMBERLAND GUID CTR	$422,734	$874,643	$1,297,377	$442,579	$918,495	$1,361,074	$433,172	$952,345	$1,385,517
GREATER TRENTON	$1,799,901	$2,649,499	$4,449,400	$1,831,669	$2,564,161	$4,395,830	$1,773,382	$2,796,301	$4,571,683
JERSEY CITY MED CTR	$100,605	$228,468	$329,073	$120,762	$259,993	$380,755	$114,342	$277,643	$391,985
JERSEY SHORE MED CTR	$225,743	$701,985	$927,728	$281,054	$704,515	$985,569	$281,221	$744,377	$1,025,598
MID BERGEN CMHC	$694,119	$1,252,201	$1,946,320	$736,813	$1,338,019	$2,074,832	$718,147	$1,413,678	$2,131,825
MT CARMEL GUILD	$280,429	$404,567	$684,996	$284,747	$414,193	$698,940	$280,445	$432,692	$713,138
NEWARK BETH ISRAEL	$110,839	$431,768	$542,607	$133,628	$467,295	$600,923	$133,775	$469,285	$603,060
RUTGERS MED SCHOOL	$118,693	$342,647	$461,340	$94,446	$314,217	$408,663	$94,299	$330,732	$425,031
ST CLARE'S HOSP	$323,708	$726,637	$1,050,345	$355,454	$1,056,117	$1,411,571	$342,168	$1,033,916	$1,376,084
ST MARY'S HOSP	$346,500	$666,344	$1,012,844	$352,602	$683,746	$1,036,348	$344,352	$733,452	$1,077,804
MH CTR OF BLOOM	$280,921	$758,541	$1,039,462	$263,095	$745,305	$1,008,401	$260,618	$768,099	$1,028,717
FAIRLEIGH MH CTR	$25,331	$81,286	$107,617	$22,887	$77,621	$100,508	$22,874	$81,654	$104,528
SO. BERGEN MH CTR	$462,346	$971,931	$1,434,479	$438,624	$957,552	$1,396,176	$430,045	$1,021,978	$1,452,023
PROSPECT HOUSE	$198,939	$352,431	$543,370	$184,973	$364,109	$549,082	$184,245	$391,160	$575,405
E. ORANGE GEN HOSP	$280,515	$576,272	$856,787	$303,792	$619,184	$922,976	$297,158	$662,737	$959,895
IRVINGTON MH CTR	$70,795	$135,114	$205,910	$59,118	$121,960	$181,078	$57,850	$130,471	$188,321
MT CARMEL GUILD	$267,272	$520,183	$787,455	$283,635	$579,661	$863,296	$277,466	$620,362	$897,828
BAYONNE CMHC	$83,494	$187,205	$270,699	$80,358	$186,699	$267,057	$79,150	$198,530	$277,739
RICHARD HALL CMHC	$135,540	$393,636	$529,176	$141,028	$446,535	$587,574	$135,841	$429,646	$565,477
GUID CTR OF WARREN	$81,660	$192,319	$273,979	$73,052	$183,845	$256,947	$72,044	$195,170	$267,214
RIVERVIEW HOSP	$219,929	$378,044	$598,973	$234,523	$[illegible]	$[illegible]	$232,170	$444,589	$676,760
MH CLINIC OF OCEAN	$25[illegible],287	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
GUID CTR OF CAMDEN	$588,214	$1,129,673	$1,[illegible],887	$[illegible]	$1,177,799	$1,781,288	$589,460	$1,263,351	$1,852,331
MH SERV CARE NEW	$231,791	$430,898	$662,689	$229,549	$[illegible]	$[illegible]	$229,012	$469,111	$693,123
SALEM CNTY GUID CTR	$285,121	$454,436	$739,555	$283,753	$463,987	$747,700	$275,795	$501,813	$777,608
CLIFFWOOD MH CTR	$384,860	$721,933	$1,106,793	$404,109	$763,469	$1,167,578	$394,147	$819,944	$1,214,091
SUB TOTAL	$9,612,980	$16,909,880	$26,522,720	$10,091,000	$19,943,660	$30,034,660	$9,860,816	$21,375,230	$31,236,046
GRAND TOTAL	$10,681,080	$16,909,880	$27,590,880	$11,212,222	$19,943,660	$31,155,882	$10,956,462	$21,375,230	$32,331,692

403X

Table III

DIVISION OF MENTAL HEALTH AND HOSPITALS
STATE AND FEDERAL ALLOCATIONS TO BLOCK GRANT CENTERS BY PROGRAM ELEMENT

	FY 86 FUNDING		FY 86	FY 87 FUNDING		FY 87	FY 88 FUNDING		FY 88
PROGRAM	STATE	BLOCK GRANT	CLIENTS	STATE	BLOCK GRANT	CLIENTS	STATE	BLOCK GRANT	CLIENTS
EMERGENCY/SCREENING	$3,611,362	$2,298,343	39457	$4,160,160	$2,114,838	36185	$4,387,605	$2,220,020	36909
PARTIAL CARE	$3,210,379	$2,043,149	4180	$3,781,961	$1,922,580	3880	$3,988,722	$2,018,200	3968
OUTPATIENT	$4,368,651	$2,780,424	41674	$5,134,750	$2,631,612	38433	$5,384,225	$2,825,480	39201
RESIDENTIAL	$2,156,445	$1,378,789	774	$2,547,378	$1,345,866	508	$2,792,112	$1,412,740	518
CLINICAL CASEMANAGEMENT	$655,300	$417,046	1720	$945,491	$480,645	1950	$997,183	$504,550	2534
OTHER	$1,928,307	$1,163,323	310	$2,280,080	$1,157,419	11376	$2,193,803	$1,110,010	1804
TOTAL	$15,841,244	$10,081,684	88115	$18,909,820	$9,652,900	92332	$19,343,660	$10,091,000	95824

404X

Table IV

[illegible] BLOCK GRANT [illegible] SET ASIDE REQUIREMENTS
INCREASED ALLOCATION TO CENTERS IN HIGH NEED AREAS AND RURAL AREAS FOR SERVICES TO UNDERSERVED POPULATIONS

AGENCY	FY 84 TOTAL	FY85 TOTAL	FY84-FY85 DIFFERENCE	FY85 TOTAL	FY86 TOTAL	FY85-FY86 DIFFERENCE	FY86 TOTAL	FY87 TOTAL	FY86-FY87 DIFFERENCE	FY87 TOTAL	FY88 TOTAL	FY87-FY88 DIFFERENCE	TOTAL DIFFERENCES
HIGH NEED													
CAMDEN	$2,189,487	$2,106,671	($082,816)	$2,106,671	$1,713,779	($352,892)	$1,713,779	$1,671,103	($42,676)	$1,671,103	$1,707,912	$36,809	($481,575)
GREATER TRENTON	$3,023,709	$4,295,829	$272,120	$3,295,829	$4,307,399	$011,570	$4,307,399	$4,[illegible]	$[illegible]	$4,[illegible]	$4,338,830	$[illegible]	$1,[illegible]
JERSEY CITY NEO CTR	$249,619	$279,813	$30,194	$279,813	$256,224	($18,589)	$256,224	$329,073	$30,849	$329,073	$380,755	$[illegible]	$[illegible]
JERSEY SHORE NEO CTR	$586,137	$742,636	$156,319	$742,636	$[illegible]	$[illegible]	$[illegible]	$827,728	$[illegible]	$827,728	$[illegible]	$[illegible]	$139,232
NEWARK NEO- [illegible]	$390,545	$458,941	$68,356	$458,941	$[illegible]	$22,833	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$58,316	$[illegible]
ST MARY'S [illegible]	$330,000	$715,135	$385,135	$715,135	$761,042	$47,907	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
PROSPECT [illegible]	$613,361	$472,845	($58,884	$472,845	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$614,862	$761,[illegible]	$[illegible]	$761,[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$614,841	$660,478	$45,637	$660,478	$700,885	$40,408	$700,885	$767,455	$66,569	$767,455	$[illegible]	$[illegible]	$[illegible]
SUB TOTAL	$8,[illegible]	$9,574,376	$[illegible]	$9,574,376	$[illegible]	$462,950	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$2,574,130
[illegible]													
[illegible]	$785,263	$857,428	$72,165	$857,428	$1,032,404	$[illegible]	$1,032,404	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$309,208	$395,324	$[illegible]	$395,324	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
SUB TOTAL	$1,[illegible]	$1,677,301	$[illegible]	$1,677,301	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible] SERVED													
[illegible]	$[illegible]	$[illegible]	$32,451	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$1,[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$1,035,298	$1,177,226	$[illegible]	$1,[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible] BERGEN	$1,331,301	$1,585,762	$[illegible]	$1,585,762	$1,721,446	$[illegible]	$1,721,446	$1,906,330	$[illegible]	$1,906,330	$2,074,822	$[illegible]	$[illegible]
[illegible] CTR CAMDEN	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
SUB TOTAL	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
CHILDREN'S SERVICE													
[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
SUB TOTAL	$1,673,546	$1,876,772	$[illegible]	$1,876,772	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]
GRAND TOTAL	$17,238,259	$19,272,220	$2,033,961	$19,272,220	$[illegible]	$4,075,666	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]	$[illegible]

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Table V

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PROJECTED NUMBERS OF CLIENTS TO BE SERVED AT CONTINUATION LEVELS, EXCLUSIVE OF NEW INITIATIVES

AGENCY	OUTPATIENT	PARTIAL CARE	EMERGENCY/ SCREENING	RESIDENTIAL	CLINICAL CASEMANAGEMENT	OTHER
[illegible]CARE	4,220	250		9		430
[illegible] MENTAL HEALTH SERVICES	1,480	130		18		312
[illegible]RIST HOSPITAL	750		300			0
[illegible]MUNITY CENTER FOR MH	1,100	305	615	75		200
[illegible]MBERLAND GUIDANCE CENTER	2,137	137	1,452	37	150	125
[illegible]REATER TRENTON CMHC	1,534	212	2,330	77	1,100	743
[illegible]RSEY CITY MEDICAL CENTER			2,240			825
[illegible]RSEY SHORE MEDICAL CENTER	2,300	185	1,300			4,835
[illegible] BERGEN CMHC	1,300	175	320	72		250
[illegible]T CARMEL GUILD ESSEX	1,725	170	1,150			0
[illegible]SHAW SETH (SPACE	1,350	55	2,000			25
[illegible]TERS MEI SCHOOL ESSEX		24	128			0
[illegible]T CLARE'S HOSP MORRIS	3,550	120	1,350	25		90
[illegible]T. MARY'S HOSP HOBOKEN	300	75	1,200			0
[illegible]H CENTER OF GLOUCESTER	1,340	146	315	18		168
[illegible]FIELD MH CENTER	500					0
[illegible]. BERGEN MH CENTER	1,350	310	5,319	102		1,025
[illegible]PROJECT [illegible]LEE		400				120
[illegible]. [illegible]E MEMORIAL HOSPITAL	447		5,111			1,007
[illegible]INGTON MH CENTER	1,200					108
[illegible]T. [illegible]EL GUILD JERSEY CITY	750	135		15		320
[illegible]EVONNE CMHC	300	70				450
[illegible]RICHARD HALL CMHC	2,200	175	1,700			240
[illegible]IDANCE CENTER OF WARREN	950	95	520			0
[illegible]RVIEW HOSPITAL	300	195	1,050			0
[illegible] CLINIC OF IRVING	1,300	113	1,300	24		85
[illegible]EINHARDT CENTER			3,600		700	0
[illegible] SERVICES OF CAPE MAY	1,400	115	450	20		515
[illegible]LEM COUNTY GUIDANCE CENTER	1,540	243	475			115
[illegible]CLIFFWOOD MH CENTER	1,300	85	540	15		300
TOTAL	38,433	3,880	35,185	508	1,950	11,376

406K

Table VI shows new programs and/or service activities for severely disturbed children and adolescents initiated and provided in Fiscal Year 1985 under the 10% set aside requirements for the mental health portion of the Block Grant.

Table VII depicts new comprehensive community mental health programs and/or service activities for unserved areas or underserved populations initiated and provided in Fiscal Year 1985 in accordance with the 10% set aside requirement.

Table VIII indicates new comprehensive community mental health programs and/or service activities for severely disturbed children and adolescents and for unserved areas or underserved populations provided in Fiscal Year 1986. It should also be noted that those new programs initiated in Fiscal Year 1985 were continued in Fiscal Year 1986.

Tables VI, VII and VIII also summarize the rationale for the selection of each program, the objectives of each program and indicate that the objectives were met in Fiscal Year 1985 and Fiscal Year 1986.

As noted in these tables the new comprehensive community mental health programs and/or service activities funded were primarily for Centers in high urban need and high rural need areas of the State and were selected through application of the Regional Need-Based Planning Methodology and the County-Based Need Assessment Process, both described earlier. Additionally, a State plan for expansion of children's services was also initiated in FY'87. Other new funding was allocated to identified underserved populations (such as inmates in county jails) and populations identified as underserved in county mental health plans.

Table VI

New Services for Children/Adolescent - FY'85

AGENCY/COUNTY/REGION	NEW PROGRAM/SERVICE	OBJECTIVES	OBJECTIVES MET?
UMDNJ-CMC, Essex County, Central Region	Partial Care (Adolescent)	Establish day care program for adolescents with psychiatric disorders, with family therapy component	Yes
Newark Beth Israel Medical Center, Essex County, Central Region	Outpatient Services	Activities related to the prevention of child abuse; hire one Clinical Specialist to provide services	Yes
T.R.I.S., Inc., Camden County, Southern Region	A) Residential (Child)	Initiation of a specialized foster care program for Camden County children; hire and train staff, coordinate efforts with other service agencies	Yes
	B) Residential (Child)	Establishment of a 5-bed group home for children at risk of institutionalization; hire staff; purchase equipment; develop service network	Yes
Catholic Charities M.H. Clinic, Middlesex County, Central Region	Partial Care (Child)	Initiate transportation services for client population; purchase a van	Yes
Hudson County YWCA, Hudson County, Northern Region	Residential Services	Develop 12-bed group home for severely emotionally disturbed children, with family therapy, support and outreach services	Yes
Christ Hospital CMHC, Hudson County, Northern Region	Outpatient Services/ Consultation & Education	Extend family treatment, and group services and art therapy for adolescents; start suicide prevention program in schools	Yes
St. Mary's Hospital CMHC, Hudson County, Northern Region	Outpatient Services	Develop service network for adolescents and better coordination with justice system; increase family counseling	Yes

Table VI.

New Services for Children/Adolescent - FY'85 (cont'd.)

AGENCY/COUNTY/REGION	NEW PROGRAM/SERVICE	OBJECTIVES	OBJECTIVES MET?
UMDNJ-CMHC, Middlesex County, Central Region	Partial Care (Adolescent)/ Consultation & Education	Develop school programs on child abuse, incest, parenting, latchkey kids; offer vocational training for adolescents	Yes
Children's Psychiatric Center, Monmouth County, Central Region	Outpatient Services	Establish case management and advocacy services for adolescents returning from a psychiatric hospital setting	Yes
Greater Trenton CMHC, Mercer County, Central Region	Partial Care (Adolescent)	Expand family therapy and family support groups; hire counseling staff; set up Youth Services Planning Committee	Yes
Irvington M.H. Center, Essex County, Central Region	Outpatient Services; Consultation & Education	Develop various C & E programs in schools; offer therapy groups for severely abused children	Yes

409X

Table VII

New Services in FY'85 for Underserved Areas/Populations

AGENCY/COUNTY/REGION	NEW PROGRAM/SERVICE IN FY 85	RATIONALE FOR SELECTION	OBJECTIVES	OBJECTIVES MET
	B) Case Management		Hire and train 2 case managers. one for crisis service coordination and one for liaison services at TPH	Yes
Camcare CMHC. Camden County. Southern Region	A) Outpatient Services	High need urban area	Hire and train one staff person to coordinate services for clients at the VOA homeless shelter	Yes
	B) Special Services		Establish an array of services for selected deaf/hearing impaired clients in Southern half of N.J.	Yes
St. Clare's Hospital CMHC. Morris County. Northern Region	Emergency/Screening Services	Response to an identified service need for an underserved population, per County M.H. Plan	Initiate a county-wide screening service to divert persons from unnecessary hospitalizations and into proper community services	Yes
East Orange General Hospital. Essex County. Central Region	Emergency/Screening Services	High need urban area	Hire support staff person and adjust program funding to remove barriers to service	Yes
Christ Hospital CMHC. Hudson County. Northern Region	Outpatient Services	High need urban area	Hire and train one staff person to serve young adult chronic population	Yes
Jersey City Medical Center CMHC. Hudson County. Northern Region	Liaison Services	High need urban area	Addition of one social worker to provide State-mandated services	Yes
Mt. Carmel Guild - J.C.. Hudson County. Northern Region	Residential/Partial Care	High need urban area	Establish recreational and counseling programs for young adult population; increase capacity of boarding home; provide security for group homes	Yes
Bayonne CMHC. Hudson County. Northern Region	Outpatient/Partial Care	High need urban area	Program improvement through the increase in psychiatrist hours and the addition of one clinician	Yes

Revised 11-20-85

Table VII

New Services in FY'85 for Underserved Areas/Populations (cont'd.)

AGENCY/COUNTY/REGION	NEW PROGRAM/SERVICE IN FY 85	RATIONALE FOR SELECTION	OBJECTIVES	OBJECTIVES MET?
Jersey Shore Medical Center, Monmouth County, Central Region	A) Outpatient Services	Response to an identified underserved population	Hire staff and initiate program in County Jail, for counseling and case management for inmates	Yes
	B) Outpatient Services	Extension of aftercare services to identified clients in need, per County Mental Health Plan	Hire 6 staff and increase psychiatrist hours; purchase 2 vans; extend aftercare services to at-risk clients	Yes
Newark Beth Israel Medical Center, Essex County, Central Region	Partial Care	High need urban area	Extend partial care services to the elderly through the use of support staff and the purchase of a van	Yes
Cumberland County Guidance Center, Cumberland County, Southern Region	Emergency/Screening Services	High need rural area	Hire and train one staff person to provide on-site coverage and crisis intervention at Bridgeton Hospital	Yes
Salem County Counseling Services, Salem County, Southern Region	A) Outpatient Services	High need rural area	Hire and train one Counselor to respond to a severe shortage of Outpatient counseling hours	Yes
	B) General & Administrative		Emergency repairs and improvements to the agency's inadequate physical facility	Yes
Richard Hall CMHC, Somerset County, Central Region	A) Partial Care	Extension of services to identified underserved populations, per County M.H.Plan	Add 2 case management staff to provide outreach services to program-resistant clients, and to improve linkages; purchase a van to increase transport services to clients	Yes
	B) General & Administrative		Purchase computer hardware/ software to improve agency management information system	Yes
Greater Trenton CMHC, Mercer County, Central Region	A) Emergency/Screening Services	High need urban area	Establish a county-wide screening service, and a county-wide capability for mobile outreach services to clients in crisis	Yes

Revised 11-24-86

411X

Table VII

New Services in FY'85 for Underserved Areas/Populations (cont'd.)

AGENCY/COUNTY/REGION	NEW PROGRAM/SERVICE IN FY 85	RATIONALE FOR SELECTION	OBJECTIVES	OBJECTIVES MET?
Community Center for Mental Health, Bergen County, Northern Region	Liaison Services	Response to underserved populations	Purchase of a van to provide transport services within a State-mandated service	Yes
Cliffwood M.H. Center, Bergen County, Northern Region	Residential Services	Response to underserved populations	Establish housing for identified transitional clients; hire and train 8 staff; purchase a vehicle	Yes
South Bergen M.H. Center, Bergen County, Northern Region	Consultation & Education	Response to underserved population	Provide a suicide prevention program	Yes
Mid-Bergen CMHC, Bergen County, Northern Region	Residential Services	Response to underserved population	Extend housing to clients in need; hire & train 4 staff; purchase equipment and vehicle	Yes
Guidance Center of Camden County, Camden County, Southern Region	Emergency/Screening Services	High need urban area	Reorganize crisis service to include holding and screening beds	Yes

412X

Table VIII

NEW SERVICES IN FY 88 FOR UNDERSERVED AREAS/POPULATIONS AND SEVERELY DISTURBED CHILDREN

AGENCY/COUNTY/REGION	NEW PROGRAM/SERVICE IN FY 88	RATIONALE FOR SELECTION	OBJECTIVES	OBJECTIVES MET?
Jersey Shore Medical Center, Monmouth County, Central Region	Outpatient Services: General & Administrative	Response to an identified underserved population	Add one counselor to existing Outpatient program to provide additional services to children and adolescents; equipment and supplies.	Yes
Newark Beth Israel Medical Center, Essex County, Central Region	Partial Care/Elderly: Outpatient	High need urban area	Extend partial care services to the elderly through the use of support staff and the purchase of a van	Yes
Cumberland County Guidance Center, Cumberland County, Southern Region	Emergency/Screening Services; Outpatient; Liaisons; Child Partial Care	High need rural area	Extend Emergency Outreach; add Hispanic social worker; add Case-management Coordinator; add alcoholism consultant; purchase van	Yes
Salem County Counseling Services, Salem County, Southern Region	Outpatient Services; Emergency/Screenings; Partial Care; General & Administrative	High need rural area	Hire and train 12 new staff, to respond to a severe shortage of qualified personnel to meet client needs. Emergency repairs and improvements to the agency's inadequate physical facility.	Yes
Greater Trenton CMHC, Mercer County, Central Region	Emergency/Screening Services; Child Partial Care; Partial Care; General & Administrative	High need urban area	Implement necessary repairs to several facilities, provide adequate heat, air conditioning; replace used vehicles; upgrade computer operations.	Yes
Cliffwood M.H. Center, Bergen County, Northern Region	Partial Care	Response to underserved population	Add one full-time case manager to existing program	Yes
South Bergen M.H. Center,	Consultation & Education;	Response to underserved	Provide an adolescent suicide pre-	Yes

Revised 11-24-88

413X

Table VIII(cont'd)

NEW SERVICES IN FY 88 FOR UNDERSERVED AREAS/POPULATIONS AND SEVERELY DISTURBED CHILDREN

AGENCY/COUNTY/REGION	NEW PROGRAM/SERVICE IN FY 88	RATIONALE FOR SELECTION	OBJECTIVES	OBJECTIVES MET?
Bergen County, Northern Region	Emergency/Screening	population (Severely disturbed children)	vention program, hire & train 2 staff; add one case manager to existing Emergency Services program.	
Mid-Bergen CMHC, Bergen County, Northern Region	Emergency/Screening; Other/Dual Diagnosis	Response to underserved population	Extend Emergency Services coverage with 3 new staff; implement new service for mentally ill alcohol abusers, hire & train 4 staff.	Yes
Guidance Center of Camden County, (Steininger Center) Camden County, Southern Region	Clinical Casemanagement	High need urban area	Reorganize case management services on a county-wide basis, coordinate with existing agencies, hire and train 20 staff	Yes
Shore Mental Health Center, Ocean County, Central Region	Partial Care	Response to underserved population	Expansion of day activity center to serve mentally ill alcohol abusers; hire 2 full-time and 4 part-time staff.	Yes
Prospect House/Essex Co. M.H. Assoc. Essex County, Central Region	Partial Care; Targeted Jobs Program	High need urban area	Provide needed facility repairs; implement jobs program for selected clients.	Yes
CMHC for Gloucester County Gloucester County, Southern Region	Partial Care; Outpatient; Consultation & Education	Response to underserved population	Implement adolescent suicide prevention program; add 2 staff positions for MICA clients and for outreach to boarding home residents.	Yes
Mental Health Services of Cape May Cape May County, Southern Region	Outpatient; General & Administrative	Response to underserved population	Use of a QA consultant; facility improvements; addition of two Outpatient staff positions.	Yes
Irvington Mental Health Center Essex County,	Outpatient Services; General & Administrative	High need urban area	Upgrade staff salaries to comparable scale; purchase equipment & supplies.	Yes

Revised 11-24-88

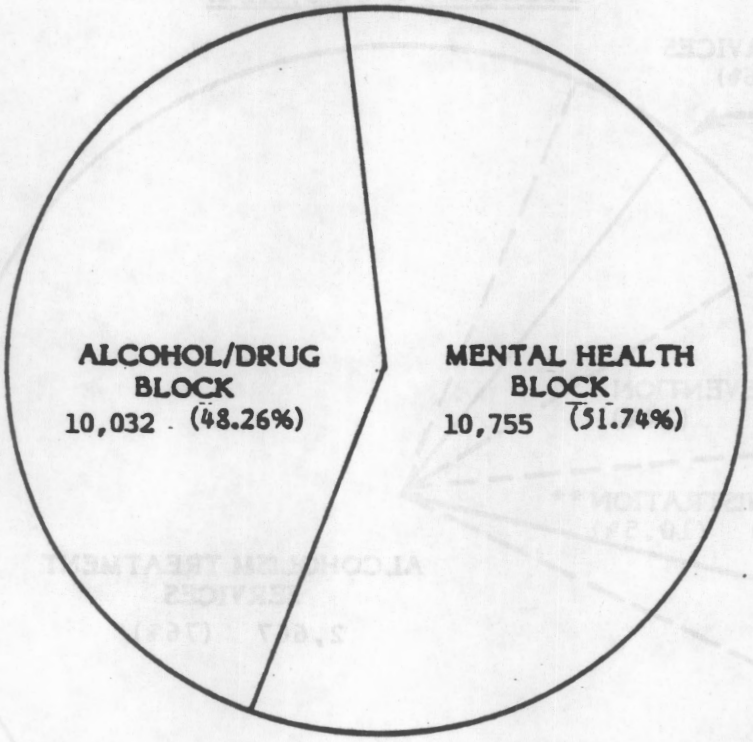
Table VIII (cont'd.)

NEW SERVICES IN FY 86 FOR UNDERSERVED AREAS/POPULATIONS AND SEVERELY DISTURBED CHILDREN

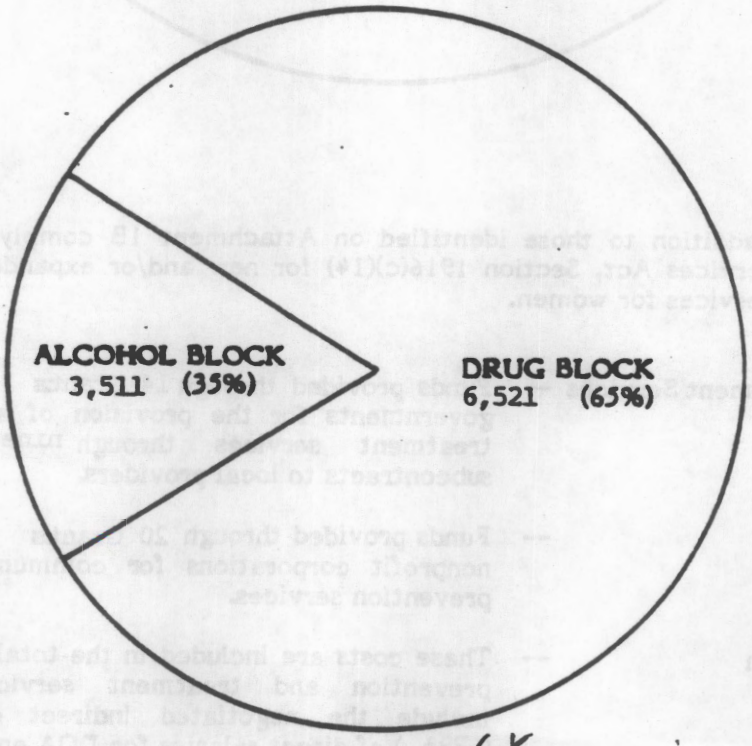
AGENCY/COUNTY/REGION	NEW PROGRAM/SERVICE IN FY 86	RATIONALE FOR SELECTION	OBJECTIVES	OBJECTIVES MET?
Central Region				
Community Center for Mental Health Bergen County, Northern Region	Partial Care; General & Administrative	Response to underserved population	Implement planned facility improvements, and expand Partial Care program space.	Yes
Family Guidance Center of Warren Warren County, Northern Region	Outpatient; Partial Care; General & Administrative	Response to underserved population	Hire Medical Director; make needed facility repairs & improvements; provide staff training.	Yes
Riverview Hospital Monmouth County, Central Region	Emergency/Screening	Response to underserved population	Establish 24-hour holding bed to serve clients in crisis.	Yes

415-X

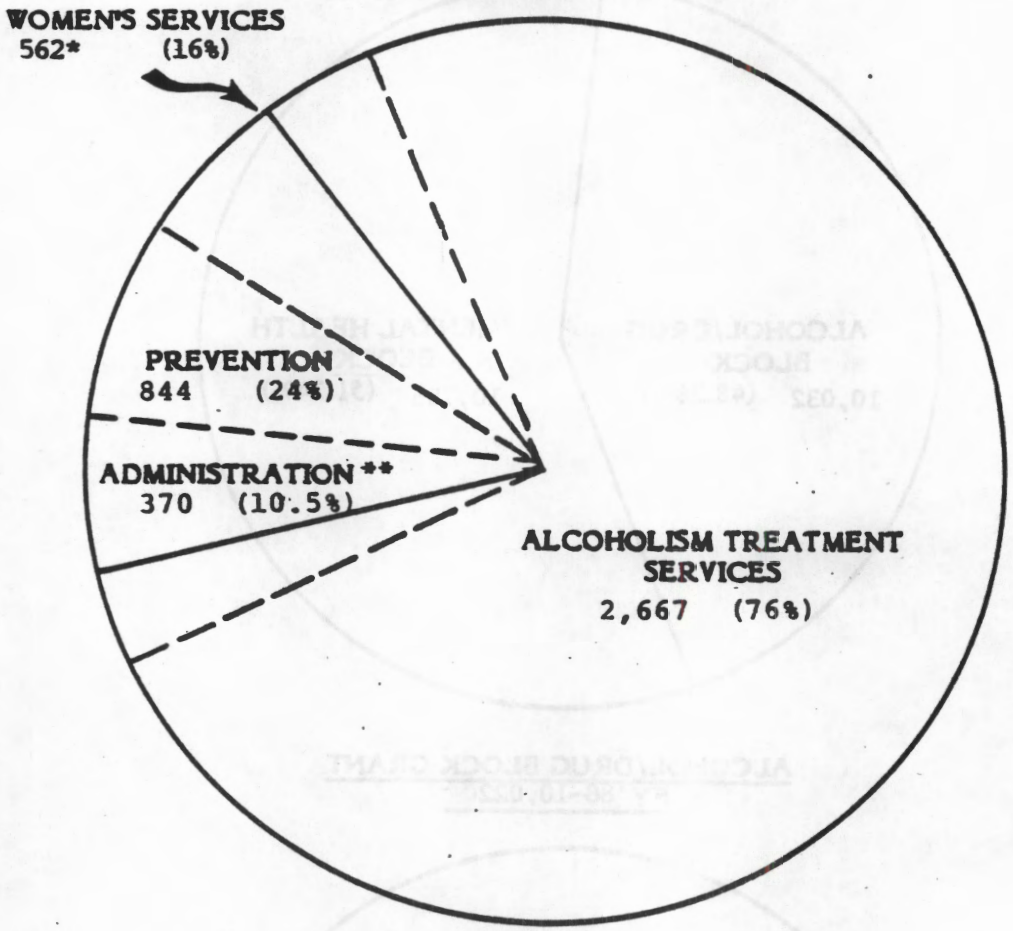
ALCOHOL/DRUG/MENTAL HEALTH BLOCK GRANT
FEDERAL FY '88-20,787 M



ALCOHOL/DRUG BLOCK GRANT
FY '88-10,022



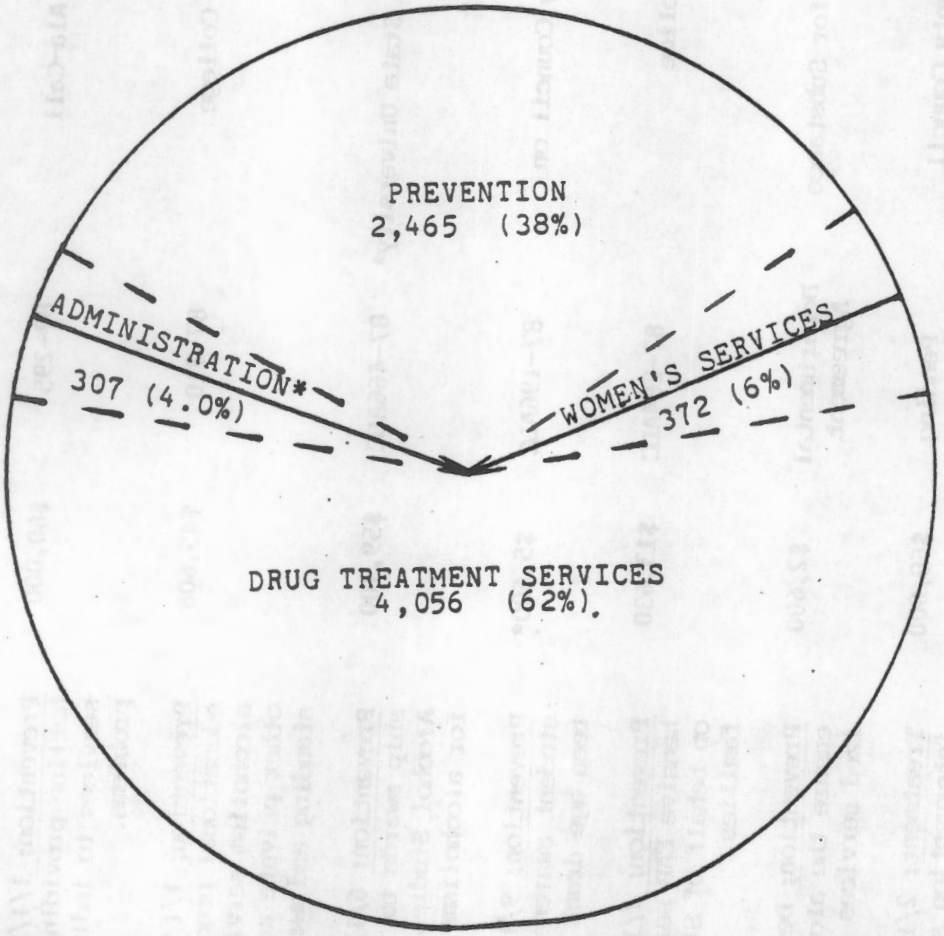
ALCOHOL BLOCK GRANT
FEDERAL FY '87-3,511 M



*These funds in addition to those identified on Attachment 1B comply with the Public Health Services Act, Section 1916(c)(14) for new and/or expanded alcohol and drug abuse services for women.

Alcoholism Treatment Services	--	Funds provided through 14 Grants to county governments for the provision of alcoholism treatment services through nineteen subcontracts to local providers.
Prevention	--	Funds provided through 20 Grants to private nonprofit corporations for community based prevention services.
**Administration	--	These costs are included in the total costs for prevention and treatment services; they include the negotiated indirect cost rate (29%) of direct salaries for DOA employees.

DRUG BLOCK GRANT
FEDERAL FY 88 - 6,521



Drug Treatment Services - - Funds provided through 22 Health Service Contracts to private, nonprofit agencies, local government and hospitals for provision of residential treatment services, outpatient methadone maintenance services, and inpatient intermediate medical units.

Prevention - - Funds provided through 50 contracts to private, nonprofit corporations, local governments, hospitals, etc., to support community based prevention efforts; 22 of the grantees which provide drug treatment services are contracted to provide prevention services as well.

*Administration - - These costs are included in the total costs for prevention and treatment services.

Attachment II

1987 ADM BLOCK GRANT
CONTRACT LIST
Division of Alcoholism

1.	Contact 609 - Ala-Call	87-295	$60,000	Prevention; 1/1/87 Start Date; A statewide alcoholism hotline providing alcoholism information and referral services to individuals experiencing alcohol related problems.
2.	Trenton State College	87-310	$45,608	Prevention; 1/1/87 Start Date; Provision of statewide educational programs in several formats targeted to alcoholism service personnel; outreach services to other private and public services to promote understanding and awareness of alcoholism use and misuse.
3.	Rutgers - The State University*	87-466ALC	$59,100	Prevention; 6/1/87 Start Date; Provision of scholarship awards to the three week Summer School of Alcohol Studies to facilitate counselor certification for alcoholism service personnel.
4.	Bergen County Council on Alcoholism	87-196ALC	$5,600*	Prevention; 9/1/87 Start Date; Provision of county based student awareness services to reduce the incidence of teen age drunk driving.
5.	N.J. State Police	87-284ALC	$13,630	Prevention; 1/1/87 Start Date; Provision of comprehensive EAP services to facilitate early intervention on behalf of State Police employees and their families.
6.	Signed Help for Substance Abuse	Departmental Agreement	$2,600	Prevention; Development of educational services to ensure the alcoholism constituency to provide specialized services to hearing impaired alcoholics.
7.	Somerset County Council on Alcoholism	Pending	$60,000	Treatment; 2/1/87 Start Date; Provision of early intervention services to troubled youth through team screening and provision of counseling and family services.
8.	Somerset County Council on Alcoholism	87-222ALC	$13,000*	Prevention/Women; 9/1/87; Comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.

* Grant partially funded through 1987 ADM BG funds.

NAME OF AGENCY	GRANT NO.	1987 BG AWARD	TYPE AND LEVEL OF SERVICE
9. Atlantic County Council on Alcoholism	87-227	$25,525	Prevention; 9/1/87 comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
10. Rutgers - The State University	87-71-NAR	$15,000**	Prevention; 6/1/87* start date; provision of scholarship awards to current and potential alcoholism service personnel to promote counselor certification.
11. Passaic County Council on Alcoholism	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
12. Atlantic County Council on Alcoholism	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
13. Bergen Council on Alcoholism	Pending	$25,000***	Prevention/Women; 9/1/87; start date comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
14. Cape May Council on Alcoholism	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
15. Hunterdon Council on Alcoholism	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
16. Mercer Council on Alcoholism	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.

** Supplemental provided through DNDAC Grant

*** Approximately $12,000 of this total will be provided through 1987 ADM BG funds.

NAME OF AGENCY	GRANT NO.	1987 BG AWARD	TYPE AND LEVEL OF SERVICE
17. Middlesex Council on Alcoholism	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
18. National Council on Alcoholism of North Jersey (Essex Co.)	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
19. National Council on Alcoholism of Monmouth County	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
20. Union County Council on Alcoholism	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
21. NCA of Ocean County	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
22. NCA of Morris County	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
23. Sussex County Council on Alcoholism	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
24. Tri-County Council on Alcoholism (Burlington, Camden, Gloucester)	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council serving three counties targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
25. Somerset County Council on Alcoholism	Pending	$25,000***	Prevention/Women;9/1/87; comprehensive county based alcoholism council serving three counties targeting public awareness, education and prevention activities focusing on the specific needs of alcoholic women.

NAME OF AGENCY	GRANT NO.	1987 BG AWARD	TYPE AND LEVEL OF SERVICE
26. Salem/Cumberland Counil on Alcoholism	Pending	$25,000***	Prevention/Women; 9/1/87; comprehensive county based alcoholism council serving three counties public awareness, education and prevention activities focusing on the specific needs of alcoholic women.
27. Morris County	87-206-ALC	$116,578	Treatment Hospital based detoxification services - 18 beds; Treatment/Women - women's halfway house - 16 bed.
28. Burlington County	87-114-ALC	$182,939	Treatment; Hospital based detoxification facility - 25 beds; freestanding outpatient service; Treatment/Women - Women's hafway house - 20 beds.
29. Bergen County Health Department	87-103-ALC	$ 91,875	Treatment; freestanding residential detoxification treatment facility - 13 beds, Treatment/Women - Women's halfway house - 20 beds.
30. Somerset County	87-151-ALC	$ 96,285	Treatment/Women; women's halfway house - 14 beds.
31. Mercer County	87-3-ALC	$ 7,500	Treatment/Women; Women's Halfway House services.
32. Essex County	87-106-ALC	$ 82,484	Treatment; freestanding residential alcoholism treatment facility, residential services; Treatment/Women; women's halfway house - 14 beds.
33. Camden County	87-8-ALC	$ 91,154	Treatment; Hospital based detoxification services - 20 bed; Treatment/Women; female halfway House services.

DOA: PROPOSED LIST OF GRANTEES TO BE FUNDED WITH 1988 ADM BG FUNDS

Prevention Grants

1. Contact "609"
2. Trenton State College
3. N.J. State Police
4. UMDNJ - Rutgers
5. Bergen Council on Alcoholism
6. Cape May Council on Alcoholism
7. Hunterdon Council on Alcoholism
8. Mercer Council on Alcoholism
9. Middlesex Council on Alcoholism
10. National Council on Alcoholism of North Jersey (Essex Co.)
11. National Council on Alcoholism Monmouth County
12. National Council on Alcoholism of Morris County
13. National Council on Alcoholism of Ocean County
14. Passaic Council on Alcoholism
15. Salem and Cumberland Council on Alcoholism
16. Somerset Council on Alcoholism,
17. Sussex Council on Alcoholism
18. Union Council on Alcoholism
19. Tri-County Council on Alcoholism
20. Atlantic County Council on Alcoholism

Treatment Grants

21. Atlantic County
22. Bergen County
23. Burlington County
24. Essex County
25. Camden County
26. Gloucester County
27. Hudson County
28. Mercer County
29. Middlesex County
30. Monmouth County
31. Morris County
32. Passaic County
33. Salem County
34. Union County

423 X

ATTACHMENT IV.

1987 ADM BLOCK GRANT
CONTRACT LIST
Division of Narcotic and Drug Abuse Control

	Name of Agency	Prevention Contract #	1987 BG Award	Type and Level of Service*
1.	Archway Programs	87-314 NAR	-0-	Primary Prevention/Early Intervention
2.	Barnert Memorial Hosp	85-186 NAR	-0-	Substance Abuse Assessment and Counseling in a hospital setting
3.	Bayshore Youth Services	87-59 NAR	15,410	Primary Prevention/Early Intervention
4.	Bridge (The)	87-110 NAR	23,115	Primary Prevention/Early Intervention Outpatient Drug Free
5.	Bricktown Outreach Center, Inc.	87-18 NAR	6,600	Primary Prevention/Early Intervention
6.	Burdette Tomlin Hospital	86-175 NAR	-0-	Substance Abuse Assessment and Counseling in a hospital setting
7.	Burlington Co. Board of Chosen Freeholders	87-61 NAR	13,208	Outpatient Drug Free Intervention Services
8.	Camden County (Turning Point)	87-63 NAR	61,640	Primary Prevention/Early Intervention Outpatient Drug Free Intervention Services
9.	Cape May County Board of Chosen Freeholders	87-274 NAR	29,719	Outpatient Drug Free Intervention Services
10.	Children's Psychiatric Ctr	87-68 NAR	58,337	Outpatient Drug Free Intervention Services
11.	City of East Orange	87-65 NAR	18,712	Outpatient Drug Free Intervention Services
12.	Community Guidance Center	87-16 NAR	59,438	Primary Prevention/Early Intervention Outpatient Drug Free Intervention Services

* Level of Service Definitions on page

	Name of Agency	Prevention Contract #	1987 BG Award	Type and Level of Service*
13.	CURA, Inc.	87-24 NAR	128,782	Primary Prevention/Early Intervention Outpatient Drug Free Intervention Services
14.	Damon House, Inc	87-25 NAR	25,316	Outpatient Drug Free Intervention Services
15.	Department of Education Memorandum of Agreement	Memo**	169,099	Substance Abuse Education and Prevention to schools, agencies and communities throughout New Jersey
16.	Discovery Institute	87-62 NAR	-0-	Primary Prevention/Early Intervention
17.	Family Guidance Ctr of Warren County	87-60 NAR	15,410	Primary Prevention/Early Intervention
18.	Family Service/Child Guidance Center	87-10 NAR	61,639	Primary Prevention/Early Intervention
19.	Freehold Area Hospital	85-185 NAR	-0-	Substance Abuse Assessment and Counseling in a hospital setting
20.	Hispanic Health	87-29 NAR	28,618	Outpatient Drug Free Intervention Services
21.	Hope House, Inc.	87-72 NAR	18,712	Outpatient Drug Free Intervention Services
22.	Hunterdon Drug Awareness	87-20 NAR	17,611	Primary Prevention/Early Intervention Outpatient Drug Free Intervention Services
23.	Hunterdon Medical Center	87-89 NAR	11,007	Primary Prevention/Early Intervention Outpatient Drug Free Intervention Services
24.	Integrity Inc. - Newark	87-22 NAR	126,580	Primary Prevention/Early Intervention Outpatient Drug Free Intervention Services
25.	Intercounty Council on Drug Abuse	87-19 NAR	22,014	Primary Prevention/Early Intervention Outpatient Drug Free Intervention Services

* Level of Service Definitions on page

	Name of Agency	Prevention Contract #	1987 BG Award	Type and Level of Service*
26.	Institute for Human Development	87-28 NAR	15,410	Outpatient Drug Free Intervention Services
27.	JFK Medical Center (Twp of Woodbridge, Way Counseling Ctr)	86-501 NAR	80,934	Outpatient Drug Free Intervention Services
28.	Morristown Memorial Hosp	86-213 NAR	-0-	Primary Prevention/Early Intervention
29.	Mount Carmel Guild	87-56 NAR	23,115	Outpatient Drug Free Intervention Services
30.	Newark Renaissance House	87-31 NAR	16,510	Outpatient Drug Free Intervention Services
31.	New Brunswick Counseling	87-30 NAR	41,827	Outpatient Drug Free Intervention Services
32.	Newton Memorial Hosp	85-221 NAR	-0-	Substance Abuse Assessment and Counseling in a hospital setting
33.	New Well Rehabilitation Ctr	87-32 NAR	91,358	Outpatient Drug Free Intervention Services
34.	North Essex Dev/Action	87-27 NAR	41,622	Outpatient Drug Free Intervention Services
35.	Orange City	87-23 NAR	61,639	Outpatient Drug Free Intervention Services
36.	Overlook Hospital	87-11 NAR	29,719	Outpatient Drug Free Intervention Services
37.	Princeton Corner House	87-58 NAR	49,531	Outpatient Drug Free Intervention Services
38.	Proceed Inc.	87-69 NAR	36,323	Outpatient Drug Free Intervention Services
39.	Raritan Bay Health Services	87-255 NAR	38,524	Outpatient Drug Free Intervention Services
40.	Reality House, Inc.	87-14 NAR	69,941	Outpatient Drug Free Intervention Services
41.	Rutgers - The State University	87-71 NAR	15,500	Education & Training, Statewide Community Organization (SCOP)
42.	SODAT, Inc.	87-13 NAR	57,236	Outpatient Drug Free Intervention Services

* Level of Service Definitions on page

	Name of Agency	Prevention Contract #	1987 BG Award	Type and Level of Service*
43.	Soul-O-House	87-17 NAR	134,285	Outpatient Drug Free Intervention Services
44.	Straight & Narrow, Inc.	87-15 NAR	126,580	Outpatient Drug Free Intervention Services
45.	Together Inc.	87-21 NAR	46,230	Outpatient Drug Free Intervention Services
46.	Toms River Outreach Ctr	87-26 NAR	48,431	Outpatient Drug Free Intervention Services
47.	Wall Youth Center	86-326 NAR	-0-	Primary Prevention/Early Intervention
48.	Wayne General Hospital	85-184 NAR	-0-	Substance Abuse Assessment and Counseling in a hospital setting
49.	West Jersey Hosp	85-201 NAR	-0-	Substance Abuse Assessment and Counseling in a hospital setting
50.	Women's Resource Center	87-66 NAR	20,913	Outpatient Drug Free Intervention Services

* Level of Service Definitions on page

	Name of Agency	Treatment Contract #	1987 BG Award	Type and Level of Service*
51.	Burlington Co Board of Chosen Freeholders	87-43 NAR	-0-	Residential Drug Free
52.	Camden Co (Turning Pt.)	87-91 NAR	230,186	Residential Drug Free, Methadone Maintenance, Intermediate Medical Unit
53.	Christ Hospital	86-272 NAR	-0-	Substance Abuse Assessment and Counseling in a Hospital Setting
54.	City of East Orange	87-87 NAR	94,850	Methadone Maintenance
55.	CURA, Inc.	87-35 NAR	197,090	Residential Drug Free
56.	Damon House, Inc.	87-53 NAR	237,125	Residential Drug Free
57.	Essex Substance Abuse Treatment Center	87-38 NAR	-0-	Methadone Maintenance
58.	Faith Farm	87-46 NAR	64,670	Residential Drug Free
59.	Hunterdon Medical Center	87-90 NAR	11,007	Methadone Maintenance
60.	Integrity, Inc.	87-36 NAR	274,080	Residential Drug Free
61.	Intercounty Council on Drug Abuse	87-45 NAR	69,555	Methadone Maintenance
62.	Institute for Human Development	87-42 NAR	416,805	Residential Drug Free, Methadone Maintenance
63.	Mount Carmel Guild	87-85 NAR	82,120	Intermediate Medical Unit
64.	Newark Renaissance House	87-34 NAR	123,180	Residential Drug Free
65.	New Brunswick Counseling	87-54 NAR	115,925	Methadone Maintenance

* Level of Service Definitions on page

	Name of Agency	Treatment Contract #	1987 BG Award	Type and Level of Service*
66.	Plainfield Treatment Center	87-41 NAR	123,645	Methadone Maintenance
67.	Raritan Bay Health Serv.	87-256 NAR	68,500	Methadone Maintenance
68.	St. Barnabas Medical Ctr	85-220 NAR	-0-	Substance Abuse Assessment and Counseling in a hospital setting
69.	St. Clare's Hospital	85-222 NAR	-0-	Substance Abuse Assessment and Counseling in a hospital setting
70.	S.M.A.R.T.	87-226 NAR	41,230	Vocational Training
71.	So. Jersey Drug Treatment	87-50 NAR	71,665	Methadone Maintenance
72.	Straight & Narrow, Inc.	87-44 NAR	289,475	Residential Drug Free, Day Care

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* Level of Service Definitions on page

Primary Prevention/Early Intervention

Counseling and support services for adolescents experiencing stress, and whose peer, family and school problems are acted out through the use and/or misuse of drugs or alcohol or are displaying dysfunctional behavior (truancy, vandalism, etc) and are considered "high risk."

Outpatient Drug Free Intervention Services

Assessment for applicants whose individual, group, and/or family counseling displays a pattern of abuse less frequent than 2-3 times per week with problem duration less than 18 mos. (opiate or medical addiction not considered for this modality)

Residential Drug Free

Medical/substance use assessment, medical services, counseling (individual, group, family) for applicants who display a heavy pattern of abuse and/or addiction. Social systems fragmented or absent, pattern of drug use severe enough to preclude educational/vocational effort. History of antisocial behavior for extended period of time usually in excess of five years.

Intermediate Medical Unit

Inpatient detoxification for applicants who are experiencing severe medical and/or major psychiatric problems and require hospital treatment.

Methadone Maintenance

Medical assessment and administration of methadone, counseling services for applicants dependent on opiate drugs for at least one year, except as specified in FDA Regulations. Drug pattern has precluded educational/vocational involvement at time of treatment.

Day Care

Assessment of substance use, counseling and support services for applicants who evidence a pattern of abuse less than 4times weekly with problems of up to 24 months. Social supports weakened but not absent, educational and vocational involvement minimal. Antisocial behavior of up to three years.

Regional Services Map**

NORTHERN — REGIONAL OFFICE

BERGEN
MORRIS
PASSAIC
SUSSEX
HUDSON
WARREN

100 Hamilton Plaza
Box 4, Room 800
Paterson, N.J. 07505
201-977-4397

STATE HOSPITAL:
Greystone Park
Psychiatric Center

COUNTY HOSPITAL:
Bergen (Bergen Pines)
Hudson (Meadowview)

CENTRAL — REGIONAL OFFICE

MIDDLESEX
MONMOUTH
OCEAN
UNION
SOMERSET
HUNTERDON
MERCER
ESSEX

13 Roszel Rd.
Princeton, N.J. 08540
609-987-0834

STATE HOSPITAL:
Marlboro Psychiatric
Trenton Psychiatric

COUNTY HOSPITAL:
Essex County Hospital Center

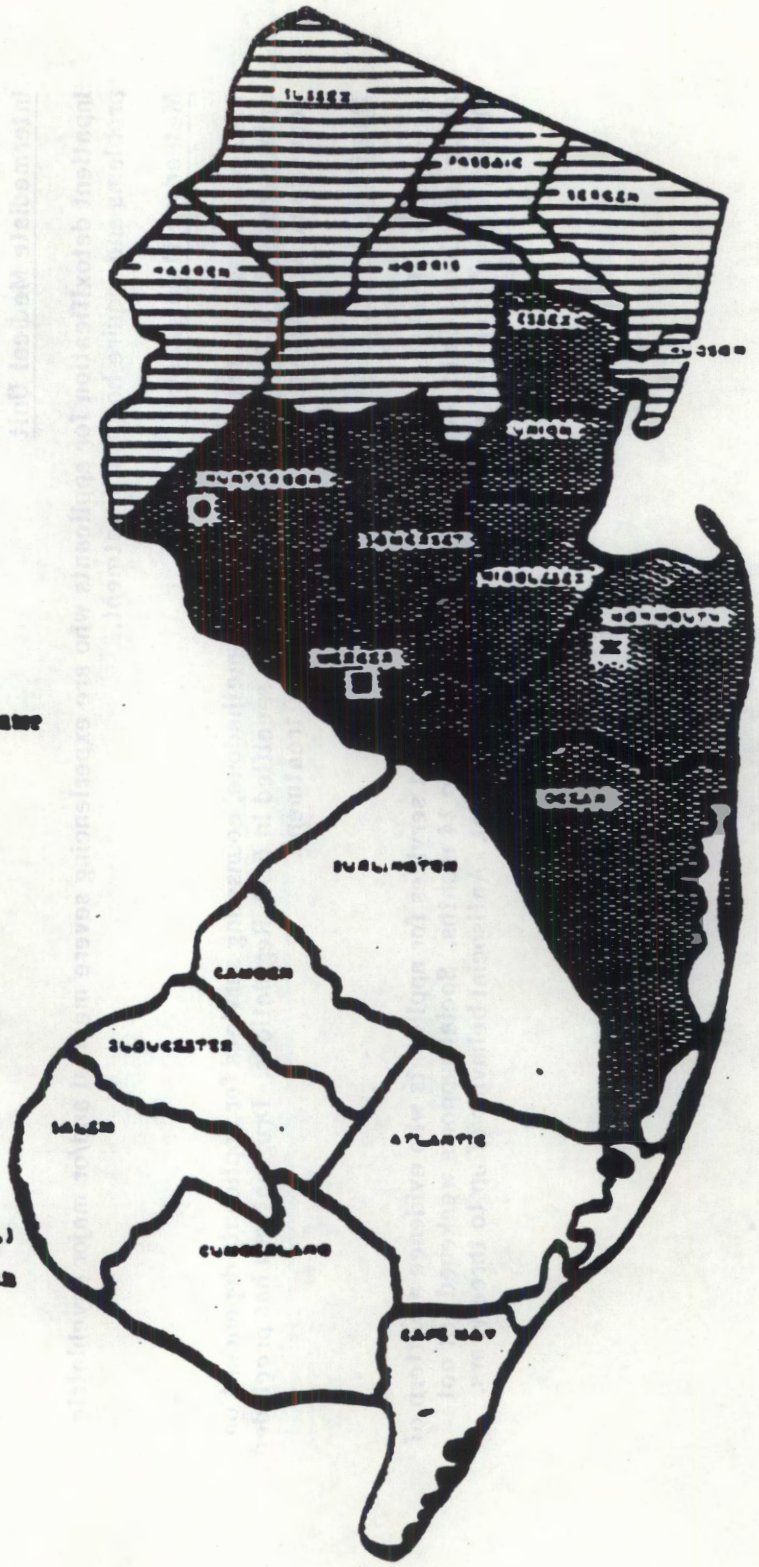
SOUTHERN — REGIONAL OFFICE

ATLANTIC
BURLINGTON
CAMDEN
CAPE MAY
CUMBERLAND
GLOUCESTER
SALEM

Evergreen Hall
Ancora Psychiatric
Hammonton, N.J. 08037
609-561-7812

STATE HOSPITAL:
Ancora Psychiatric

COUNTY HOSPITAL:
Burlington
(Buttonwood Hospital)
Camden
(Camden County Health
Services Center)



STATE SPECIALTY HOSPITALS
- Arthur Brisbane Child Treatment Center
- Hagedorn Center for Geriatrics
- Forensic Psychiatric Hospital

**Division of Mental Health and Hospitals' Regions

Administrators

County Mental Health Boards

Northern Region

Nancy Willick, Administrator
Bergen Co. Mental Health Board
Community Services Bldg.
327 East Ridgewood Avenue
Paramus, NJ 07652

Ernest Kosa, Administrator
Sussex Co. Mental Health Board
175 High Street
Newton, NJ 07860

John Carman, Administrator
Passaic Co. Mental Health Board
Co. Administration Bldg.
First Floor
317 Pennsylvania Avenue
Paterson, NJ 07503

Grace-Ann Haughton, Administrator
Hudson Co. Mental Health Board
Meadowview Hospital
595 County Avenue
Secaucus, NJ 07094

William Lehr, Administrator
Morris Co. Mental Health Board
Cn 900
Morristown, NJ 07960

Karen Rosanoff, Administrator
Warren Co. Mental Health Board
P.O. Box 15
Belvidere, NJ 07823

Central Region

Essex Co. Mental Health Board
P.O. Box 500
125 Fairview Avenue
Cedar Grove, NJ 07009

Patricia McNally, Administrator
Somerset Co. Mental Health Board
Richard Hall CMHC
500 North Bridge Street
Bridgewater, NJ 08807

Lucille Traina, Administrator
Middlesex Co. Mental Health Board
701 Amboy Avenue
Woodbridge, NJ 07095

James Eddleton, Administrator
Union Co. Mental Health Board
Union Co. Administration Bldg.
Elizabeth, NJ 07207

William Wood, Administrator
Monmouth Co. Mental Health Board
P.O. Box 1255
Freehold, NJ 07728-1255

Jane Silver, Ed.D., Administrator
Ocean Co. Mental Health Board
CN 2191
Toms River, NJ 08753

Angelo DiOrio, Administrator
Hunterdon Co. Mental Health Board
Hunterdon Co. Administration Bldg.
Main Street
Flemington, NJ 08822

Hugh Adams, Administrator
Mercer Co. Mental Health Board
640 S. Broad Street
Trenton, NJ 08650

Southern Region

Gary A. Miller, Administrator
Burlington Co. Mental Health Board
Raphael Meadow Comprehensive Health Center
Woodlane Road
Mt. Holly, NJ 08060

David Pratt, Mental Health Coordinator
Cumberland Co. Mental Health Board
790 E. Commerce Street
Bridgeton, NJ 08302

Peter Molnar, D.D.
Camden Co. Mental Health Board
Central Services Building
Camden Co. Health Services Center
Lakeland Road
Blackwood, NJ 08012

Kathleen Spinosi, Administrator
Gloucester Co. Mental Health Board
Gloucester Municipal Co. Office
251 Delsea Drive
Deptford, NJ 08096

Michael Gallagher, Administrator
Atlantic Co. Mental Health Board
201 Shore Road
3rd Floor, A Wing
Northfield, NJ 08225

Patricia DeVaney, Administrator
Cape May Co. Mental Health Board
Planning Board-Library Board Office Bldg.
Cape May Court House, NJ 08210

Jane Masker, Administrator
Salem Co. Mental Health Board
R.R. #2, Box 346
Woodstown, NJ 08098

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196