




NJ Health
New Jersey Department of Health

PARTNERING FOR A HEALTHY NEW JERSEY

New Jersey Chronic Disease Prevention & Health Promotion Plan

2013 - 2018

State of New Jersey

From the Office of the Commissioner:

It is with great pleasure that I present the *New Jersey Chronic Disease Prevention and Health Promotion Plan: Partnering for a Healthy New Jersey*. This initiative began in November 2011, when a wide range of stakeholders gathered to address the growing chronic disease burden in New Jersey. Bringing in expertise and experience from organizations and initiatives all over the state, they created workgroups that shared the common goal of creating a framework that would allow us all to initiate an evidence-based strategy to promote disease prevention and wellness programs for a healthier New Jersey.

Chronic disease puts a tremendous burden on individuals, families, and communities. It is a major cause of disability and death and a major contributor to escalating healthcare costs in the United States. Seven of the leading causes of death in NJ are chronic diseases. Heart disease, cancer, stroke, and diabetes caused 59% of deaths in New Jersey last year. Chronic disease has been characterized as the public health challenge of the 21st century. *Partnering for a Healthy New Jersey* documents the activities and recommendations of these workgroups and provides the framework for a statewide approach to implement evidence-based prevention programs and environmental strategies to promote prevention and wellness programs, and to support healthy lifestyles for a growing population over the next five years.

We are grateful to the scores of individuals representing nonprofit organizations, advocacy organizations, academic institutions, and businesses, who participated in these meetings and workgroup activities. It is our hope that this plan and the work that follows will move us towards achieving sustainable reductions of the chronic disease burden in New Jersey.

Sincerely,

Mary E. O'Dowd, M.P.H.
COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF HEALTH

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INTRODUCTION

The Planning Context in New Jersey

According to The Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), chronic diseases – such as heart disease, stroke, cancer, diabetes, and arthritis – are among the most common, costly, and preventable of all health problems in the United States. The NCCDPHP has called upon all states and territories to strengthen and better coordinate activities within health departments and in the community aimed at preventing chronic diseases and promoting health. This CDC initiative aims to improve health and the quality of life by promoting environmental and policy changes related to nutrition, physical activity, and clinical preventive services, and by promoting education and management skills for people diagnosed with or at high risk for chronic diseases.

A major portion of this CDC initiative is the joint development of this State Plan for Chronic Disease Prevention and Health Promotion in New Jersey. This plan represents the work of a wide variety of New Jersey stakeholders including various parts of state government, the healthcare sector, private business, local government, and community service providers. An integrated approach to reducing the individual and community burden of chronic disease will require this joint effort.

New Jersey is well on its way towards improving health and wellness. New Jersey made the largest improvement by any state for overall state health between 2011 and 2012. According to the 2012 *America's Health Rankings*, compiled by the United Health Foundation, New Jersey ranked 8th overall, up from 17th in 2011. New Jersey was also in the top ten of all states in a number of healthcare core measures. Besides having one of the lowest smoking rates and one of the highest income per capita rates in the nation, New Jersey excelled in several specific core measures:[1]

Table 1 | Non-Social Determinants of Health and Actual Health Outcomes

Core Measures[1]	National Ranking
Over-18 smoking rates	3rd out of 50 states
Adult obesity rates	4th out of 50 states
Teen birth rate	5th out of 50 states
Infectious disease rate	6th out of 50 states
Premature death rates; Percentage of adult population who have been told by a healthcare professional that they have had a stroke	7th out of 50 states
Infant mortality rate	9th out of 50 states

The fourth smallest state in land mass, New Jersey has a very strong "home rule" ethos with 21 counties, 565 local municipalities, 95 local health departments, and 690 public school districts. It is also the most densely populated state and one of the most diverse, with close to 30% of the population speaking a language other than English at home. Such diversity and local control mean that one size never fits all, and local policy decisions carry at least as much weight as state level policy. Thus, such rankings are possible because of the efforts not just of state-level organizations, but local policy makers. In fact, the CEO of UnitedHealth attributed New Jersey's commendable rankings to the wellness programs instituted by employers in many local municipalities,[2] brought about by state and federal healthcare reform efforts.[3]

New Jersey is bordered by the first and fourth largest media markets in the country. The absence of print and broadcast media dedicated to New Jersey limits the state's direct messaging to residents, and health promotion messaging to residents must compete with messaging from New York and Pennsylvania. This is a challenge that New Jersey news organizations describe not as a hindrance, but as "a rare opportunity to...share resources, and reach broader audiences throughout the state...encouraging the public to participate more actively in their communities."[4]

Although some of the above factors present challenges, they also present opportunities. Activities at the "ground level" can more effectively address the specific needs of target populations in that community. Over 390 local communities have registered and established local Green Teams under the Sustainable Jersey certification program. These communities are

customizing evidence-based toolkits to build local sustainability and improve community health. At the same time, the current economic climate in a state with very high property taxes has forced communities to seriously consider economy of scale and regionalization. There are new and exciting examples of shared services across municipalities – a trend that was unthinkable just a few years ago. These new shared services include mergers of local health departments, combined county-wide transportation services for the disabled and elderly, and shared public health nurses across municipalities.

Similar challenges and opportunities exist within state agencies. There are currently 5,200 fewer state government employees than in 2011, with most of the reductions coming from unfilled positions and retirements. A prolonged hiring freeze and budget reductions have impacted every state department and have affected state department infrastructure capabilities, particularly in technology. The goal for leaner, more efficient government is changing the role of every part of state government and the relationships between departments.

The New Jersey Chronic Disease Prevention and Health Promotion Plan is directly connected to the NJDOH Strategic Plan (see page 14), which means that the New Jersey Chronic Disease Prevention and Control Unit (NJCDPC) can better leverage its efforts within the NJDOH as a whole and across a number of state departments.

Of course, successful messaging is only part of the solution; messaging has no influence on social determinants like personal income. Thus, while Table 2 shows that the personal income rates in New Jersey are higher than average, these rates vary drastically by county; poverty levels range from 3.6% in Hunterdon County to 15.7% in Cumberland County. More than half of the counties in the state have poverty levels above the national average, but this is offset by counties whose poverty levels are far, far lower than the rest of the country. This is true of most social determinants (e.g. in 2011, Cumberland County's Memorial High School had a graduation rate of 14%; Hunterdon County's South Hunterdon Regional High had a graduation rate of 100%[5], but New Jersey ranks 6th in the nation for high school graduation rates), so a commendable national ranking like those in Table 2 should not be taken to mean that there is not a significant proportion of the state population in need of customized healthcare initiatives and community supports.

Table 2 | Social Determinants of Health and Actual Health Outcomes

Core Measures [1]	National Ranking
Personal income per capita	3rd out of 50 states
Percent of incoming 9th graders who graduate in four years	6th out of 50 states
Number of primary care physicians[i]	9th out of 50 states

Reducing the burden and impact of chronic disease and building healthy communities will require the coordination of efforts of many state departments, most notably departments dealing with human services, insurance, transportation, municipal land use, education, agriculture, and environmental protection. It will also require the full engagement of outside partners in healthcare, local government, and community-based services. While state government has an important and unique role to play, it is clear that nurturing and supporting strong public-private partnerships is becoming a key role of state government.

Changes at the federal level in healthcare delivery are creating powerful forces that currently are and will continue to significantly redefine health systems in New Jersey. The planning process made evident that New Jersey has significant public and private health resources available but has lagged in cross-system collaboration and communication. Our "home rule" ethos can create unique obstacles to collaboration. Some indicators that NJ is lagging in key areas include:

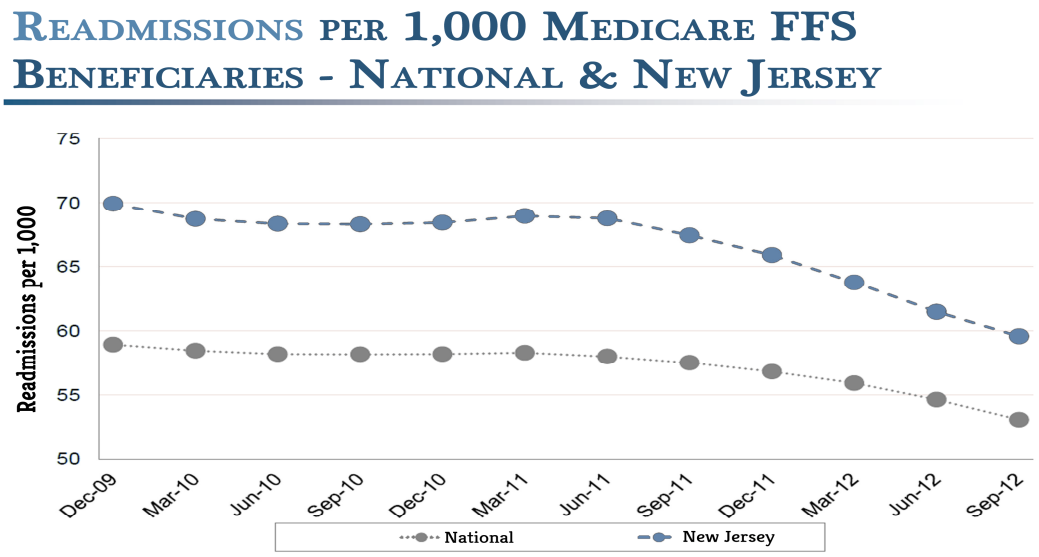
- 71.8% of office-based physicians are using an electronic health records (EHRs) system in the United States while only 53.8% of New Jersey's office-based physicians are using an EHR system.[6]
- Medicare hospital readmission rates in New Jersey far exceed the national average. Care transitions are generally problematic and insufficient for community-based care and support, but especially among high risk populations.[7]

Reducing hospital readmissions will require that New Jersey follow the comprehensive approach to wellness described by the National Prevention and Health Promotion Strategy. We will join with other private partners in shifting the focus from illness to wellness. We will expand our focus from living well with chronic disease to also include primary prevention through making the healthy choice the easy choice in local communities. We are joining with our partners

[i] Based on the number of primary care physicians per 100,000 residents.

in the private sector in making the shift to evidence-based practice and data-informed decision-making to reduce costs and improve quality care.

Figure 1 | National vs. New Jersey Readmission Rates



Annual data ending in the time frame specified
SOURCE: HQSI's analysis of ICPC Scorecard for New Jersey prepared by the Integrating Care for Populations & Communities National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. (Jan - 2009 to Apr - 2012)

Such system changes offer opportunities for restructuring and new role definition for all government, clinical and community partners. New Jersey already has a number of existing state, regional, and local collaborations focused on chronic disease prevention and healthcare reform, presenting both an opportunity and a challenge. Using the principles of community engagement, we must all work to:

- Share a common agenda;
- Respect the unique culture, social networks, norms and values of various communities;
- Build trust across all sectors;
- Accept the right and responsibility for community based self determination;
- Share power at all levels and across all sectors;
- Engage in continuous communications and capacity building; and
- Ensure a strong infrastructure to support sustainable long term collaboration.

> *John Kania and Mark Kramer in "Collective Impact," Stanford Social Innovation Review, Winter 2011, speak about the need for coordinated efforts across sectors to address social issues. They also speak to the time and effort that must be expended to build the communication and structure for collaboration.*[8]

In summary, any New Jersey-specific chronic disease prevention and health promotion efforts should:

- Always be adapted for a wide variety of diverse audiences;
- Include both community-based and regional health & wellness models;
- Include communication strategies that can break through the noise of other media markets;
- Have strong and broad public and private co-ownership and engagement in implementation; and
- Build adequate state government infrastructure for contributing to the process of community engagement.

PART ONE
Stakeholder Engagement in Planning

First Phase

The New Jersey Chronic Disease Prevention and Control Services Unit (NJCDPC), housed under the Family Health Services (FHS) Division, Public Health Services Branch, within the New Jersey Department of Health, kicked off the planning process by convening an internal Chronic Disease Planning Team (the Planning Team) in November 2011. The Chronic Disease Planning Team met regularly through 2012 to discuss internal opportunities for integration and to initiate planning efforts.

The Chronic Disease Planning Team identified a preliminary list of key external stakeholders with expertise in each of the categorical areas of interest: heart disease, stroke, cancer, diabetes, arthritis, poor nutrition, lack of physical activity, and tobacco use. Many of these individual stakeholders were already actively involved in at least one of the existing chronic disease-related partnership groups but to date had not formally worked together across disciplines on the issue of integration of efforts.

Representatives of the NJCDPC Planning Team visited and/or conducted phone interviews with representatives of the partnership groups in June 2012 to begin discussions about future integration efforts and to identify key representatives that would participate in the external planning process. Overall, stakeholders were very interested and anxious for details about the New Jersey State Plan initiative and participating in the planning process. However, as the principles inherent in an integrated New Jersey State Plan would require changes to existing approaches stakeholders also expressed discomfort and concern in a number of areas:

- How will the new coordinated planning approach affect existing initiatives?
- How will funds be allocated under the new coordinated plan?
- How will the Workgroup meetings be scheduled so as not to interfere with collaborations already underway?
- How will the activities be coordinated and information shared?

- How can the planning process ensure that evidence-based programs currently underway will be incorporated?
- Will there be support for the New Jersey State Plan at top levels within the State, particularly in the Executive and Legislative branches?
- Will there be sufficient resources, particularly staff, at the Department of Health to support the planning process and implementation of the plan itself?
- How will we ensure that initiatives for important population groups are properly addressed (e.g. children, the mentally ill, and other disparate populations)?

Second Phase

A new Director of the NJCDPC Unit was appointed and began work in September 2012. The transition to new leadership created a slight delay in the planning process to ensure that the new leadership had time to get oriented and assess the internal needs of the unit.

The New Jersey Chronic Disease Advisory Council (NJCDAC) acted as the external advisors to NJCDPC on the plan process and content. During the process they requested more information about the emerging paradigm shift from a chronic illness model to a wellness model. The Governor's Task Force on Cancer Prevention, Early Detection and Screening was also preparing to update their plan and was eager to coordinate efforts with an eye toward greater integration of strategies in the future. The two groups met together in January 2013 and heard presentations about New Jersey Community Transformation grant activities, the ShapingNJ Obesity Prevention Plan implementation efforts, and the National Prevention Strategy.

> *"The New Jersey Chronic Disease Advisory Council (NJCDAC) includes NJDOH Commissioner-appointed members representing a wide range of constituents including healthcare providers, government agencies, professional organizations, healthcare organizations, and minority health groups. The purpose of CDAC is to act in an advisory capacity in the areas of chronic disease prevention, detection, and treatment."*

In late January 2013, a full stakeholder meeting was held to kick off the external planning process and respond to some of the concerns expressed in the initial planning phase. Invitees included representatives from the existing and independently operating chronic disease partnership entities including the Pediatric Adult Asthma Coalition, NJ Breathes, Governor's Task Force on Cancer Prevention, ShapingNJ, and the NJCDAC. Key additional representatives from private businesses, health

insurance companies and others who will play a critical part in healthcare reform were invited to this meeting.

The group received training in the core concepts of chronic disease prevention and health promotion. They then broke into domain workgroups to begin discussing available data about the chronic disease burden and related risk factors in New Jersey. The four domains outlined by the CDC provided the workgroup framework for the planning process:

- *Domain One: Epidemiology, Surveillance and Evaluation*, in which we gather, analyze and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health.
- *Domain Two: Environmental Strategies*, in which we promote health and support and reinforce healthful behaviors statewide in schools, worksites, and communities.
- *Domain Three: Health System Interventions*, in which we improve the effective delivery and use of clinical and other preventive services to prevent disease, detect disease early, reduce or eliminate risk factors, and mitigate or manage complications.
- *Domain Four: Community-Clinical Linkages*, in which we ensure that communities support and clinics refer patients to programs that improve management of chronic conditions.

The external planning process was created to cover the following topics in each of four domains:

- Prioritization of key disparate populations across risk factors and disease areas, including identification of the barriers faced by these populations;
- Assessment of current evidence-based strategies for each domain that should be integrated and brought to scale in the future, and opportunities for pilot testing new strategies that will be needed to address the needs of the identified disparate populations;
- Assessment of existing policy that supports wellness in NJ and future policy needs to support new community and population norms about wellness; and
- Identification of key messaging that will support this integrated shift to wellness.

During the spring of 2013, twenty-two stakeholder meetings were held. Bracketed by two statewide meetings, workgroups designated by domain met five times each. A list of the various people and the organizations represented is in Appendix I: Planning Stakeholders. Each workgroup was facilitated by NJCDPC staff representatives.

The stakeholder priorities from the workgroups were summarized and shared in July 2013 with the New Jersey Chronic Disease Advisory Council, NJDOH leadership, and at a follow-up

meeting of stakeholders. This New Jersey Chronic Disease Prevention & Health Promotion Plan (the Plan) represents the final consensus of priorities that will guide all activities aimed at reducing the burden of chronic disease in New Jersey for the next five years.

The final stakeholder planning meeting was held July 11, 2013, and stakeholder representatives presented the findings from each domain workgroup. Participants also shared the lessons learned from the planning process including:

- There is much happening in New Jersey to help our residents get healthy. Working together leads to better coordination and use of resources for building networks and breaking out of silos.
- Workgroup members found that the greatest risk factors for chronic disease are often the same across diseases, and there are opportunities to work together toward the common goal of decreasing chronic disease.
- Workgroup members were highly engaged in the process and are committed to staying engaged through implementation.
- This process differed from other past processes in that stakeholders were treated as equal partners in the development of final plan recommendations.

PART TWO
State Plan Integration

The work of this five-year plan is directly correlated with the NJDOH Strategic Plan: 2012-2015: *Lead Proactive Efforts to Drive Measurable Improvements in the Health of the People of New Jersey*. Both have a common goal of leading proactive efforts to drive measurable improvements in the health of the people of New Jersey:

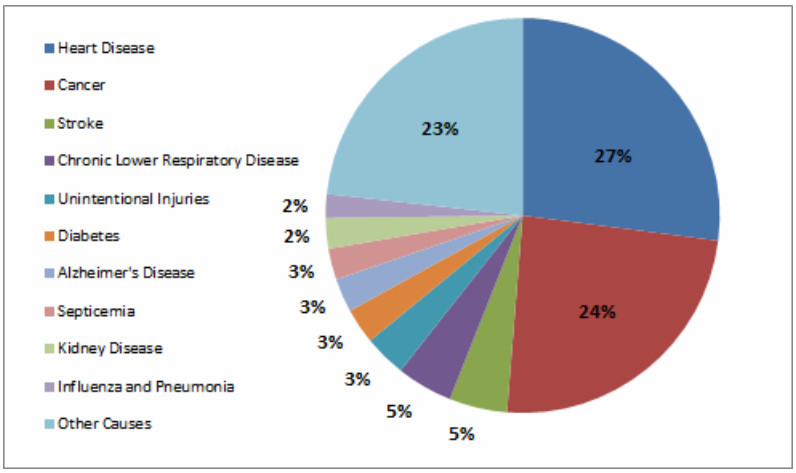
Table 3 | Common Goals of the NJDOH Strategic Plan and NJCDPHP Plan

NJ Department of Health Strategic Plan, 2012-2015	Partnering for a Healthy New Jersey: New Jersey Chronic Disease Prevention and Health Promotion Plan, 2013-2018
Strengthen the demonstrated impact of public health programs.	Improve access, application, communication and collaboration around data collection, analysis, and distribution to ensure population management and data-based decision making at all levels.
Communicate the value & contributions to public health.	Establish advanced and culturally appropriate communication channels to stakeholders and the public at large, with special attention paid to ensuring that people can easily act on information so they can live healthier lives.
Foster accountable, accessible health & prevention services.	Prioritize evidence-based strategies for: • Achieving policy and environmental changes to make the healthy choice the easy choice for everyone in NJ; • Achieving important improvements so that state healthcare systems detect, manage, and control chronic disease, conditions and risk factors through better use of chronic disease early detection and clinical preventive services; and • Enhancing clinical-community linkages so that people at high risk can better take charge of their health through self-management and other community supports.
Optimize the acquisition & utilization of resources.	Leverage both public and private resources to implement plan strategies and build sustainable infrastructure for collaboration.
Strengthen organizational effectiveness & adaptability.	Develop and implement a NJCDPC staffing structure that ensures high quality strategy integration, external collaboration, and evaluation.
Expand & strengthen key partnerships.	Using the principles of "community engagement," build strong public-private partnerships that make the best use of each other's skills, time and available resources.

PART THREE
Disease Burden

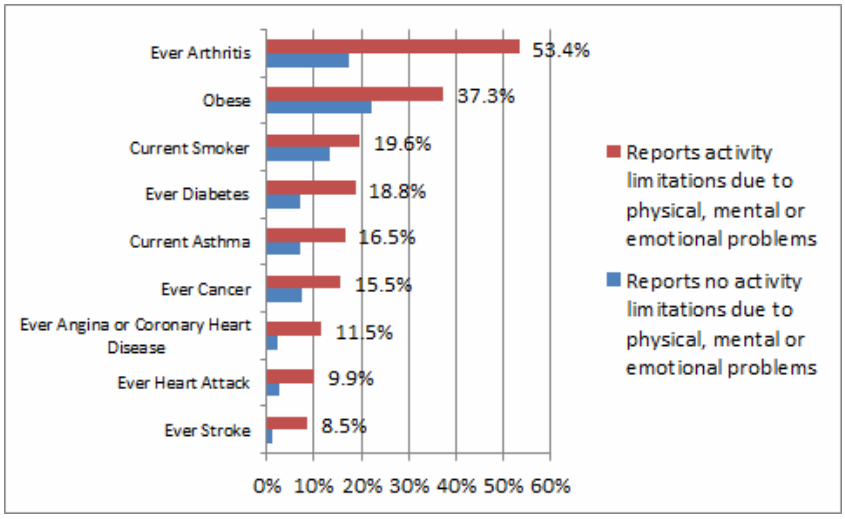
Chronic Disease is a major cause of disability and death in New Jersey and the United States. In New Jersey in 2009, heart disease, cancer, stroke and diabetes caused 59% of deaths.[9] Reducing this burden with an emphasis on wellness across the diseases would have a major impact on the residents of the State, both personally and collectively. For example, in 2009, according to America's Health Rankings, New Jersey spent an estimated $2.2 billion in obesity-attributable healthcare.

Figure 2 | Distribution of New Jersey Deaths by Underlying Cause, 2009[9]



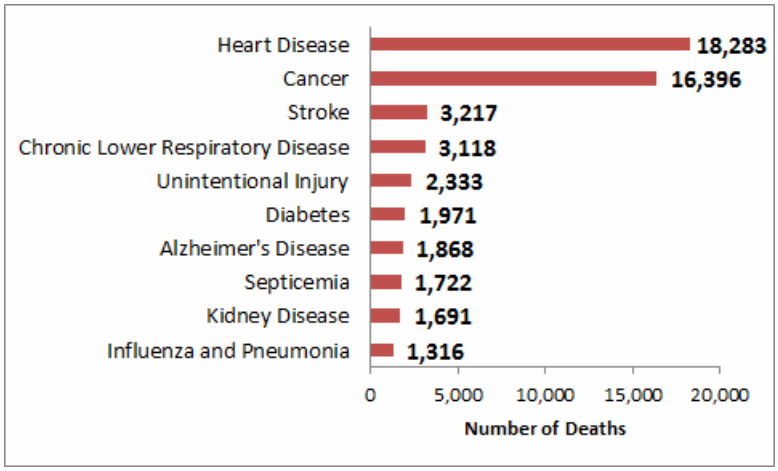
Chronic disease puts a tremendous burden on families and communities. According to the Centers for Disease Control and Prevention (CDC), chronic diseases are responsible for about 70% of all deaths nationally and lead to disabilities for nearly 10% of Americans.[10] Experts estimate that about 83% of health care spending in the U.S. is accounted for by people with chronic conditions.[11] It is not surprising that chronic disease has been characterized as the public health challenge of the 21st century.[12]

Figure 3 | Chronic Disease Prevalence by Activity Limitation, New Jersey Adults, 2009-2010[13]



Arthritis is known nationally as the leading cause of disability. Among New Jersey adults with activity limitations, about 53% have arthritis.

Figure 4 | Leading Causes of Death, New Jersey and the United States, 2009[9]



Seven of the ten leading causes of death in New Jersey are chronic diseases. Despite advances in diagnosis, treatment, and prevention, stroke for example, remains a leading cause of death in New Jersey.[14] Just last year, there were more than 20,000 hospitalizations attributable to stroke and more than 1,000 of those patients died while in the hospital.

According to the CDC, New Jersey women younger than 65 years of age had a higher incidence rate of breast cancer (129.7) compared to the national rate (121.2). New Jersey ranking by cancer incidence nationally includes: breast (10th), cervical (16th), colorectal (17th), and, prostate (6th). In NJ, the age-adjusted cancer incidence rate for both males and females is significantly higher than the national average. Primary cancers with the ten highest age-adjusted incidence rates from 2006 to 2010 in New Jersey were prostate, lung, colon and rectum, urinary bladder, melanoma of the skin, non-Hodgkin lymphoma, kidney and renal pelvis, leukemia, pancreas and oral cavity and pharynx for men; and breast, lung, colon and rectum, endometrial (corpus and uterus, NOS), thyroid, melanoma of the skin, non-Hodgkin lymphoma, ovary, urinary bladder, and pancreas for women. These cancer cases accounted for 79 percent of the total cancers.[15]

In New Jersey, diabetes was the sixth-leading cause of death in 2009. Adult diabetes is a major risk factor for heart disease and stroke. What is important about this is that diabetes has become a Top 10 Leading Cause of Death in New Jersey and the U.S. over the last decade.

> *"Tobacco use, followed by poor diet and physical inactivity, is the leading modifiable risk factors associated with death."*[16]

The most recent asthma surveillance data for New Jersey shows that approximately 14.2% of the State's children have a history of asthma and approximately 9% of the children have current asthma.[17] Asthma was the leading cause of hospitalization for New Jersey children aged one through seventeen years.[18] About 44% of New Jersey children aged birth through four years with a diagnosis of asthma experience activity limitation due to their asthma symptoms. Residents had nearly 52,000 emergency department visits and 15,000 hospitalizations for asthma in 2011.[19]

In New Jersey, 24% of adults and 11% of high school students are obese.[10] Over the past ten years, rates of adult obesity increased 40%. If obesity rates continue to increase at the current pace, nearly half of NJ adults will be obese in 2030.

Tobacco use is the single most preventable cause of death and disease in the United States. Tobacco use increases the risk for lung cancer and cardiovascular disease. Between 2000 and 2010, the smoking prevalence for New Jersey was less than the national average, but there is

still room for improvement. About 17 percent of adults and 14 percent of high school students are current smokers.[13,20]

The burden of these conditions is not uniformly distributed amongst the residents of New Jersey.

Poverty Affects Chronic Disease Burden

According to the 2012 U.S. Census, approximately 9.4% of New Jersey's population lives below the poverty level compared to 14.3% nationally. New Jersey has a higher mean family income ($111,800) compared to the U.S. as a whole ($84,422). These statistics are somewhat misleading. While New Jersey as a whole fares better than the national average, there are still areas of the State impacted by higher rates of poverty than others, with some "hot spots" as high as 15.7% of the population below poverty level (Cumberland County). Table 4 and Figure 5, with data provided by the U.S. Census Bureau, 2012, illustrate the variation in poverty level by county.

Figure 5 | Percent of Residents below Poverty Level in New Jersey, By County

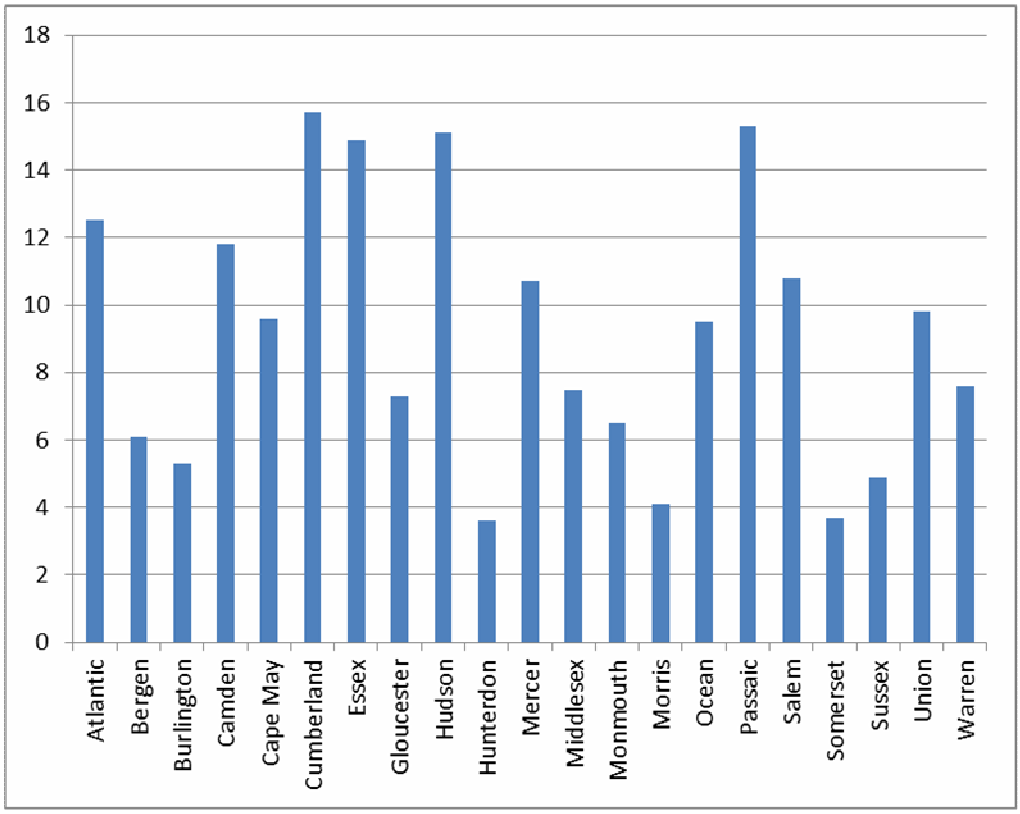


Table 4 | Poverty in New Jersey by County

County	Below Poverty Line
Atlantic	12.5%
Bergen	6.1%
Burlington	5.3%
Camden	11.8%
Cape May	9.6%
Cumberland	15.7%
Essex	14.9%
Gloucester	7.3%
Hudson	15.1%
Hunterdon	3.6%
Mercer	10.7%
Middlesex	7.5%
Monmouth	6.5%
Morris	4.1%
Ocean	9.5%
Passaic	15.3%
Salem	10.8%
Somerset	3.7%
Sussex	4.9%
Union	9.8%
Warren	7.6%

New Jersey residents living below the poverty level experience a higher chronic disease burden. Obesity prevalence among low-income children ages two to less than five years is one of the highest in the nation.[13]

Among residents living in households where total income is less than $15,000 per year:

- Adult and childhood asthma prevalence is highest (14.5% and 14.4%, respectively);[20]
- Adult arthritis prevalence is highest (33.8%);[12]
- Adult diabetes prevalence is highest (15.1%);[12] and
- Adults smoking prevalence is highest (27.2%)[12]

Race and Ethnicity Affect Chronic Disease Burden

Black residents have the:

- Highest asthma prevalence, hospitalization and ED visit rates across all ages;[21]
- Highest diabetes prevalence among adults;[12]
- Highest age-adjusted diabetes, heart disease, and stroke mortality; [12]
- Highest smoking and obesity prevalence among adults; [12]
- Highest age-adjusted cancer mortality rate; [12] and
- Highest percent with late-stage breast cancer diagnosis across all ages among women with breast cancer.[22]

Hispanic residents have the:

- Highest percent of adults with arthritis who report fair or poor health status (47%);[23]
- Second-highest diabetes prevalence (9.5%);[12] and
- Second-highest age-adjusted mortality rate for diabetes. [12]

Geography Affects Chronic Disease Burden

Asthma Emergency Department visits vary widely by county with age-adjusted rates ranging from 232 per 100,000 among residents of Hunterdon County to 1,254 per 100,000 among residents of Essex County.[16]

Hot Spots and Readmission Rates

New Jersey has clear "hot spots" for the chronic disease burden. Significant future healthcare cost savings will require specific, targeted shorter-term investments, especially in high-risk communities. For example, a recent study from the Rutgers University Center for State Health Policy describes the differences in hospital readmissions by income.[24] While the State ranks high in income level, the unfortunate reality is that there are many counties in which the poverty level is significantly higher than average (See Table 4, Page 19). Table 5

shows how New Jersey readmission rates across the board are some of the highest in the nation, ranking very last out of 50 states and three U.S. territories for readmissions of patients discharged to skilled nursing facilities (SNF).[25]

Table 5 | Readmission Rankings

30-Day Readmission	NJ 2011 Rank (out of 53)	NJ 2011 Rate	National Rate[26]
All Readmissions	50	21.2%	17.6%
Readmissions of Patients Discharged to Home without Home Healthcare	49	18.1%	17.1%
Readmissions of Patients Discharged to SNFs	52	26.1%	22.2%
Readmissions of Patients Discharged with Home Healthcare	42	23.4%	22.3%
Readmissions of Hospice Patients	24	2.8%	2.6%

In the past, hospitals had no financial incentives to reduce readmission rates and even benefited from higher readmission rates due to the cost of repeated treatments. Since 2010, however, hospitals have been penalized for high readmission rates and pushed to increase the quality of post-discharge care. The national average for readmissions has been about 19 percent for several years, but New Jersey readmission rates have seen no significant reduction in that time period.[27]

It is important to note that although a readmission rate on the surface does not appear to be significantly above the national average, the ranking reflects the reality: New Jersey readmission rates are very nearly the highest in the nation. Much of this is because of the disproportionately high poverty rates in over half the counties in the State. Overall, New Jersey poverty rates are ranked among the lowest in the nation, but this is because of extremely low rates in Hunterdon, Sussex, and Warren counties, among others (see Table 4, page 19). Not surprisingly, readmission rates in Hunterdon, Sussex, and Warren counties are the lowest in the State and well below the national average, while readmission rates from the poorest counties (e.g. Hudson, Essex, and Salem) are well above average.[28]

Table 6 demonstrates the association of poverty levels and readmission rates in several NJ counties.

Table 6 | Positive Correlation Between Poverty and Readmission Rate

County	Below Poverty Line	Readmission Rate
Hunterdon	3.6%	16.9%
Sussex	4.9%	17.0%
Warren	7.6%	18.0%
Salem	10.8%	22.7%
Essex	14.9%	22.9%
Hudson	15.1%	23.9%

PART FOUR
Winnable Battles

Chronic disease and the related modifiable risk factors such as physical inactivity, poor diet, tobacco use, and obesity are clearly contributing causes of death and disability in New Jersey. Winnable Battles are public health priorities with large-scale impact on health and with known, effective strategies to address them. Winning these battles through use of evidence-based strategies and a focus on "health in all policies" is at the core of the Plan priorities.

New Jersey has identified the following priorities of winnable battles for chronic disease prevention and health promotion:

- Increase physical activity;
- Improve nutrition;
- Eliminate tobacco use;
- Improve environmental health;
- Enable self management;
- Increase early detection; and
- Improve access to quality health care.

The planning process kept these modifiable risk factors front and center when identifying key disparate populations and when evaluating future use of evidence-based strategies.

PART FIVE
Selecting Populations and Strategies

Addressing Health Inequity

According to the World Health Organization (WHO), "health inequities are avoidable inequalities in health between groups of people…Social and economic conditions and their effects on people's lives determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it occurs."[30] Few of these factors exist in isolation. For example, a migrant worker is also likely to be an ethnic minority of low economic status. The intersectionality of the social determinants of health increases the likelihood of individuals losing the "winnable battles" through no fault of their own.

> *Disparities in health and healthcare are now viewed not only as an issue of justice, but also as one of quality. During the past 2 decades, one of Healthy People's overarching goals has focused on disparities. In Healthy People 2000, it was to reduce health disparities among Americans. In Healthy People 2010, it was to eliminate, not just reduce, health disparities. In Healthy People 2020, that goal was expanded even further: to achieve health equity, eliminate disparities, and improve the health of all groups.*[29]

Each of the planning workgroups answered the question, "What groups of people are most likely to lose the winnable battles?" The planning process intentionally started with this discussion in order to frame the selection of priority strategies for the future. It was important to keep in mind those groups for whom current policy, environmental, clinical and behavioral strategies have been inadequate in achieving positive health outcomes.

A listing of population groups, such as that below, is significant in the planning process in that it points to certain populations that need to be counted (e.g. prisoners), populations that need to have an extra effort made to find them (e.g. rural populations), or those for whom we need to have culturally appropriate materials developed (e.g. low health literacy). All residents deserve access to quality healthcare whether or not they fall into the various groups and categories that emerged from the discussions so

far, but access to quality healthcare comes with special challenges and burdens for these groups. Combining data about disease burden and community knowledge of those groups that experience a disparity in health outcomes, the planning workgroups produced the following list of high-risk populations.

- Children and youth
- Those living with a physical and/or mental health disability
- The uninsured, underinsured
- Low-income households
- Rural & urban residents
- Racial/ethnic communities[ii]
- Individuals with low literacy skills
- Seniors
- New/undocumented immigrants/migrant workers[iii]

> *"Prisoner's disease burden is often "invisible" in traditional health data. An April 2013 daily health survey at Monmouth County Corrections revealed 37% of inmates had some form of long-term medical concern requiring treatment (with high blood pressure, diabetes, asthma, and cancer high on the list) and 26% had mental health issues. Adapting strategies for different communities will ensure that the needs of high-risk communities are addressed."*[31]

Inadequate Data

The Domain One Epidemiology, Surveillance and Evaluation Workgroup identified populations whose disease burden and modifiable risk factors were most likely to be invisible in the data. Individuals with physical and/or mental health disabilities, children generally, prisoners, veterans, and the LGBT population were specifically identified as having data disparities. While there may be community knowledge about disparate health outcomes for these groups, there is a lack of specific data to track their health outcomes. Future data-improvement strategies should include adequate sampling targets and customized questions to identify potential health disparities for these groups.

[ii] The workgroups identified a variety of specific racial/ethnic groups that experience disparate health outcomes. The goal here was to call attention to the need to take into consideration the specific groups in that community when implementing any evidence-based strategy.

[iii] Note that federal and state funds can not be used to relieve the chronic disease burden on these people. Private grants must be acquired in order to address the health disparities for this population.

Responding to Health Inequity

As a result of this early and repeated focus on disparate populations, a number of specific strategies for addressing health inequities were highlighted across the domains:

Health Literacy

The issue of health literacy came up repeatedly. One size does not fit all, especially in New Jersey. Both health system and community providers will need to customize their messages for many different audiences. Multi-channel messaging—print, web-based, oral, and visual—is always more effective than single-channel messaging.

Health literacy is not simply the ability to read. It requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations. For example, it includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctors' directions, discharge instructions, consent forms, and the ability to negotiate complex healthcare systems. Urban residents who experience daily trauma and pervasive fear of crime will require health messaging that takes into account their circumstances. Senior citizens will require more than an appointment slip to remember the next appointment.

The NJCDPC will continue to work with the Office of Minority and Multicultural Health's Language Access Initiative. That Office has greatly expanded access to Spanish-language health education documents as well as a limited number of other documents in Hindi, Mandarin Chinese and Haitian Creole. The Office has also worked with the New Jersey Hospital Association to create and distribute a Communication Picture Board to help providers better communicate with patients who speak a language other than English.

In addition, NJCDCP will coordinate with all partners implementing this Plan to develop customized public messaging that creates an even playing field for all residents in making healthcare and wellness care decisions.

Continuity of Care

There was also much discussion about the need for self-management and patient

navigation strategies that are clear, culturally competent, and reflect the daily realities of high-risk populations. Adapting these strategies for different communities and pilot testing a variety of models will ensure that the needs of high-risk communities are addressed in the design and final array of strategy choices.

Risk reduction and prevention are key, and patient screenings were specifically referenced as a gateway for disparate populations to enter the system. Workgroups described screenings as a "teaching moment" that should be readily available to all populations in traditional and non-traditional settings, and treatment after screenings needs to be easily accessible. Community-based care that is directly and seamlessly linked to local, accessible and culturally competent prevention resources is therefore required.

State Plan Logic Model

Table 8 | New Jersey Chronic Disease Prevention & Health Promotion Plan, 2013 - 2018

Resources ⇨	Domains ⇨	Strategies ⇨	Goals
Federal & state laws Funding (federal/state/private) National, regional, state and local partners Epidemiology, surveillance, & evaluation support Health communication support Healthy NJ 2020 Targets	Environmental Strategies Health systems interventions Community-clinical linkages Epidemiology, Surveillance and Evaluation	Improved data access, application, communication and collaboration Promote health and support healthful behaviors statewide in schools, worksites, and communities Improved effective delivery, coordination and use of clinical services Ensure communities support and clinics refer patients to programs that improve health outcomes and prevent chronic disease onset where possible Ensure broad cross-sector coordination of efforts Increased common messaging across sectors	Reduced burden of all chronic diseases Improved management of chronic disease for those living with chronic disease Prevention of onset of chronic disease by decrease of modifiable risk factors

Overarching Strategies That Support Integration of Effort

Several overarching strategies appeared as priorities in multiple domains:

Communication

One of the factors that the various workgroups noted as being a significant barrier to integration is communication among providers of healthcare and prevention services, as well as communication between providers and consumers.

To establish and improve communication channels to stakeholders and the public at large:

- Develop statewide user-friendly websites focused on the health and wellness needs of NJ residents;
- Define and improve the way consumers can find healthcare providers and community-based wellness services, and the way providers can find up-to-date information on wellness care;
- Bring the technology infrastructure of state government, especially the Department of Health, in line with its role as a clearinghouse of information and facilitator of public-private partnerships;
- Develop a strategic communications plan featuring an integrated focus on wellness that ensures common messaging across all sectors and among all stakeholders. This communications plan must include an integrated social media strategy that has both the public and private sector as content providers and administrators;
- Increase communication links between the State and local health departments; and
- Develop personal stories and testimonials to convey a Wellness Lifestyle.

To improve health literacy for all groups with culturally competent products and services:

- Focus on the end user in developing health and wellness materials. Customize messages and communications strategies to reach the full range of high-risk disparate populations; and
- Support healthcare providers through training and incentives in using new techniques for providing culturally appropriate quality care.

Collaboration

There are and have been many examples of successful partnerships and collaborations in New Jersey. The future goal must be to share power, co-brand efforts, and share expertise to create efficiencies and maximize the most effective features of existing groups.

Building on past success while unifying efforts through the process of community engagement is much preferable than starting over building all new collaborations and alliances. Past success at collaboration that will inform future success includes the work of:

- NJ Breathes, in enacting, enhancing, expanding and monitoring smoke free legislation in New Jersey;
- The Governor's Task Force on Cancer Prevention, Early Detection, and Treatment in their use of "Choose Your Cover," an AHRQ Healthcare Innovation Exchange-recognized skin cancer screening and education program, as the catalyst for enacting stricter regulation of tanning beds;
- ShapingNJ partners in developing and implementing new regulations and policies for child care centers (i.e. nutrition and fitness standards) and maternity hospitals (e.g. supporting breastfeeding); and
- The Pediatric/Adult Asthma Coalition in supporting New Jersey's Asthma Friendly School Award program has reached more than 388,900 students and nearly 29,500 school faculty. To qualify for an award, a school has to fulfill six components, including signing a no-idling pledge for school buses, training school nurses, and having a nebulizer on site. The six components also help schools comply with New Jersey's laws for asthma management and indoor air quality. About 600 schools have received the award since 2006. In 2012, the New Jersey asthma program launched a similar program for child care centers, reaching more than 800 children and more than 200 child care staff.
- The partnership between New Jersey's Office of Tobacco Control (OTC) and Office of Cancer Control and Prevention (OCCP) resulted in four additional municipal smoke-free outdoor ordinances, impacting about 113,000 residents. The purpose of the collaboration between the OTC and OCCP was to develop strategies aimed at mobilizing the community to raise awareness around the impact of secondhand smoke, and to facilitate the adoption of smoke-free outdoor recreational ordinances through Integrated Municipal Advisory Councils (IMACs). Together, OTC and OCCP grantees launched a collaborated effort for the implementation of the OTC's Smoke-Free Policy Toolkit. The toolkit provides step-by-step guidance for the drafting and development of smoke-free municipal outdoor ordinances, including answers to questions frequently asked by town councils, sample letters and press releases, and strategies to develop and sustain an IMAC.
- A cross-sector collaboration cosponsored by Region II Center for Medicare and Medicaid, ShapingNJ and New Jersey's Office of Nutrition and Fitness at the Department of Health was titled "Bringing the Affordable Care Act Home." The all-day meeting held at Rutgers University was attended by over two-hundred people from a wide range of sectors. The goal was to learn and network with other organizations/collaborations working to implement health reform in the state. To that end, breakout groups were organized to highlight challenges and opportunities in the three regions of the state. Experts spoke to a range of topics from electronic records, to reaching the uninsured, to care-coordination success stories.[32]
- The NJ Department of Children & Families, Office of Licensing and the ShapingNJ Child Care Workgroup collaboration in the development and implementation of

revised child care regulations pertaining to nutrition, physical activity, TV/screen time and breastfeeding support.

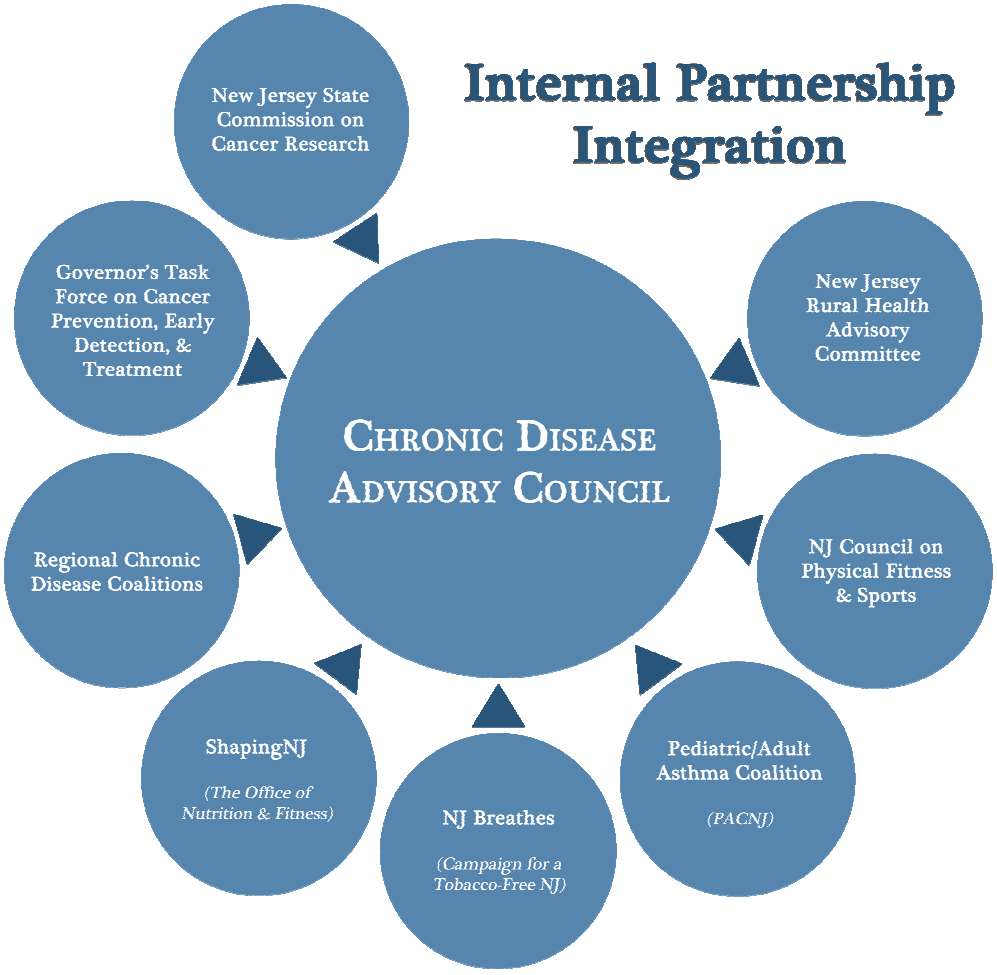
- Just in time for the 2013 baseball season, Horizon BCBSNJ and ShapingNJ opened a new Healthy Plate Concession Stand at Campbell Field, where fans at every game will be able to find nutritious alternatives to the traditional ball park fare. Campbell Field is one of three New Jersey minor league baseball parks where fans can find the Horizon Healthy Plate Concession Stand this season. Stands are also up and running at Arm & Hammer Park (Trenton Thunder) and FirstEnergy Park (Lakewood BlueClaws).

Future collaboration is critical to develop a set of seamless, comprehensive health models that are right for New Jersey, through:

- Developing State, regional and local partnerships to integrate the resources of the government, private and nonprofit sectors into a seamless system of care that is easily accessible, culturally appropriate and sending a common message about wellness;
- Distinguishing among the FQHC/Community Health Center/Patient Center Medical Home models and build on the strengths of each so that high-risk residents can access a full range of health and prevention services in their own community and from a variety of public and private payers;
- Developing and promoting multiple Patient Navigation models in order to bridge and forge necessary linkages to address both clinical needs and community support for sustaining optimal health and wellness;
- Enhancing the collaborative use of allied health professionals and paraprofessionals in a team-based approach to care; and
- Supporting the use of electronic health records and data collaborations to improve practice performance outcomes and support a seamless system of wellness care.
- Enhancing the engagement of large and small business and industry in growing worksite wellness efforts that lead to better health outcomes and healthcare cost savings.

Another clear example of the need for better collaboration is the need to integrate the activities of several existing coalitions that are internal to state government. The current disease- and risk factor-specific coalitions and planning efforts must be better integrated with the Chronic Disease Advisory Council (CDAC), and future disease- and risk factor-specific plans must be vetted against the integrated priorities in this Plan. See Appendix II for a full list of existing coalitions.

Figure 6 | Internal Partnership Integration



The creation of this Plan includes the understanding that any future chronic disease-specific and risk factor-specific plans will align with the priority strategies, health messaging and high-risk populations included here. While there may be customization for unique circumstances, a core requirement and future mission standard is the focus on prevention, and comprehensive, accessible, seamless health and wellness services across the lifespan. As well, there must be a focus on living well and optimal health, rather than only medical treatment.

Develop a strong network of partners for implementation of stakeholders' policy priorities

Changing policy, whether at the State or institutional level, is a long-term process that requires joint action by a variety of stakeholders. Creating better technology and other mechanisms for communication with partners can ensure that interested parties can find, analyze and support plan identified policy solutions faster and more effectively. As noted above, past policy success in tobacco control, obesity prevention, asthma self-management, and cancer prevention have benefited from strong historical collaborations. A future focus on Health in All Policies (HIAP) to support chronic disease prevention and health promotion as a central consideration in food, environmental, building and land use, transportation, safety and other policy discussions will also benefit from the support of current and future partners.

Goals & Strategies by Domain

Domain One: Epidemiology, Surveillance and Evaluation

Domain One priorities were defined: "Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health."

Stakeholder-Identified Strategies

Improve Access

- Provide an inventory of reliable data sources;
- Make translated data available in a user-friendly format for the spectrum of data users; and
- Make standardized data available at the county level through county profiles or other formats.

Improve Application

- Provide technical assistance in the presentation or application of data;
- Acknowledge the continuum of data users and desired data use;
- Identify advanced data strategies and implement them; and
- Ensure the publications are culturally competent and linguistically appropriate.

Improve Communication

- Provide key messages that are targeted for specific audiences;
- Develop, implement, and evaluate communication and health marketing strategies;
- Consider length and depth of materials to meet data-user needs;
- Include a one-page summary of key facts and recommendations for action in large reports; and
- Utilize health communication experts to develop proactive communication strategies.

Improve Collaboration

- Collaborate with partners who are already making data more available;
- Collaborate with partners who can take on data analysis and presentation;
- Improve collaboration between Department of Health and other state agencies;

- Engage a wide range of data users on a continuous basis to ensure that data-user needs are met;
- Align strategic initiatives to complement the role of public health in the implementation of the Patient Protection and Affordable Care Act and the Healthcare and Education Reconciliation Act;
- Identify missing partners;
- Improve partnership between the Department of Health and School of Public Health;
- Consider School of Public Health fieldwork requirements as a resource; and
- Integrate the work of evaluation within and outside state government.

Continuum of Data Users

The Domain One Work Group identified a continuum of chronic disease data-users in New Jersey, including individual constituents for change, service providers in health systems, and population-based advocates for change.

The activities of each data user group must be considered in order to effectively gather, analyze, and disseminate chronic disease data and information. Therefore, the Domain One Work Group outlined the data each user group is currently using, how the data should be used, and some other related activities that can help to reduce the chronic disease burden in New Jersey. For example, individuals may look for data on diseases for personal decision making and increased knowledge while funders may look for data to support grant developing and evaluation.

Table 9 (a) | Data Usage

Individual constituents for change, including the general public, media, legislators, government officials, school administrators, students, and constituents for the public	
Current data usage	**Future usage of data**
• Review general information when diagnosed (e.g. American Heart Association one-page sheet with statistics) • Review information on clusters of diseases for personal decisions • Grassroots advocacy agenda-building • Assess environmental hazards	• Gather credible information • Make healthy choices based on data • Gather clinical, rather than statistical, information • More grassroots use (e.g. vaccines) • Use data to develop agendas

Table 9 (b) | Data Usage

Service providers in health systems, including clinicians, payers, hospital administrators, service providers, and hospital-based surveillance staff	
Current data usage	Future usage of data
• Planning • Cost-based analysis • Best practices • Quality improvement indicators • Surveillance at hospital level • Hospital needs assessment	• Best practices • Quality improvement • Surveillance • Community efforts • Program planning • Looking at community or catchment-level data (community level indicators) • Connecting systems and data sharing • Grant writing • Inform community-clinical linkages • Reimbursement for community-clinical linkages • Medical home assessments

Table 9 (c) | Data Usage

Population-based advocates for change, including funders, researchers (students, academics, professionals), , federal agencies, local public health professionals, state government staff (non-appointed)

Current data usage	Future usage of data
• Program planning and monitoring • Advocacy • Policy • Grant writing and funding • Research studies • Evaluating performance • Contributing to evidence base	• Creating best practices • Cost-effectiveness • Return on Investment • Creating population-based change • Creating environmental strategies • Local-level assessments and developing a transparent process for obtaining data • Accessibility of data for research • Prioritizing advanced technology and making it available • Building a strong partnership between the NJDOH and School of Public Health • NJMS and Newark City Health Department as a model

Domain Two: Environmental Strategies

Domain Two Working Group defined priorities as: "Promote health and support and reinforce healthful behaviors statewide in schools, worksite, and communities." Environment approaches were identified as those actions through which we would "implement policies and environmental strategies to eliminate tobacco use, promote life-long respiratory health, increase routine physical activity, and increase consumption of healthy foods and beverages at the point where such decisions are made." Strategies should align with federal and state laws and guidelines.

Stakeholder-Identified Strategies

AT THE STATE LEVEL

- Support tobacco control, cessation, and implementation of statewide comprehensive tobacco-free policies for all schools, communities, parks and multi-unit housing through such mechanism as regulation and licensing of all tobacco products including flavored products, e-cigarettes, and hookahs;
- Promote Baby Friendly Certification for all maternity hospitals;
- Make maximum use of federal, state and regional funds for active, accessible transportation (especially walking and biking) and open/recreational space; put active transportation policies in writing; and
- Promote radon testing and mitigation to include schools.

AT THE REGIONAL, COUNTY, AND MUNICIPAL LEVELS

- Promote enforcement of and compliance with the 2006 NJ Smoke Free Air Act and the accompanying 2007 NJDOH regulations, as well as all other state, county, and local laws, such as smoke-free parks;
- Encourage safe and routine physical activity per the 2008 Physical Activity Guidelines for Americans through state, regional (i.e. metropolitan planning organizations), county, and municipal written policies and practice;
- Promote shared use of public recreation space, especially school playgrounds, through Joint Use Agreements between municipalities and school districts;
- Provide safety from crime and traffic hazards in all neighborhoods and public spaces through application of such concepts as Crime Prevention Through Environmental Design (CPTED);
- Increase affordable options for underserved communities and neighborhoods to buy or obtain fresh fruits and vegetables and other healthy foods and beverages;
- Develop policies to support local food production and distribution in low-income urban neighborhoods, including joint-use agreements to open up commercial-grade kitchens for community use;

- Develop tools to assist municipalities implement land-use planning and zoning policies that will support local food production and distribution; and
- Use food service guidelines that align with the 2010 Healthy Hunger-Free Kids Act and the 2010 Dietary Guidelines for American to create healthier food environments in public venues.

AT THE SCHOOL DISTRICT LEVEL

- Enforce comprehensive strategies to promote respiratory health and reduce environmental exposure in schools, including comprehensive smoke-free school policies;
- Provide abundant opportunities for physical activity for children (from pre-k through 12th grade) before, during and after the school day to instill life-long physically active lifestyles; and
- Use food service guidelines to create healthier food environments in schools that align with the 2010 Healthy Hunger-Free Kids Act.

Domain Three: Health Systems Interventions

Domain Three Working Group priorities were defined: "Improve the effective delivery and use of clinical and other preventive services to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications."

Stakeholder-Identified Strategies

PROMOTE AND SUPPORT IMPLEMENTATION AND EXPANSION OF ELECTRONIC HEALTH RECORDS (EHR) AND HEALTH INFORMATION EXCHANGES/ORGANIZATIONS (HIE/HIO)

- Promote the full implementation and use of EHRs among healthcare providers;
- Explore opportunities to enhance EHR systems to help promote chronic disease prevention and control;
- Explore mechanisms for healthcare reimbursement to help promote chronic disease prevention and control;
- Develop business support for EHRs and (HIOs);
- Promote healthcare providers participation in HIOs;
- Support EHR and HIO mechanisms that provide patients electronic access and ability to track their healthcare; and
- Ensure that EHR and HIO systems track, monitor and share standard clinical health indicator data.

DEVELOP AND PROMOTE PATIENT NAVIGATION AND CARE COORDINATION SYSTEMS ACROSS THE LIFESPAN

- Expand centralized training to provide basic core knowledge among navigators and coordinators;
- Evaluate the effectiveness and return on investment of different types of patient navigation and care coordination models; and
- Encourage linkages between healthcare system and insurance company models as well as community models for patient navigation and care coordination.

PROVIDE TRAINING AND INCENTIVES TO HEALTHCARE PROVIDERS, ENSURING THE DELIVERY AND ACCESSIBILITY OF QUALITY WELLNESS-FOCUSED CARE

- Provide, support and incentivize healthcare provider training to deliver culturally appropriate wellness care, including addressing health literacy and general literacy concerns;
- Develop accountability standards, incentives and mechanisms for tracking quality, accessible wellness-focused care (i.e. report cards); and
- Promote the reporting of standard healthcare indicators by all private and public healthcare systems and funders.

DEVELOP AND STREAMLINE A COMMUNITY HEALTH CENTER (CHC) MODEL, NOT UNLIKE FEDERALLY QUALIFIED HEALTH CENTERS (FQHC), FOR IMPLEMENTATION AMONG PRIVATE, NON-PROFIT AND/OR FEDERALLY-FUNDED ENTITIES TO PROVIDE COMPREHENSIVE HEALTH AND WELLNESS SERVICES ACROSS THE LIFESPAN.

- Link the efforts of Accountable Care Organizations to CHC models;
- Identify and disseminate models of effective collaboration between medical, public health and community practitioners to improve coordination of services; and
- Evaluate, encourage and expand the use of multi-disciplinary team-based approaches to care that include medical professionals, allied health professionals, and paraprofessionals.

COORDINATE PARTNERSHIPS AMONG STAKEHOLDERS TO EXPAND OR ENHANCE THE DELIVERY OF SERVICES FOR ALL LEVELS OF CHRONIC DISEASE PREVENTION

- Reassess, evaluate and build upon the existing infrastructure of partnerships and collaborations to ensure optimal integration of efforts and efficiency in support of CHC models; and
- Build on partnership success to date while linking efforts into a cohesive whole.

Domain Four: Community-Clinical Linkages

Domain Four Working Group priorities were defined: "Ensure that communities support and clinics refer patients to programs that improve management of chronic conditions."

Stakeholder-Identified Strategies

IMPROVE AND ENHANCE EXISTING SERVICES AND PROGRAMS RELATED TO COLLABORATION

- Enhance availability of family-focused services in the community where people live, work, pray and play;
- Strengthen collaboration and linkages between local healthcare provider, hospital, home, and school communities so there is seamless, mutually-reinforcing and integrated care for individuals. Individuals should move seamlessly between community and clinical systems, hearing common messages that support routine self-management and/or prevention activities;
- Increase use of allied professionals, especially certified school nurses, as a bridge between a family and their medical home; and
- Increase healthcare provider training and education in best practice standards and protocol for dealing with patients who have mental health issues.

IMPROVE AND ENHANCE EXISTING SERVICES AND PROGRAMS RELATED TO COMMUNICATION

- Redesign State website so that the information is consumer-focused, consumer-friendly, current and relevant;
- Improve the way consumers can find and access a healthcare provider or wellness service in their community;
- Increase use of tele-health and telemedicine systems;
- Enhance physicians' use of technology to access and assess patients through trained on-site paraprofessionals, especially in rural areas; and
- Increase communication linkages between state and local health departments.

PILOT NEW LINKAGES RELATED TO COLLABORATION

- Engage insurance providers and other payers in planning and implementation phases of electronic communication system in order to increase effective collaboration;
- Develop a centralized clearinghouse and uniform registry of services that is easily accessible;
- Develop a uniform, user-friendly directory (State Model) of integration of chronic disease programs and county-wide services;
- Develop training of Community Health Workers, incentive and funding in order to create a better network of CHW;

- Develop a standard screening tool for lay professionals to use at community outreach events as a means of sharing health related data; and
- Ensure that a mechanism is in place for referral and follow-up between provider and patient.

PILOT NEW LINKAGES RELATED TO COMMUNICATION

- Develop webinars, webcasts, and other forms of individual and community health education;
- Use data to impact policy and influence decision makers;
- Develop a shared electronic platform that is based on best practice and ensures uniform accessibility by all partners; and
- Develop a communication plan that includes use of social media to increase awareness of programs and services for the community and professionals.

Plan Strategy Summary

Table 10 | Strategies That Surfaced Across Multiple Domains

Domain One: Epidemiology, Surveillance & Evaluation	Domain Two: Environmental Strategies	Domain Three: Health Systems	Domain Four: Community-Clinical Linkages
Improve Communications Includes need for common messaging across all sectors on the shift to a wellness focus. Heavily focused on improving state web resources, state IT infrastructure to support partner engagement and capability to use cutting-edge social media.			
Improve Collaboration (Community engagement) There was consensus that there are sufficient health and wellness resources and innovations in NJ, but both professionals and the public are unaware of what is available and how it connects to other parts of the wellness system. Significant concern about finding efficiencies among all the different coalitions and collaborations. Also includes unified advocacy support for Health in All Policies (HIAP)/Health Impact Assessments.			
Improve Health Literacy Efforts Focus on the end user in developing health/wellness materials. Customize messages and communications strategies to reach the full range of high risk disparate populations – one size does not fit all. Support healthcare providers in using new techniques for providing culturally appropriate quality care.			
Support Implementation of Electronic Health Records Support the use of electronic health records and data collaborations to improve practice performance outcomes and support a seamless system of wellness care.			
	Pilot Test Variety of Community-Based Care Models Identify, pilot, and disseminate models of seamless collaboration between medical, public health and community practitioners to improve coordination of health and wellness services. Ensure services are easily accessible, culturally appropriate and located where people live, work, play, and pray.		
		Pilot Test Variety of Patient Navigator and Community Health Worker Models Develop core standards for care and consistent training standards. Pilot test hospital, insurance company, and community models to determine which is best for which populations.	

Table 11 | Domain–Specific Strategies: Summary

Domain One: Epidemiology, Surveillance & Evaluation	Domain Two: Environmental Strategies	Domain Three: Health Systems	Domain Four: Community-Clinical Linkages
Collect appropriate data to monitor risk factors and chronic conditions of interest through public and private surveillance systems Collect appropriate and consistent data to evaluate existing strategies and pilot projects (shared measurement) Develop and disseminate data reports in easy-to-use and understandable formats Provide data to drive state and local public health action and decision making	Promoting existing Smoke Free and Clean Air Acts & radon testing Leverage investments in tobacco control efforts Institute community wellness policies in worksite, school, childcare, and government, across all risk factors (tobacco, physical activity, healthy food, self-management and clean air) Increase local adoption of Complete Streets policies Increase Joint Use policies (i.e. community use of schools) Implement Crime Prevention Through Environmental Design (CPTED) in communities Increase local access to healthy foods – farm markets, gardens, healthy corner stores Increase Baby Friendly hospitals Implement Healthy Homes Assessments & Remediation	Develop accountability standards, incentives and mechanisms for tracking quality, accessible wellness-focused care (i.e. report cards) Promote the reporting of standard healthcare indicators by all private and public healthcare systems and funders	Increase team-based care, use of allied health professionals Enhance screening tools & follow up Support and integrate self-management and lifestyle changes seamlessly across sectors Increase use of tele-health & telemedicine systems Enhance physicians' use of technology to access/assess patients through trained on-site paraprofessionals especially in rural areas.

PART SIX
Resources for Implementation of State Plan

Building on Success

The work of chronic disease prevention and health promotion is not happening in a vacuum. There are a number of state, federal, and private initiatives that directly impact this work and bring both expertise and funding to the implementation of this plan. Below is a list of existing efforts and organization that must be at the core of any future partnership for a healthy New Jersey. The list contained here is not exhaustive but represents the core resources (expertise and funding) available to support plan implementation in New Jersey.

Centers for Medicare & Medicaid Services (CMS): CMS has funded and is providing technical assistance for several critical pilot projects under its Innovation Center. Please see Appendix IV for a full listing of NJ CMS projects.

- *Comprehensive Primary Care Initiative*: 70 practices, 272 providers, and five payers are currently working together to test models for improved care coordination.
- *FQHC Advanced Primary Care Practice Demonstration*: Seven federally-qualified health center sites in NJ are implementing and testing the medical home model for care coordination.
- *Bundled Payments for Care Improvements (BCPI)*: 33 sites in NJ are pilot testing new payment models that may lead to higher quality, more coordinated care at a lower cost to Medicare.
- *Community-Based Care Transitions Program (CTCP)*: One funded pilot for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
- *State-Level Healthcare Innovation Awards*: Six awards to organizations located in or serving New Jersey for testing new payment and service delivery models that will deliver better care and lower costs for Medicare, Medicaid, and/or CHIP enrollees.
- *Electronic Health Records Incentive Program*: Will provide EHR incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade, or demonstrate Meaningful Use of certified Electronic Health Record (EHR) technology.

New Jersey Health Information Technology Extension Center (NJHITEC): NJHITEC is working with NJ physicians on the selection, implementation, and achievement of Meaningful Use of an accredited Electronic Health Record (EHR) system. This work is partially funded by the Office of the National Coordinator (ONC), U.S. Department of Health and Human Services (HHS)

through a grant awarded to the New Jersey Institute of Technology (NJIT). Through this grant, NJ-HITEC is responsible for assisting five thousand Primary Care Providers (PCPs) attain Meaningful Use of an EHR system.

Robert Wood Johnson Foundation: There are several current initiatives that are supported by the Foundation that will have a direct impact on plan success. These include but are not limited to:

- *The New Jersey Partnership for Healthy Kids*: The goal of the program is to convene, connect, and empower community partnerships across the state to implement environment and policy changing strategies that prevent childhood obesity. Community coalitions in Camden, New Brunswick, Newark Trenton, and Vineland are leading these efforts.
- *Aligning Forces for Quality* (AF4Q): The Robert Wood Johnson Foundation's goal is to lift the overall quality of healthcare in targeted communities, reduce racial and ethnic disparities and provide models for national reform. While none of the targeted communities are in New Jersey, the lessons learned from this work and other healthcare reform and public health studies sponsored by the Foundation will strongly inform efforts in New Jersey.

Coalition for a Healthy NJ: The Coalition for a Healthy NJ works to create healthier communities across New Jersey by building capacity among professionals and community members in a thirteen-county target area. This capacity-building grant serves communities in Atlantic, Burlington, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Morris, Passaic, Salem, Somerset, Sussex, and Warren.

The project is funded through a grant from the Centers for Disease Control and Prevention (CDC) and is part of the U.S. Department of Health and Human Services' (HHS's) Community Transformation Grants to support public health efforts to reduce chronic diseases, the leading causes of death and disability. The CTG program's goal is to create healthier communities by making healthier living easier and more affordable where people work, live, learn and play.

New Jersey Healthcare Quality Institute (NJCHQI): Their mission is to promote projects and system changes that ensure quality, safety, and cost-containment for patients and consumers. NJCHQI is currently oversees and provides technical support for:

- *The Leapfrog Patient Safety Initiative*, which promotes a marketplace in which consumers can easily discern hospital and physician quality and value, and creates a healthcare system in which superior providers are rewarded;
- *Affiliated Accountable Care Organizations (AACO),* which serves as a resource for current regional healthcare coalitions that are seeking to become operational Accountable Care Organizations (ACOs), facilitates the growth of new regional

healthcare coalitions, and links current and emerging healthcare coalitions to share best practices;

- *NJ Mayor's Wellness Campaign* to develop active living initiatives in local communities;
- *The Workplace Wellness Campaign,* in partnership with the New Jersey State Chamber of Commerce and the New Jersey Business and Industry Association; and
- *How's Your Health, NJ?,* a program to help residents improve their health by fostering better communication with their medical providers and by providing customized preventative care and self-management information to consumers. This project is supported by the State Chamber of Commerce and the State of New Jersey.

Other Private Funding and Resource Partners

There are several other foundations that currently support work specific to this plan including the Bristol Myers Squibb Foundation (asthma self-management), Campbell Soup Foundation (nutrition and healthy communities) and Nemours Foundation (child care nutrition standards).

Private healthcare payers are investing in new continuum of care models that can significantly impact a number of strategies highlighted in the plan. Horizon Blue Cross Blue Shield recently announced that fewer hospital admissions and trips to the ED, and better and less costly diabetes care, are among the 2012 results of the patient-centered medical home program of Horizon Blue Cross Blue Shield of New Jersey. Horizon said it plans increase enrollment in medical homes, which seek to coordinate medical care in order to improve quality while lowering costs.[33]

Private organizations such as the Healthcare Institute of New Jersey (representing the research-based biopharmaceutical and medical technology industry in New Jersey), the NJ Business and Industry Association, the New Jersey Hospital Association, and the Medical Society of New Jersey all have access to important data and expertise that can support plan implementation and evaluation.

Federal Funding for Chronic Disease Prevention and Control

The President's FY14 budget request includes "a new, competitive cooperative agreement program that refocuses activities from disease-specific programs into a more comprehensive approach. Because many chronic disease conditions share common risk factors, the new program will improve health outcomes by coordinating the interventions that can reduce the

overall burden of chronic disease. CDC will award grants to health departments to implement evidence-based strategies and will address the leading causes of death and health disparities. In addition, CDC will award grants to academic health centers to develop, test, and evaluate effective interventions to reduce chronic conditions; and to national organizations to provide technical assistance, training, and support to health departments. CDC will provide performance awards for states that significantly improve health outcomes."[34]

The President's proposed budget "eliminates duplicative community grant programs and the Preventive Health and Health Services Block Grant. CDC will address the goals of these activities through the new comprehensive grants program and new Community Transformation Grants funded through the Prevention Fund...[and consolidate] the Asthma, Childhood Lead Poisoning Program, and Healthy Homes programs into one comprehensive program."[34]

State Funding for Chronic Disease Prevention and Control

Like many states, much of the funding for public health and chronic disease prevention originates at the federal level and is passed through to numerous state departments. Investments of direct state aid for chronic disease prevention are in the NJDOH FY2014 budget for specific diseases and modifiable risk factors, including funding for cancer research, cancer screening, breast cancer awareness, obesity prevention pilot grants, diabetes self-management, and worksite wellness programs for small businesses. The fiscal year 2014 budget provides $20 million in new funding specifically for cancer research and treatment and to support the state's Cancer Programs.

There are also related resources to support plan strategy implementation through the Departments of Transportation, Banking & Insurance, Human Services (Divisions of Aging and Medical Assistance & Health Services) and Agriculture. New Jersey already has one of the most expansive and generous Medicaid programs in the nation, including the second-highest eligibility rate for children. Expanding Medicaid will mean that more New Jerseyans at or near the poverty line will have access to critical health services, while saving New Jersey taxpayers approximately $227 million in fiscal year 2014. Nursing homes will see their Medicaid reimbursement increase by $10.3 million in State funding ($20.6 million with matching federal funds), providing them with additional resources as New Jersey begins its transition to managed long-term services.

PART SEVEN
Evaluation

Core Indicators of Success

The evaluation standards directly reflect Healthy New Jersey 2020 objectives[35] for the related burden of chronic disease and modifiable risk factors. These targets will become the preliminary long-term goals for the plan. During the development of HNJ2020 , numerous data gap areas were identified. Collaboration between state and local public health officials, academia, and private health organizations will be required to close the data gaps and better inform health improvement activities statewide. An inventory of all data gaps is currently being drafted by the NJDOH Healthy New Jersey Coordinating Committee.

Table 12 | Objective: Reduce the Chronic Disease Burden in NJ

HNJ 2020 Indicator	Baseline (Year)	2020 Target
Asthma		
Reduce the death rate due to asthma (ages 35-64)	1.3 per 100K (2007)	0.8 per 100K
Reduce hospitalization rate due to asthma (ages 5-65)	140 per 100K (2009)	112 per 100K
Reduce the rate of Emergency Room visits due to asthma (ages 5-65)	626 per 100K (2009)	501 per 100K
Cancer		
Reduce the death rate due to all cancers	179.4 per 100K (2007)	161.5 per 100K
Reduce the incidence rate of invasive colorectal cancer	44.7 per 100K (2009)	39.7 per 100K
Reduce the incidence rate of invasive uterine cervical cancer	8.5 per 100K (2009)	7.2 per 100K

Table 12 (Contd) | Objective: Reduce the Chronic Disease Burden in NJ

HNJ 2020 Indicator	Baseline (Year)	2020 Target
Reduce the incidence rate of late-stage female breast cancer	46.9 per 100K (2009)	43.7 per 100K
Diabetes		
Reduce the death rate due to diabetes	24.4 per 100K (2007)	15.8 per 100K
Reduce the rate of lower extremity amputations in persons with diagnosed diabetes	31.8 per 1000 diagnosed with diabetes (2007)	28.6 per 1000 diagnosed with diabetes
Reduce the death rate due to coronary heart disease	140.1 per 100K (2007)	112.1 per 100K
Reduce the death rate due to stroke	35.8 per 100K (2007)	28.6 per 100K

Table 13 | Objective: Win the Winnable Battles—Reduce Modifiable Risk Factors

HNJ 2020 Indicator	Baseline (Year)	2020 Target
Environmental Health		
Reduce the number of unhealthy days throughout the state, as determined by the Air Quality Index	5 days (2010)	0 days
Increase the percentage of homes in New Jersey that have ever been tested for radon	25.3% (2010)	35%
Nutrition and Fitness		
Prevent an increase in the proportion of the population that is obese:		
• Adults	23.8% (2011)	23.8%
• High School Students (grades 9-12)	10.3% (2009)	10.3%
Increase the proportion of the population consuming at least five servings of fruits & vegetables daily:		
• Adults	26.1% (2011)	28.7%
• High School Students (grades 9-12)	20.1% (2009)	22.1%

Table 13 (Contd) | Objective: Win the Winnable Battles—Reduce Modifiable Risk Factors

HNJ 2020 Indicator	Baseline (Year)	2020 Target
Increase the proportion of NJ Adults who meet current Federal physical activity guidelines for moderate or vigorous physical activity	53.2% (2011)	58.5%
Increase the proportion of NJ high school students that meet current physical activity guidelines for aerobic physical activity	21.3% (2009)	23.4%
Increase the proportion of High School students who watch TV for no more than two hours a day	67.4% (2009)	74.1%
Increase the proportion of High School students who use the computer for no more than two hours a day	71.1% (2009)	78.2%
Reduce the proportion of high school students (grade 9-12) who drank soda one or more times per day in the past 7 days	19.9% (2009)	13.9%
Increase the proportion of infants who are breastfed:		
• Ever	72.1% (2007)	85%
• At 6 months	42.3% (2007)	60%
• Exclusively for 3 months	29.8% (2007)	45%
Increase the percentage of NJ delivery facilities that provide maternal and newborn care consistent with the WHO/UNICEF Ten Steps to Successful Breastfeeding	None (2007)	50%
Tobacco Use		
Reduce the proportion of the population who are current smokers:		
• Adults	17.7% (2011)	13.6%
• High School	14.3% (2010)	12.8%
• Middle School	4.4% (2010)	3.9%

Table 13 (Contd) | Objective: Win the Winnable Battles—Reduce Modifiable Risk Factors

HNJ 2020 Indicator	Baseline (Year)	2020 Target
Reduce current tobacco use (cigarettes, cigars, smokeless tobacco) by high school students	23.3% (2008)	20%
Reduce the proportion of high school student nonsmokers exposed to secondhand smoke	48.1% (2010)	43.3%
Enable Self-Management		
Reduce the proportion of persons with asthma who miss school or work days	Not Available (2013)	TBD
Increase the proportion of persons with asthma who have ever received an asthma action plan or asthma management plan from a health professional	Not Available (2013)	TBD
Increase the proportion of persons with asthma who have ever been advised by a health professional to change things in the home, school, or work to improve their asthma	Not Available (2013)	TBD
Increase the proportion of adults with diabetes who have an annual dilated eye examination	65.6% (2009 – 2011)	72.2%
Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement (A1C) at least twice a year	59.4% (2009 – 2011)	64%
Increase Early Detection		
Increase the proportion of oral and pharyngeal cancers detected at the earliest stage (in situ/local disease)	31.5 per 100K (2009)	36.9 per 100K

Table 13 (Contd) | Objective: Win the Winnable Battles—Reduce Modifiable Risk Factors

HNJ 2020 Indicator	Baseline (Year)	2020 Target
Increase the proportion of cancer survivors who are living five years or longer after diagnosis	66.6 per 100K (2010)	74.6 per 100K
Increase the proportion of women who receive a cervical cancer screening and a breast cancer screening based on the most recent guidelines	Not Available (2012)	TBD
Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines	Not Available (2012)	TBD
Increase the proportion of men (males aged 40 and over) whose doctor, nurse or other health professional has ever talked to them about the advantages and disadvantages of the prostate-specific antigen (PSA) test to screen for prostate cancer	Not Available (2012)	TBD
Increase the proportion of adults who have had their blood cholesterol checked with the preceding five years	78.8 per 100K (2011)	86.7 per 100K
Increase Access to Care		
Increase the proportion of persons with health insurance		
• Under 65	82.6% (2010)	93.3%
• Under 19	90.5% (2010)	95%
Increase the proportion of adults aged 18 and older with a personal doctor or healthcare provider	83.5% (2011)	90%

Over the course of the next year, the Epidemiology, Surveillance and Evaluation Workgroup will create final domain-specific logic models and an evaluation plan to track implementation and impact. It will also identify other missing core health indicators at both the state and local level, which reflect the shift to a focus on wellness. Reducing the burden of diseases and reducing risk factors must be combined with increasing protective factors: "winning the winnable battles." Some Healthy New Jersey 2020 objectives do not currently have baseline data but will become available in the period covered by HNJ 2020.

> *In 2013, NJ-AEEP received the NACP Evaluation Award for its State Asthma Partnership Assessment. This assessment was initiated by the AAEP Evaluation Team comprised of members from NJDOH, PACNJ, and Rutgers University. Its mission is to address and plan evaluation strategies for the Asthma Program.*

Plan Evaluation Processes

Plan evaluation is a core backbone function for the NJCDPC Unit even though plan evaluation activities will require the expertise and effort of a wide variety of public and private partners and a shared data system. Unlike grant evaluation, plan evaluation depends on the voluntary participation of stakeholders and must be designed in a manner that meets the needs of many different stakeholders.

The Epidemiology, Surveillance and Evaluation Workgroup will continue to meet and will design an integrated evaluation process that captures:

- Key process and short-term outcome data for each listed strategy that documents adaptations made for reaching and engaging disparate populations, lessons learned from pilot implementation, and core levels of service (i.e. the number of complete street policies adopted, the number of CHWs trained, and the number of private practices achieving meaningful use of EHR systems);
- Core health indicators that measure interim progress in improving health outcomes (i.e. blood pressure, A1C, BMI , increase in physical activity);
- Long-term progress on reducing disease burden overall and health disparities for targeted groups; and
- Indicators of collaboration on plan implementation, and evaluation functions, including the development of integrated evaluation tools for use with all internal and external partnerships.

We will build on the evaluation tools used by Pediatric/Adult Asthma Coalition of New Jersey (PACNJ) & ShapingNJ to develop an integrated partnership assessment tool for the

future. The Workgroup will create a plan that involves a broad range of partners in routinely capturing and sharing additional core indicators of success:

- Government, community, worksite, school, and faith community environments that have policies and practices to promote and reinforce healthful behaviors and practices across the life span;
- Meaningful use of EHR systems in public and private settings;
- Hospital readmissions across all disease categories;
- Health literacy: the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions;
- Easy and seamless access to care in local communities and services available where they live, work, pray, and play;
- Policy implementation that extends current policies into new settings;
- Data on existing HNJ 2020 targets where current data is not yet available; and
- All health indicators for high-risk disparate populations identified in the plan.

> *ShapingNJ is the obesity prevention public-private partnership that was designed to make the healthy choice the easy choice in New Jersey. This partnership was evaluated each of the last three years using the Wilder Collaboration Inventory and findings were used to develop quality improvement plans each year.*

The goal of evaluation efforts is to inform continuous quality improvement over the term of the plan. As such, it will be important to implement a strong and timely feedback loop between partners and a venue for discussion and establishment of corrective action plans as needed. It is expected that plan progress will be reported annually at an overall partnership meeting, bringing together all the individuals and organizations that developed this plan and will participate in implementation.

PART EIGHT
Messaging/Communication Plan

Health promotion requires individual and population-based strategies that address health disparities in culturally relevant and culturally sensitive ways. Health promotion also requires common messaging to support community systems, norms, and values around health and wellness.

At our final full stakeholder planning meeting in July 2013, it was clear that a common style guide will need to be developed to support consistent messaging among all stakeholders. There are still several concepts relevant to the paradigm shift where the language used varies by field and would benefit from more discussion and clarification. Some of these concepts include:

- Living well with chronic disease (optimal health with both self and clinical management);
- Making the healthy choice the easy choice (population based primary prevention efforts);
- Expanding the continuum of the care paradigm to include both clinical care in traditional health systems and preventive/wellness care in the community;
- Winnable battles;
- Health inequity and health disparities; and
- Terminology for new innovations in care models: patient-centered medical homes, accountable care, and comprehensive community health systems.

A major overarching task for Year One is the development of a Strategic Communications Plan featuring an integrated focus on wellness that ensures this common messaging across all sectors and among all stakeholders.

As noted in the beginning section of this Plan and from all the workgroups, any communications strategy in New Jersey must break through the noise of the New York and Philadelphia media markets. Messages specifically targeted to New Jersey residents will need to use alternative communication channels and common messaging from all partners. The use of social media and web-based tools by both the public and private sector will be critical. Integrating our efforts as content providers and administrators for these tools must become a top partnership priority.

PART NINE
Future Role of the NJCDPC

Partnering for a Healthy New Jersey aptly names the key role of the NJCDPC Unit in building seamless and integrated chronic disease prevention systems. At all levels (i.e. local, county, cross-county, state) and within all sectors (i.e. government, non-profit, private), chronic disease prevention and health promotion activities are taking place in New Jersey. Based on input from the planning workgroups though, there is little coordination and a resultant concern for potential gaps of coverage and possible redundancy. Stakeholders repeatedly expressed concern about the lack of information available about the efficacy of these programs and that consumers, the end-user, often get lost as they try to navigate the health system.

Therefore, a key function for the NJCDPC Unit is to act as the *coordinator* by inventorying and categorizing the myriad of initiatives and services available in the State. It will then be a *supporter of current and future growth* in practices and policies by identifying gaps, potential growth, best practices, and change agents. It will support and encourage evaluation and implementers of successful initiatives.

With partners, it will develop and provide toolkits for effective strategies. It will be *a resource agent* as it collates and disseminates positive efforts ranging from grass roots activities to policy improvements and a *leveraging agent* as it seeds innovation and works with private funders to take new initiatives to scale.

It will *coordinate evaluation* as it tracks evidence-based efforts to increase the return on investment. It will support and encourage research and track the desired changes in health status of high-risk disparate populations. It will *communicate with all partners* so that they stay informed during major changes in the fields of healthcare and prevention. It will also ensure that appropriate and effective communication is provided for consumers so they can make healthcare and daily life decisions that support wellness.

Stakeholders raised the issue that partnerships frequently falter because no one group has the specific charge to unite and facilitate the required host of activities. The NJCDPC Unit is

ideally suited to bridge the activities within and beyond State government under a common wellness goal. The NJCDPC Unit is also positioned to provide specific coordinating functions of gathering information, providing the time and space for aligning partner activities, establishing shared measurement, mobilizing public-private resources and communicating both to the consumer as well as to healthcare and community prevention partners.

Finally, the NJCDPC Unit will be a *champion for keeping health in all policies* by identifying opportunities for stronger public-private partnerships within multiple government agencies and policy-making bodies at the local, county, and state level.

APPENDICES

Appendix I: Planning Stakeholders

Last Name	First Name	Organization
Gallagher	Fran	AAP/NJ and NJPCORE
Orlando	Corinne	American Heart Association/American Stroke Association
Gruskiewicz	Linda	Arthritis Foundation
Lotkowictz	Peggy	Arthritis Foundation
Lederman	David, Dr.	Atlantic Oral & Maxillofacial Pathology
Geydoshek	Marilyn	Camp Nejeda (camp for kids w/ Diabetes)
Cervantes	Kim	Cape May County Health Department
D'Oria	Robyn	Central NJ MCH Consortium
Morton	Jessica	Central/South Jersey Affiliation - Komen for the Cure
Sullivan	Jamie	COPD Foundation
Morrison	Joe	COPD Foundation
Bulthius	Aimee	COPD Foundation
Paige	Cynthia, Dr.	Cypress Health Institute of NJ
DiMemmo	Kate	Department of Children and Families (DCF)
Blumenfeld	Karen	GASP
Bischoff	Martin	Gladius Health
Cantor	Jeff	Gladius Health
Vasil	Margaret	Henry J. Austin Health Care Center
Haran, RN,BSN	Linda	Horizon Foundation for NJ Horizon Blue Cross Blue Shield
Pivnick	Elyse	Isles, Inc.
Katz	Carol	Katz Government Affairs (for CVS Caremark)
Narayan-Reddy	Namith	Morris County Health Department
Stoller	Arlene	Morris County Office of Health Management
Lanza	Denise	Morris County Parks Department
Hunsinger	Stephanie	National MS Society
Jani	Nisha	Newark Health Department
Stearns	Christine	NJ Business / Industry Assoc.
Burnett	Suzanne	NJ Department of Education (DOE) – Head Start
DeWitt-Parker	Christene	NJ Department of Education (DOE) – Office of Student Support Services
Anderson	Linda	NJ Department of Health (DOH) – Family Health Services, Primary Care
Collins	Cynthia	NJ Department of Health (DOH) – Child and Adolescent Health Program
Dellas	Sylvia	NJ Department of Health (DOH) – Child and Adolescent Health Program
Schwartz	Suzanne	NJ Department of Health - Cancer Registry (DOH)
Kelly	Loretta	NJ Department of Health - Center for Health Statistics (DOH)
Baron	Maria	NJ Department of Health (DOH) – Center for Health Statistics
Schooley	Carlton	NJ Department of Health (DOH) – Family Health Services, Fiscal
Bookbinder	Sylvia	NJ Department of Health - Office of Public Health (DOH)

Last Name	First Name	Organization
Ahia	Ruth	NJ Department of Health – WIC (DOH)
Parikh	Sunil H.	NJ Department of Human Services / Comm for Blind
Bremer-Nei	Elise	NJ Department of Transportation (DOT)
Sanchez-Perez	Jacqueline	NJ Division of Women
Chalker	Melissa	NJ Foundation for Aging
Barnett	Pat	NJ Nurses Association
Smith	Barbara	NJ Nurses Association
Anderson	Darrin	NJ Partnership for Healthy Kids
Litterer	Diane	NJ Prevention Network (NJPN)
Liga	Diane	NJ Prevention Network (NJPN)
Polonsky	Connie	NJ Prevention Network (NJPN)
Lovett	Bill	NJ State Alliance of the YMCA
Robbins	Tim	NJ State Organization of Cystic Fibrosis
Blizzard	Lisa	Novartis Pharmaceuticals
Laws-Krause	Carol	Novo Nordisk Pharmaceuticals
Levinson	Deb	Ocean-Monmouth Regional Chronic Dis. Coalition Coord.
Lampman	Teresa	Pediatric/Adult Asthma Coalition of NJ (PACNJ)
Sherman	Melissa	Pediatric/Adult Asthma Coalition of NJ (PACNJ)
Dunnings	Russel	Princeton Center for Leadership Training
Mehrotra	Noween	Private Practice Pediatrician
Connor	Judi	Programs for Parents
Taylor	Seema	Programs for Parents
Evans	Kiameesha	Rutgers Cancer Institute of NJ
Morgan	Kathleen	Rutgers Cooperative Extension
Fitzgerald	Nurgul	Rutgers Cooperative Extension
Grenci	Sandra	Rutgers Cooperative Extension
Cirignano	Sherri, Dr.	Rutgers Cooperative Extension of Warren County
Rosenheck	Arnold, Dr.	Rutgers School of Dental Medicine
Echeverria	Sandra	Rutgers School of Public Health
Sass	Marcia	Rutgers School of Public Health
Hogan	Christine	Samuel L. Bailey Huntington's Disease Ctr @ Rowan Univ.
Wright	Barbara	Self-Employed
Mallette	Carol	Southern Jersey Family Medical Center (SJFMC)
Butler	Cathy	Southern NJ Perinatal Cooperative
Rivera	Mimi	Southern NJ Perinatal Cooperative
Weitz	Merle	Southern NJ Perinatal Cooperative
Healey	Nancy	Susan G. Komen - NJ
Joice	Eric	The Family Resources Network
Rhodes	Nancy	University Medical Center of Princeton at Plainsboro
Baskies	Arnold, Dr.	Virtua Surgical Associates (ACS)
Bennison	Anita	YMCA

Appendix II: Summary of Existing Internal Coalitions

This is a summary of the existing and independently operating chronic disease partnership entities that function with staff support, funding or leadership from the New Jersey Department of Health.

- Chronic Disease Advisory Council: The Chronic Disease Advisory Council (CDAC) includes DOH Commissioner appointed members representing a wide range of constituents including healthcare providers, government agencies, professional organizations, healthcare organizations, and minority health groups. The purpose of CDAC is to act in an advisory capacity in the areas of chronic disease prevention, detection, and treatment.
- Regional Chronic Disease Coalitions: New Jersey has 10 regional chronic disease coalitions that receive funding through the New Jersey DOH's Office of Cancer Control and Prevention. These coalitions originated from the State's 21 county cancer coalitions and were recently consolidated into regional coalitions that are engaged in both comprehensive cancer control efforts and chronic disease interventions.
- Governor's Task Force on Cancer Prevention, Early Detection, and Treatment: This task force is comprised of a wide range of experts charged with addressing the impact of cancer on New Jersey citizens. Several workgroups and committees were developed as an extension of this task force and are currently working to implement the New Jersey Comprehensive Cancer Control Plan.
- The New Jersey State Commission on Cancer Research (NJCCR) promotes significant and original research in New Jersey into the causes, prevention and treatment of cancer and serves as a resource to providers and consumers of cancer services.
- Pediatric/Adult Asthma Coalition of New Jersey (PACNJ): The Pediatric/Adult Asthma Coalition of New Jersey is sponsored by the American Lung Association of the Mid-Atlantic and receives funding from the New Jersey DOH's Asthma Awareness and Education Program. The PACNJ has over 70 members and is currently working with schools, child care providers, healthcare providers, health insurers, community groups and environmental agencies to reduce the burden of asthma in New Jersey.
- NJBreathes: New Jersey Breathes is a coalition of organizations from public, private, government and non-profit sectors interested in decreasing tobacco use in the State. Membership for this coalition includes many existing State partners such as the American Cancer Society, New Jersey Global Advisors on Smoke-Free Policy, and the Southern New Jersey Perinatal Cooperative.
- Rural Health Advisory Committee: The Rural Health Advisory Council serves as a statewide resource for rural health concerns, to improve rural health, and to foster available and accessible health services for rural New Jerseyans. The Council has an

open membership and includes planners, providers and consumers of rural health services throughout the state.

- ShapingNJ: ShapingNJ is a public-private partnership that was designed to make the healthy choice the easy choice in New Jersey. The partnership was originated by the DOH's Office of Nutrition and Fitness and now includes over 200 members. ShapingNJ is implementing a number of evidence-based strategies in communities, schools, child care centers, healthcare facilities and worksites throughout New Jersey.
- New Jersey Council on Physical Fitness and Sports: serves the residents of the State by developing safe, healthful and enjoyable physical fitness and sports programs. The council provides instruments of motivation and education, and promotes public awareness to ensure that all citizens of the State have the opportunity to pursue a more healthful lifestyle.

Appendix III: First Draft of Domain Logic Models

Epidemiology, Surveillance & Evaluation Domain				
Inputs ⇨	Strategies ⇨	Outputs ⇨	Interim Outcomes ⇨	Long-Term Impact
Funding (federal/state/private) National, regional, state and local partners Federal & state laws/policies	Improve access to data Improve application of data Improve communication of data Improve collaboration of partners invested in data	An inventory of reliable datasets in NJ Data translated in a user-friendly way for use by the full spectrum of data consumers Advanced data strategies Culturally competent and linguistically appropriate publications County/community wellness data profiles available in more communities Collaboration with partners who can access/analyze data	Increased use of data for policy, strategy and funding decision making at the program, community and state level Increased collaboration among data partners across all levels of the user continuum • Increase in shared data • Increase in collaborative publication/presentation of data • Increase in reliable data sources available to all data users	Reduced morbidity and mortality among leading causes of death and disability including; cancer, heart disease, stroke, diabetes and arthritis

Environmental Approaches Domain				
Inputs ⇨	Strategies ⇨	Outputs ⇨	Interim Outcomes ⇨	Long-Term Impact
Federal and state laws Funding (federal/state/private) National, regional, state & local partners	Smoke-Free/Clean Air policies and radon testing Worksite, school, childcare, government, and community wellness policies (tobacco, physical activity, healthy food, self-management and clean air) Healthy Home Assessment & Remediation Baby Friendly hospitals initiative Strategies to support access to healthy foods	Worksites, schools, childcare settings, government settings and community settings with comprehensive wellness policies Complete Streets Local access to healthy foods Joint-use agreements that promote physical activity Crime prevention through environmental design	Decrease in smoking prevalence Decrease in exposure to second hand smoke Decrease in rates of obesity Increase in physical activity Increase in consumption of healthy foods and beverages Decrease in asthma triggers in schools, homes, etc. Increased management of asthma	Reduced morbidity and mortality among leading causes of death and disability including cancer, heart disease, stroke, diabetes and arthritis

Health Systems Intervention Domain				
Inputs ⇨	Strategies ⇨	Outputs ⇨	Interim Outcomes ⇨	Long-Term Impact
Funding (federal/state/private) National, regional, state and local partners Federal & state laws/policies	Electronic health records Patient navigators, community health workers, care coordination Community-based care models including patient-centered medical home, accountable care organization, comprehensive primary care Team-based care and use of allied health professionals	Identify mechanisms to tie healthcare reimbursement and use of EHR systems Promote reporting of core health indicators across systems Centralized and standardized training available using common standards on required core knowledge Pilot test and evaluate variety of models for patient navigation & care coordination especially for high-risk populations Pilot test and evaluate private community health center models for comprehensive community-based health services across the lifespan	Increase percentage of public and private providers who have EHR systems and achieve meaningful use Pilot-tested models available for insurance company, health system- and community-based patient navigation systems in high-risk communities Pilot-tested models of comprehensive community based health centers available for replication in high-risk communities	Reduced morbidity and mortality among leading causes of death and disability including cancer, heart disease, stroke, diabetes and arthritis

Community-Clinical Linkages Domain				
Inputs ⇨	Strategies ⇨	Outputs ⇨	Interim Outcomes ⇨	Long-Term Impact
Funding (federal/state/private) National, regional, state and local partners Federal and state laws/policies	Improve and enhance existing services and programs to facilitate more/better collaboration and communication Pilot new collaboration and communication linkages	Seamless, mutually reinforcing and integrated care for individuals Improved methods with which consumers find/access a healthcare provider or wellness service in their community Healthcare payers engaged in planning and implementation of communication systems that increase collaboration Shared electronic platform that is based on best practices and provides uniform accessibility by all partners	Increases in chronic disease self-management Increases in community resources Increases in payer coverage of self-management programs and community health resources (CHWS) Increases in the use of EHR	Reduced morbidity and mortality among leading causes of death and disability including cancer, heart disease, stroke, diabetes and arthritis

Appendix IV: CMS-Funded Projects in NJ as of June 2013

Name of Initiative	Organization Name	Notes	City
BPCI Initiative: Model 1	Inspira Medical Center Woodbury	Convening Organization: New Jersey Hospital Association (NJHA)	Woodbury
BPCI Initiative: Model 1	Robert Wood Johnson University Hospital Hamilton	Convening Organization: New Jersey Hospital Association (NJHA)	Hamilton
BPCI Initiative: Model 1	JFK Medical Center	Convening Organization: New Jersey Hospital Association (NJHA)	Edison
BPCI Initiative: Model 1	Capital Health Medical Center - Hopewell	Convening Organization: New Jersey Hospital Association (NJHA)	Pennington
BPCI Initiative: Model 1	Capital Health Regional Medical Center	Convening Organization: New Jersey Hospital Association (NJHA)	Trenton
BPCI Initiative: Model 1	St. Mary's Hospital Passaic	Convening Organization: New Jersey Hospital Association (NJHA)	Passaic
BPCI Initiative: Model 1	The Valley Hospital	Convening Organization: New Jersey Hospital Association (NJHA)	Ridgewood
BPCI Initiative: Model 1	Robert Wood Johnson University Hospital Rahway	Convening Organization: New Jersey Hospital Association (NJHA)	Rahway
BPCI Initiative: Model 1	Deborah Heart and Lung Center	Convening Organization: New Jersey Hospital Association (NJHA)	Brown Mills
BPCI Initiative: Model 1	CentraState Medical Center	Convening Organization: New Jersey Hospital Association (NJHA)	Freehold
BPCI Initiative: Model 2	The Valley Hospital	Number of Episodes: 48 // Convening Organization(s): Touchstone Health	Ridgewood
BPCI Initiative: Model 2	Bayonne Medical Center	Number of Episodes: 2	Bayonne
BPCI Initiative: Model 2	St. Luke's Hospital-Warren Campus	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Phillipsburg
BPCI Initiative: Model 2	St Joseph's Regional Medical Center	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Paterson
BPCI Initiative: Model 2	Mountainside Hospital	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Montclair
BPCI Initiative: Model 2	Morristown Medical Center	Number of Episodes: 2 // Convening Organization(s): Association of American Medical Colleges and Atlantic Health System	Morristown
BPCI Initiative: Model 2	Overlook Medical Center	Number of Episodes: 1 // Convening Organization(s): Association of American Medical Colleges and Atlantic Health System	Summit
BPCI Initiative: Model 2	Holy Name Hospital	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Teaneck
BPCI Initiative: Model 2	Jersey City Medical Center	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Jersey City
BPCI Initiative: Model 2	Hackensack University Medical Center	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Hackensack
BPCI Initiative: Model 2	Wayne General Hospital	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Wayne
BPCI Initiative: Model 3	ManorCare Health Services-Voorhees	Number of Episodes: 48 // Convening Organization(s): Optum	Voorhees
BPCI Initiative: Model 3	ManorCare Health Services-Washington Township	Number of Episodes: 48 // Convening Organization(s): Optum	Sewell
BPCI Initiative: Model 3	VNA Health Group	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Red Bank

Name of Initiative	Organization Name	Notes	City
BPCI Initiative: Model 3	ManorCare Health Services (West Deptford)	Number of Episodes: 48 // Convening Organization(s): Optum	Paulsboro
BPCI Initiative: Model 3	Bayada Home Healthcare, Inc.	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Millville
BPCI Initiative: Model 3	Bayada Home Healthcare, Inc.	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Westampton
BPCI Initiative: Model 3	Bayada Home Healthcare, Inc.	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Cherry Hill
BPCI Initiative: Model 3	Bayada Home Healthcare, Inc.	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Jersey City
BPCI Initiative: Model 3	d/b/a Amedisys Home Health	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc	Secaucus
BPCI Initiative: Model 3	ManorCare Health Services (Cherry Hill)	Number of Episodes: 48 // Convening Organization(s): Optum	Cherry Hill
BPCI Initiative: Model 4	Shore Memorial Hospital	Number of Episodes: 1	Somers Point
BPCI Initiative: Model 4	Meridian Hospital Corporation, Jersey Shore University Medical Center	Number of Episodes: 1	Neptune
Community-based Care Transitions Program	Central New Jersey Care Transition Program		Red Bank
Comprehensive Primary Care Initiative	Village Medical	Operating in the CPC market of New Jersey: Statewide	Phillipsburg
Comprehensive Primary Care Initiative	William P Boyan MD/MBA LLC	Operating in the CPC market of New Jersey: Statewide	Brick
Comprehensive Primary Care Initiative	Family Medicine Center	Operating in the CPC market of New Jersey: Statewide	Manahawkin
Comprehensive Primary Care Initiative	Alexander Biener, MD PA	Operating in the CPC market of New Jersey: Statewide	Woodcliff Lake
Comprehensive Primary Care Initiative	Omnimed	Operating in the CPC market of New Jersey: Statewide	Florham Park
Comprehensive Primary Care Initiative	East Hudson Primary Care	Operating in the CPC market of New Jersey: Statewide	West New York
Comprehensive Primary Care Initiative	Family Practice of Middletown, a practice site of Integrated Medicine Alliance	Operating in the CPC market of New Jersey: Statewide	Middletown
Comprehensive Primary Care Initiative	Wayne R. Braendle, M.D., a practice site of Integrated Medicine Alliance	Operating in the CPC market of New Jersey: Statewide	Red Bank
Comprehensive Primary Care Initiative	Highlands Family Health Center	Operating in the CPC market of New Jersey: Statewide	Hampton
Comprehensive Primary Care Initiative	Jeanne Tomaino, M.D., a practice site of Integrated Medicine Alliance	Operating in the CPC market of New Jersey: Statewide	Red Bank
Comprehensive Primary Care Initiative	Summit Medical Group - 552 Westfield Ave	Operating in the CPC market of New Jersey: Statewide	Westfield
Comprehensive Primary Care Initiative	Summit Medical Group - 8 Mountain Boulevard	Operating in the CPC market of New Jersey: Statewide	Warren

Name of Initiative	Organization Name	Notes	City
Comprehensive Primary Care Initiative	Woodbridge Internal Medical Associates	Operating in the CPC market of New Jersey: Statewide	Woodbridge
Comprehensive Primary Care Initiative	Forest Hill Family Health Associates, PA	Operating in the CPC market of New Jersey: Statewide	Newark
Comprehensive Primary Care Initiative	Harvey R Gross MD PC	Operating in the CPC market of New Jersey: Statewide	Englewood
Comprehensive Primary Care Initiative	Jersey Coast Family Medicine LLC	Operating in the CPC market of New Jersey: Statewide	Brick
Comprehensive Primary Care Initiative	Raritan Family Healthcare	Operating in the CPC market of New Jersey: Statewide	Raritan
Comprehensive Primary Care Initiative	Red Bank Medical, a practice site of Integrated Medicine Alliance	Operating in the CPC market of New Jersey: Statewide	Red Bank
Comprehensive Primary Care Initiative	Richard Corson, MD, LLC	Operating in the CPC market of New Jersey: Statewide	Hillsborough
Comprehensive Primary Care Initiative	Riverfield Family Health Center	Operating in the CPC market of New Jersey: Statewide	Washington
Comprehensive Primary Care Initiative	Fair Haven Internal Medicine, a practice site of Integrated Medicine Alliance	Operating in the CPC market of New Jersey: Statewide	Fair Haven
Comprehensive Primary Care Initiative	EHMG - Seabrook Village	Operating in the CPC market of New Jersey: Statewide	Tinton Falls
Comprehensive Primary Care Initiative	Hopewell Family Practice	Operating in the CPC market of New Jersey: Statewide	Hopewell
Comprehensive Primary Care Initiative	Borowski & Borowski	Operating in the CPC market of New Jersey: Statewide	Linden
Comprehensive Primary Care Initiative	Chapel Hill Family Medicine, a practice site of Integrated Medicine Alliance	Operating in the CPC market of New Jersey: Statewide	Red Bank
Comprehensive Primary Care Initiative	EHMG - Cedar Crest Village	Operating in the CPC market of New Jersey: Statewide	Pompton Plains
Comprehensive Primary Care Initiative	Family Practice Associates of Voorhees	Operating in the CPC market of New Jersey: Statewide	Voorhees
Comprehensive Primary Care Initiative	Firstcare Medical Group	Operating in the CPC market of New Jersey: Statewide	Verona
Comprehensive Primary Care Initiative	FirstMed Family Healthcare	Operating in the CPC market of New Jersey: Statewide	Northvale
Comprehensive Primary Care Initiative	Pranay Bhatt, MD, LLC	Operating in the CPC market of New Jersey: Statewide	Bloomfield
Comprehensive Primary Care Initiative	Riverfield Family Health Center	Operating in the CPC market of New Jersey: Statewide	Clinton

Name of Initiative	Organization Name	Notes	City
Comprehensive Primary Care Initiative	Red Bank Family Medicine, a practice site of Integrated Medicine Alliance	Operating in the CPC market of New Jersey: Statewide	Red Bank
Comprehensive Primary Care Initiative	Summit Medical Group - 563 Westfield Ave	Operating in the CPC market of New Jersey: Statewide	Westfield
Comprehensive Primary Care Initiative	Your Doctors Care	Operating in the CPC market of New Jersey: Statewide	Hillsborough
Comprehensive Primary Care Initiative	Dennis Novak, MD PA	Operating in the CPC market of New Jersey: Statewide	Forked River
Comprehensive Primary Care Initiative	Max Burger MD LLC	Operating in the CPC market of New Jersey: Statewide	Southampton
Comprehensive Primary Care Initiative	RWJMG Family Medicine at Monument Square	Operating in the CPC market of New Jersey: Statewide	New Brunswick
Comprehensive Primary Care Initiative	Annandale Family Practice, LLC	Operating in the CPC market of New Jersey: Statewide	Lebanon
Comprehensive Primary Care Initiative	Columbus Family Physicians	Operating in the CPC market of New Jersey: Statewide	Columbus
Comprehensive Primary Care Initiative	Avenel Iselin Medical Group	Operating in the CPC market of New Jersey: Statewide	Iselin
Comprehensive Primary Care Initiative	Central Jersey Internal Medicine Associates	Operating in the CPC market of New Jersey: Statewide	Somerset
Comprehensive Primary Care Initiative	Branchburg Family Health Center	Operating in the CPC market of New Jersey: Statewide	Somerville
Comprehensive Primary Care Initiative	Comprehensive Family Medicine	Operating in the CPC market of New Jersey: Statewide	Warren
Comprehensive Primary Care Initiative	Cornerstone Family Practice	Operating in the CPC market of New Jersey: Statewide	Flemington
Comprehensive Primary Care Initiative	Joyce Nkwonta, MD PC	Operating in the CPC market of New Jersey: Statewide	Plainfield
Comprehensive Primary Care Initiative	Farmingdale Family Practice	Operating in the CPC market of New Jersey: Statewide	Farmingdale
Comprehensive Primary Care Initiative	Inman Medical Associates	Operating in the CPC market of New Jersey: Statewide	Colonia
Comprehensive Primary Care Initiative	Hampton Family Practice	Operating in the CPC market of New Jersey: Statewide	Hampton
Comprehensive Primary Care Initiative	HealthCare for Life	Operating in the CPC market of New Jersey: Statewide	Eatontown
Comprehensive Primary Care Initiative	Hudson Primary Care Professionals	Operating in the CPC market of New Jersey: Statewide	Jersey City

Name of Initiative	Organization Name	Notes	City
Comprehensive Primary Care Initiative	Hunterdon Family Practice & Obstetrics	Operating in the CPC market of New Jersey: Statewide	Flemington
Comprehensive Primary Care Initiative	Immedicenter	Operating in the CPC market of New Jersey: Statewide	Clifton
Comprehensive Primary Care Initiative	Immedicenter Totowa	Operating in the CPC market of New Jersey: Statewide	Totowa
Comprehensive Primary Care Initiative	Kennedy Health Alliance	Operating in the CPC market of New Jersey: Statewide	Voorhees
Comprehensive Primary Care Initiative	Marc Feingold, MD LLC	Operating in the CPC market of New Jersey: Statewide	Manalapan
Comprehensive Primary Care Initiative	Marshall Lauer MD	Operating in the CPC market of New Jersey: Statewide	Collingswood
Comprehensive Primary Care Initiative	Meetinghouse Family Physicians	Operating in the CPC market of New Jersey: Statewide	Marlton
Comprehensive Primary Care Initiative	Moreno Medical Associates	Operating in the CPC market of New Jersey: Statewide	Jersey City
Comprehensive Primary Care Initiative	Nandini Moray MD PA	Operating in the CPC market of New Jersey: Statewide	Edison
Comprehensive Primary Care Initiative	New Jersey Physicians, LLC	Operating in the CPC market of New Jersey: Statewide	Rutherford
Comprehensive Primary Care Initiative	Middlebrook Family Physician	Operating in the CPC market of New Jersey: Statewide	Bound Brook
Comprehensive Primary Care Initiative	Ocean County Internal Medicine Assoc.	Operating in the CPC market of New Jersey: Statewide	Lakewood
Comprehensive Primary Care Initiative	Orlando Mills Associates PA	Operating in the CPC market of New Jersey: Statewide	Freehold
Comprehensive Primary Care Initiative	Partners in Freedom LLC	Operating in the CPC market of New Jersey: Statewide	Sea Girt
Comprehensive Primary Care Initiative	Princeton Health Affiliated Physicians	Operating in the CPC market of New Jersey: Statewide	Princeton
Comprehensive Primary Care Initiative	Rekha Sehgal	Operating in the CPC market of New Jersey: Statewide	Vineland
Comprehensive Primary Care Initiative	Summit Medical Arts Associates LLC	Operating in the CPC market of New Jersey: Statewide	North Bergen
Comprehensive Primary Care Initiative	Summit Medical Group - 11 Cleveland Place	Operating in the CPC market of New Jersey: Statewide	Springfield
Comprehensive Primary Care Initiative	Water Street Physicians	Operating in the CPC market of New Jersey: Statewide	Toms River

Name of Initiative	Organization Name	Notes	City
Comprehensive Primary Care Initiative	Vanguard Medical Group	Operating in the CPC market of New Jersey: Statewide	Verona
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	University of Medicine and Dentistry RWJ Eric B. Chandler Health Center		New Brunswick
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Southern Jersey Family Medical Centers, Inc.		Salem
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Southern Jersey Family Medical Centers, Inc.		Pleasantville
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Southern Jersey Family Medical Centers, Inc.		Atlantic City
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Southern Jersey Family Medical Centers, Inc.		Hammonton
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	CAMcare-East		Camden
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Southern Jersey Family Medical Centers, Inc.		New Lisbon
Healthcare Innovation Awards	The Trustees Of The University Of Pennsylvania	Participant operating in New Jersey, Pennsylvania	
Healthcare Innovation Awards	Trustees Of Dartmouth College	Participant operating in California, Colorado, Idaho, Iowa, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Oregon, Texas, Utah, Vermont, and Washington	
Healthcare Innovation Awards	Developmental Disabilities Health Services	Participant operating in Arkansas, New Jersey, New York	
Healthcare Innovation Awards	Cooper University Hospital	Participant operating in New Jersey	
Healthcare Innovation Awards	Mount Sinai School Of Medicine	Participant operating in Illinois, New Jersey, and New York	

Name of Initiative	Organization Name	Notes	City
Healthcare Innovation Awards	University Of North Texas Health Science Center	Participant operating in Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Nevada, Massachusetts, Minnesota, Mississippi, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, and Wisconsin	
Navigator Grant Recipient	Center for Family Services, Inc.	Funds will be used to educate and help enroll consumers in the health insurance marketplace.	Camden, Burlington, Gloucester, Salem, Atlantic, Cape May, and Cumberland Counties.
Navigator Grant Recipient	Orange ACA Navigator Project	Help uninsured residents and small businesses in underserved and vulnerable populations.	
Navigator Grant Recipient	The Urban League of Hudson County	Partner with the Urban League for Bergen County, Urban League of Morris County, and Urban League of Union County to assist consumers in enrolling in the Marketplace.	
Navigator Grant Recipient	Public Health Solutions	Largest non-profit organization in NYC will partner with four community-based organizations in NJ to provide outreach and enrollment assistance in Hudson and Essex Counties.	Hudson and Essex Counties
Navigator Grant Recipient	FoodBank of Monmouth and Ocean Counties, Inc.	Connect uninsured and underinsured individuals with information about their health insurance options.	

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