

APPENDIX

**Testimony of Eddy A. Bresnitz, MD, MS
Deputy Commissioner/State Epidemiologist
New Jersey Department of Health and Senior Services
Assembly Regulatory Oversight Committee
Thursday, December 6, 2007**

Issue: Childhood Obesity and Asthma

Good morning Mr. Chairman and members of the Assembly Regulatory Oversight Committee.

I appreciate the opportunity to provide the Committee with an update on my testimony of May 2007 relative to the important issue of excess weight, specifically childhood obesity and overweight and asthma management.

I would like to begin with childhood obesity and overweight.

As you've heard many times, excess weight in the population is a public health crisis, often starting in childhood. It is a growing global public health problem and New Jersey is not exempt.

A CDC-sponsored survey in 2005 reported 37.1% of adults are overweight and 22.1% are obese in New Jersey

Excess weight is the nation's second leading cause of death after smoking contributing to as many as 300,000 deaths annually.

In the last 30 years, the percentage of overweight youth has doubled nationally for ages 6-11, and tripled for ages 12-19.

According to a national Survey (NHANES), 15 percent of children aged 6-11, and 12-19, are obese, estimated to rise to 20% by 2010.

The DOE and DHSS conducted a retrospective records survey of ~2400 6th graders in 2003 - 2004 selected randomly from 40 schools from varying socio-economic groupings found that 20 % were obese and 18 % were overweight, higher than the national average.

Higher obesity levels were observed among poorer school districts and among all racial/ethnic groups.

The state's African-American and Latino youth are more likely to be overweight than are white youths.

New Jersey has the nation's highest obesity rate for low income children.

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Early intervention is needed so that overweight/obese children do not become overweight/obese adults.

The overarching goals of Healthy New Jersey 2010 are to increase the quality and length of healthy life, and eliminate disparities in health outcomes based on race and/or ethnicity.

To this end, the Department has and continues to undertake activities to prevent obesity and promote physical activity and healthy eating. In May 2007, I told you about many of the activities conducted by the Department of Health and Senior Services, as well as several of the other state departments.

Let me tell you about what has happened since that time:

- The Department has reconvened the Obesity Prevention Task Force to assist us in implementation of the 2006 Action Plan outlined in their report of last year. The Task Force is assisting the department in prioritizing the goals and strategies as outlined in the report and is also being asked to continue their commitment.
- Planning is underway by the Task Force, in collaboration with NJ WIC and USDA, for a fall 2008 obesity prevention conference. The conference will engage a wide variety of statewide stakeholders to address barriers for healthy eating and physical activity and collaborative efforts to change the current negative trajectory of obesity in New Jersey. This conference is a key recommendation of the Task Force. The direction and audience is being refined to have an effective impact and I would like to invite you to attend if you have the time.
- The Department has established an Office of Nutrition and Fitness to enhance state leadership, coordinate activities and bring disparate programs under one umbrella. The Office was created in May 2007 in the DHSS, based on recommendations of the Task Force. This Office is in the formative stage but personnel have been designated to staff the new office which will consolidate existing programs within the department. The office will address five specific areas including increased sports and physical activity for all ages, decreased screen time (TV, video games, computer use), improved nutrition, increased fruits and vegetables and exclusive breastfeeding for up to 6 months of age. These programs will focus on the idea that "More Matters" in each of these critical areas of intervention.
- We are in the process of creating an Advisory Council to this Office and will include sister agencies and departments of State as well as other key stakeholders.

- Commissioner Jacobs has personally undertaken a public awareness campaign to educate NJ audiences including physicians, nurses, nutritionists, school food service personnel, PTA groups, students and others about the two major preventable causes of death - obesity and second hand smoke. Between September and December 2007, Dr. Jacobs has met with over 50 groups to discuss and strategize efforts for impacting these issues. He has not done this alone. On many occasions the dialogue with Dr. Jacobs included the presence of the Commissioners of Education, Personnel, Transportation and the Secretary of Agriculture. Addressing excess weight is a high priority to these departments as well, and includes efforts to address education regarding appropriate food choices and physical activity. Collaboration and sharing of resources among the departments is a key to achieving the goals of Healthy People 2010 to both increase the quality and length of healthy years and decrease disparities.
- The Obesity Prevention Task Force has proposed the formation of a Speakers Bureau to continue Commissioner Jacobs' Public Awareness Initiative that addresses the two leading causes of preventable death including obesity and second hand smoke. Members have volunteered for this effort. Trainings will be conducted to ensure that a uniform message is presented.
- We are in the process of collaborating on a statewide web based nutrition and fitness directory that will enable NJ citizens to access resources and expertise.
- The Department has also pursued federal grant opportunities and developed educational programs. The ACHIEVE (Action Communities for Health, Innovation, and EnVironmental ChangE) Grant Application was submitted by DHSS to the Centers for Disease Control and Prevention (CDC) in October 2007.
- ACHIEVE is designed to support a partnership between local health departments and YMCAs in communities to advance local leadership in the nation's efforts to prevent chronic diseases and related risk factors. If awarded the grant, two local health departments and local YMCAs will receive \$40,000 each for two years to promote policy and environmental change, and focus on advancing local level leadership for the prevention of chronic disease.
- A multidisciplinary team of professionals from DHSS including child and adolescent health, WIC and senior affairs as well as other education, child care and community partners have collaborated to develop PLAY Plus: A Nutrition and Physical Activity Guide for the preschool population. This curriculum was piloted in May 2007 with 90 early childhood and health professionals at the annual Health and Child Care Conference. The goal

of PLAY Plus is to address both obesity and osteoporosis prevention since the messages and audiences are the same (children, parents (home environment) and caregivers).

- Based on the pilot feedback PLAY Plus has been revised and provided by Abbott School Nurses to more than 70 preschool teachers and teaching assistants in Trenton public schools and community child care programs. Most recently a partnership has been formed with the Head Start State Collaboration Project to deliver best practice standards for nutrition and physical activity to Head Start programs statewide.
- The Governor's Council on Physical Fitness and Sports held the 2nd Annual Leaders' Academy for Healthy Community Development in May 2007. The Academy was attended by 150 participants. Following the event 22 mini grants totaling \$100,000 (range of \$2500 - \$10,000) were awarded throughout 13 counties to encourage healthy communities.
- Individual counties are also pursuing initiatives to address obesity at the local level.
- The Department's Office of Public Health Infrastructure has completed the next phase of the MAPP process (Mobilizing Action or Partnerships and Planning) called county CHIPs or Community Health Improvement Plans. Virtually all of the county data emphasize obesity as a priority health issue. This data is assisting the counties and municipalities to develop appropriate initiatives.
- The Department is collaborating with Rutgers Cooperative Extension to deliver nutrition and physical activity messages at the county level through an initiative titled, "Get Moving, Get Healthy NJ!" These initiatives result in the formation of County Coalitions to address obesity. Each coalition is funded to conduct county based activities to reach its goal of decreasing obesity among residents. This will be accomplished as Get Moving, Get Healthy New Jersey youth and families make healthy eating and physical activity choices as part of their daily lives.

Other state Departments, including DOE, DOA, and DOT have also launched initiatives addressing obesity and overweight. For example,

- The Department of Agriculture has mandated that schools have a School Wellness Policy which was effective in September 2007. Compliance with this requirement is close to 100%. Additionally, the Department of Agriculture is requiring that the contact information for the Coordinator of the Wellness Committee be submitted for on-going communications, accountability and notification of training opportunities.

- The Department has committed funding to the Department of Education to conduct the first ever survey of all NJ schools regarding the implementation of the K - 12 state core curriculum content standards for 150 minutes per week of health, physical education and safety. The NJ Association for Health, Physical Education, Recreation and Dance (NJAPERD) is partnering on this effort and has also committed funding for this collaborative effort. The results will enable state DOE to systematically address corrective actions for compliance issues.
- In July 2007, the Department of Transportation announced awards of \$4.15 million in Safe Routes to School grants to 29 communities to improve pedestrian safety through engineering and education. Grants were awarded in the range of \$7,500 - \$337,000 for projects including the creation of safer walkways, bikeways, and street crossings near schools.

To conclude my update on childhood overweight and obesity, let me just state that leading experts have indicated that for the first time in recorded public health history, that if we don't address the problem of excess weight head on in a multi-pronged approach, the current generation of youth will live shorter and sicker lives than their parent's generation. Addressing overweight and obesity NOW will improve the quality of life for our future generations and will strengthen the health of our nation.

Allow me to shift now to the topic of asthma.

The prevalence of asthma is increasing, requiring more and more resources to address prevention of the disease and its complications.

Based on estimates from the New Jersey Behavioral Risk Factor Survey in 2003:

- Approximately 711,000 New Jersey adults have ever been told by a healthcare professional that they have asthma.
- Among adults, Black non-Hispanics are the most likely to report having ever been diagnosed with asthma, followed by Hispanics and White non-Hispanics.
- In childhood, the prevalence of asthma is higher for boys than girls, while in adulthood women are more likely than men to have asthma.
- Women are 50% more likely to report having ever been diagnosed with asthma than New Jersey men.

With appropriate management plans and therapies, long term control of persistent asthma can be achieved, resulting in a decrease in preventable hospitalizations and emergency department visits for treatment.

We must ensure that we incorporate best practices as the basis for asthma management and decision-making to reduce the disproportionate impact of asthma in the pediatric population, low-income populations, and minority communities.

We have developed partnerships with private, public and community health systems to empower citizens and communities to take actions to improve the health of individuals, families, and communities.

The Department has undertaken many activities to promote best practices for asthma prevention and management.

- The Commissioner's Annual Asthma Summits, now in its third year, have provided a forum to facilitate collaboration among national and local experts on the strategies and practices required to reduce asthma disparities among the poor, minority and multicultural communities in New Jersey.
- The Department's Asthma Program is working with the New Jersey Academy of Pediatrics on a curriculum for the Educating Physicians in their Communities (EPIC) project. This project will educate private pediatric practices on proper asthma care and management for high-risk populations.
- In 2005, the Department of Health and Senior Services funded the New Jersey Primary Care Association (NJPCA) to initiate and implement a statewide Asthma Collaborative in an effort to reduce the burden of asthma and to address asthma disparities in New Jersey. The Asthma Collaborative has made remarkable progress by using a systems approach to asthma management while building a data registry that enables members to monitor their progress. From January 2006 through July 2007, the following outcomes have been observed:
 - The New Jersey Asthma Collaborative patient registry has grown in size from 9 Centers for Primary Health Care reporting on a total of 840 asthma patients in January 2006 to 12 centers reporting on a total of 2629 patients as of July 2007. This represents more than a threefold increase in the overall number of patients being monitored in less than two years.

The Centers are using several performance measures to assess their improvement in managing patients with asthma.

I will describe 3 of these measures: severity of asthma, use of anti-inflammatory drugs for treatment of persistent asthma and prevention of ED/urgent care use.

- Of the 12 centers reporting in July 2007, 7 centers have observed an overall increase in the percentage of asthma patients with a severity assessment at last contact. One center increased from a baseline of 5% to 66%.
- Of the 12 centers reporting in July 2007, 7 centers have observed an overall increase in the percentage of asthma patients with persistent asthma who are on anti-inflammatory medication at last contact. One center increased from 0% to 88%, another from 81% to 97%.
- Of the 7 centers reporting on Emergency Department (ED)/Urgent Care visits in July 2007, 5 centers have observed an overall decrease in the percentage of asthma patients with an ED/Urgent Care visit in the previous six months. One center reports a decrease from 22% to 0%, another from 37% to 20%.

Clearly our Collaborative Initiative is making a difference.

You will hear shortly from the Pediatric/Adult Asthma Coalition of New Jersey (PACNJ),

- DHSS is proud to be part of this coalition which is partially supported by a grant from the Department. PACNJ has over 150 participating member organizations and six (6) active task forces working with schools, physicians, health insurance companies, community groups, and environmental agencies to reach all individuals in New Jersey with the most effective methods for managing their asthma. The PACNJ is undertaking the following initiatives:
 - School nurse asthma training;
 - Policies and practices for asthma friendly childcare trainings;
 - Distribution of the Asthma Action Plan, a form that allows parents of school-age children, school nurses and pediatricians to personalize for individual children a plan for managing their asthma;
 - Pilot train the trainer programs in three urban cities with highest asthma hospitalization rates; and
 - Annual media campaigns.
- The "PACNJ Asthma Friendly School Award" recognizes schools for their commitment to enhance the quality of education for students and staff with asthma. In collaboration with PACNJ, Commissioner Jacobs has presented these awards to over 290 schools.
- The Department published a guidance document on "Developing Culturally and Linguistically Competent Health Education Materials: A Focus on Asthma" which is on the Department's web site.

I would like to describe one final initiative our Department has pursued to address the issue of asthma in minority children.

- In 2005, the federal Agency for Healthcare Research and Quality (AHRQ) selected New Jersey and the Pediatric/Adult Asthma Coalition of New Jersey as one of six states, to participate in the Learning Partnership to Decrease Disparities in Pediatric Asthma project. New Jersey joined Arizona, Maryland, Michigan, Oregon and Rhode Island in this groundbreaking initiative to develop and implement interventions to reduce disparities among minority children.
- The New Jersey AHRQ team developed a Disparities Action Plan that targets three cities (Newark, Camden, and Trenton) with high asthma hospitalization rates. The goal is that children with asthma utilizing emergency departments (ED) and clinics would have proper asthma management through a collaborative effort with communities/schools to decrease disparities. The strategies focused on:
 - Partnering with schools, communities and childcare providers and
 - Enhancing emergency department's capability to address asthma and create a referral system to primary care providers who should be the backbone with other health professionals in helping families develop asthma action plans.

In the upcoming months and year, the Department will continue its efforts and will work to ensure that we create systems changes in schools and day care centers to accommodate a healthy environment for children with asthma and implement public health activities to reduce asthma mortality and morbidity, with particular emphasis on asthma in children and other disproportionately affected populations.

All I did not mention this, we are also working to increase the reporting of work related asthma (WRA) and providing interventions to prevent the occurrence of asthma-related exacerbations in the workplace.

That concludes my update on obesity and asthma activities. I want to thank the committee for the opportunity to highlight these important public health activities.



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December 6, 2007

Assembly Regulatory Oversight Committee

Testimony on Childhood Obesity

Thank you for the opportunity to speak. First, I would like to tell you that the members of the NJ Dietetic Association are the premiere resource for nutrition information in the State of NJ. I am here with many interests: I hosted a reality show on The Learning Channel about unhealthy kids and their families, I am a mother, a registered dietitian & exercise physiologist, a member of the NJ Council on Physical Fitness & Sports, in addition to being a past-president of the NJ Dietetic Association. I am soon to be Dr. Felicia @ the end of this month...from UMDNJ, where my research has been in obesity & worksite wellness in adults. I am one of the few private practitioners that works with children, adolescents & teens who are overweight or obese in the state.

Overweight and obesity are problems that may actually begin in infancy, and continue to get worse throughout childhood. Since overweight and obesity is a multifactoral problem – which stems from an energy imbalance... between energy in (food) & energy expended (physical activity). Where do we start to put responsibility on this imbalance?

Do we start with the parents who are usually struggling with their own weight issues... without access to the proper support to maintain an appropriate body weight. Our culture is bombarded with information in the media – the question, which information is correct? The Federal Trade Commission estimates that over \$30 billion is spent each year on weight loss products & programs. Funny, but the obesity epidemic is getting worse, not better. Finkelstein et al estimated that NJ will have spent \$2.3 billion on obesity-attributable expenses for adults in 2003. The economic costs of an unhealthy diet and physical inactivity add up to almost \$100 billion per year or approximately eight percent of the national health care budget in direct medical costs. The CDC reported that \$31 billion of direct treatments costs for cardiovascular disease was related to overweight and obesity.

According to Olshansky et al, “obesity and its comorbidities may decrease the adult lifespan by five to 20 years” – this means that for all the advances we have made in medicine & science, we actually will have a generation of children who may not out live their parents. How can we reverse this trend in children? Schools alone cannot be the answer – they can be part of the solution, but they are challenged with the need to generate revenue in food service, vending and fundraising. Our schools are making money to sustain their existence, at the expense of our children’s health. Even with the school wellness policy that needs to be adhered to in NJ... there is still a disconnect with the access that kids have to unhealthy food during school hours.

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No child left behind, should become, no child should be left ON their behind. Physical education has taken a back seat to children's performance on standardized testing. Look at the cycle of physical education, from elementary school – children are lucky if they even have physical education once per week... then when they get into middle school, they have it more than once per week... by the time they get to high school it's daily – but by then, the damage is done... we cannot afford to wait until our kids turn 14 & 15 to instill the behavior of daily physical activity... it needs to start in kindergarten. School nurses collect data on heights & weights in school – but this information is never published or used (ie to compare performance in schools, etc.). School nurses have been shunned by parents for informing them of their child(ren)'s BMI and health risk.

Recognize that insurance companies do not pay for the intervention that is effective – nutritional counseling, unless there is diabetes or kidney disease. Insurance companies do not pay for additional physical activities. Insurance companies would sooner pay for bariatric surgery... which is expensive, invasive, and dangerous; which over time has proven to NOT be successful for sustained weight loss. Making better nutrition choices and increasing physical activity are the least expensive, least invasive and most effective way to fight overweight and obesity.

According to the the F as in Fat Report, published this past August by the Trust for America's Health:

- NJ ranks #40 in obesity with 22% of adults being "obese" (BMI \geq 30) [based on data from 2004-2006]
- 59.6% of adults are considered "overweight" & obese. (BMI >25)
- NJ Ranks #27 in cases of Diabetes
- NJ Ranks #9 in physical activity, with 27.3% of adults being physically inactive.
- NJ Ranks #22 in hypertension with 25.7% of adults having the diagnosis.
- 11.4% of high school students in NJ are overweight
- 15.4% of high school students in NJ are at risk of overweight
- 16.5% of children 2-5, who are low income & overweight
- NJ Ranks 26 in percentage of children ages 10-17 who are overweight
- 66.8% of kids ages 10-17 report more than 20 min of exercise 3 days/week or more
- The only good thing is that NJ ranked 49 in poverty rates (7.8% of citizens)

Medicare reimburses for bariatric surgeries which cost between \$15,000 and \$20,000 (and when the cost of evaluations, follow-up care and counseling are added in, the process can run from \$35,000 and \$50,000). How about good ole nutritional counseling by an RD & access to a gym?

Nutrition and exercise behavior interventions can be the most effective, least invasive & least expensive ways to treat & prevent overweight, obesity and its comorbidities.

Host of TLC's show "*Honey We're Killing the Kids*"
Past President, NJ Dietetic Association
Vice President, Greater NY Chapter American College of Sports Medicine
Nutrition Coordinator, NYRR and ING NYC Marathon
NJ Council on Physical Fitness & Sports

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**New Jersey State Legislature
Assembly Regulatory Oversight Committee
Thursday, December 6, 2007**

Testimony

Pamela Banks-Johnson

Program Specialist, American Lung Association of New Jersey

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Dear Assemblyman Payne and Committee Members:

Asthma is one of the most common chronic diseases affecting children and results from the 2003 National Survey of Children's Health suggest that about 255,484 New Jersey children (12%) have a history of asthma. This Survey also suggests that 180,159 children in New Jersey (9% of the pediatric population) currently have asthma. When uncontrolled, asthma can result in activity limitations, missed school days, emergency department visits, hospitalizations and even deaths.

The burden of asthma is outlined in the attached notes we are submitting but in speaking with you today, I want to highlight some key concerns.

Seven years ago the American Lung Association of New Jersey and its medical arm the New Jersey Thoracic Society sent out a call across the state to those interested in changing the way asthma is managed in New Jersey to come together as a coalition for statewide change. The Pediatric/Adult Asthma Coalition of New Jersey (PACNJ) was formed with over 130 interested parties representing schools, child care, physicians, health insurers, communities, and environmental agencies. Funding for statewide initiatives came from the Centers for Disease Control and Prevention through the NJ Department of Health and Senior Services, the United States Environmental Protection Agency, Region 2, Foundations, and Corporations. Maintaining a statewide coalition that targets communities most in need with new programs and then expands those programs for statewide change is becoming more difficult each year. Funding allocated annually to sustain a statewide coalition to continue the work with schools, child care, communities, physicians and environmental agencies is needed.

The National Heart, Lung, and Blood Institute had issued Guidelines for Best Practice in asthma management and the Coalition saw the need to ensure that physicians, schools, and families were following those guidelines. Experts in the field of asthma and representatives from those systems that impact on children were enlisted on six task forces to design education programs and materials to bring people together in a coordination of care. PACNJ focused on statewide system change.

Asthma Hospitalizations:

- Children are more likely to be hospitalized with asthma than adults. In 2004, there were 5,175 asthma hospitalizations for children in New Jersey, and children under 5 years of age have the highest hospitalization rate for asthma.
- In 2004, black children in New Jersey were over 3 times more likely to be hospitalized with asthma when compared to white children. In the same year, Hispanic children in New Jersey were more than 1 ½ times more likely than non-Hispanic children to be hospitalized for asthma.
- Hospitalizations for asthma demonstrate seasonal patterns among children in New Jersey. These seasonal peaks are most apparent among school age children. For example among elementary school age children, the May asthma hospitalization rate is over 41/2 times

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the July asthma hospitalization rate and the September and October rates are over 5 times the July asthma hospitalization rate.

Children are in school during their peak seasons for hospitalizations. PACNJ addressed asthma management in the schools in an effort to change the system from a **reactive response** to an emergency, to a **proactive preventive approach** that addressed triggers and recognized the early warning signs of an asthma episode so a child could get help before it became an emergency. To achieve this statewide system change, PACNJ developed all the educational materials and tools and implemented them statewide.

This was made possible because NJ has one of the most comprehensive laws in the nation on asthma management in the schools. This Law that went into effect in September 2001 and requires asthma education for schools nurses, annual asthma education for school faculty, a nebulizer in every school, and an asthma action plan that also lists triggers for every child that has permission to carry an inhaler.

This is an outstanding law and PACNJ developed the educational tools needed to facilitate schools complying. Then we created the PACNJ Asthma Friendly School Award to recognize those schools that not only complied with the NJ Law and provided the education, but also went above and beyond by taking the NJ Department of Environmental Protection Agency "No Idling Pledge" and participating in the USEPA Indoor Air Quality Tools for Schools Training, forming and IAQ team.

- 262 New Jersey schools serving over 150,000 children have received the PACNJ Asthma Friendly School Award
- We are currently partnered with the Newark public schools and are working to have all 84 schools receive the award

PACNJ would like to recommend that to expand this statewide effort for system change and continue to motivate schools to remain proactive in their approach to asthma management, that policies be established to offer those schools who are recognized as complying with the Law and being asthma friendly receive priority when state funding is made available to schools.

To reach the under five population PACNJ worked in partnership with the child care health consultants from the 21 resource and referral agencies throughout the state to develop two levels of asthma education to impact statewide on asthma management.

- PACNJ developed a bilingual asthma video resource kit "Steps to Controlling asthma in the Child Care Setting" for child care providers and this was piloted in Camden Trenton and Burlington. The 21 Child Care Health Consultants were trained to continue offering the program in their counties across the state and over 500 child care providers have received the training.
- PACNJ recently developed a training for child care center directors and family home providers, "Policies and Practices for Asthma Friendly Child Care" for those who establish policies at their centers. That program was piloted in Newark, Plainfield and New Brunswick. All 21 Child Care Health Consultants were trained to facilitate this program and continue to conduct it across the state. Over 200 directors have received the training at local sites and statewide conferences since September 2006.
- PACNJ is currently working with Professional Impact NJ to establish these trainings as part of their Directors Training Academy so that it will be sustained as an on-going

training program statewide for Child Care Center Directors and Family Child Care Providers.

- PACNJ is partnering with the Newark Pre-School Council Head Start program to provide both training programs to their 300 child care providers and 30 center directors.

The next step in establishing this system change to reach over 9000 child care settings in New Jersey is to establish an incentive program with an Asthma Friendly Child Care Center Award. PACNJ would like to recommend that funding be targeted to continue this effort and that PACNJ continue in the role of bringing the partners together to facilitate progress.

Emergency Room Visits:

- Children are more likely to visit the emergency department for asthma when compared to adults. In 2004 alone, there were 19,160 emergency department visits for asthma among children in New Jersey.
- In 2004, black children in New Jersey were over 3 times more likely to visit the emergency department with asthma when compared to white children. In the same year, Hispanic children in New Jersey were more than 1 ½ times more likely than non-Hispanic children to be hospitalized for asthma.
- The burden of asthma is disproportionately distributed throughout the state with Essex County experiencing the highest age adjusted hospital discharge rate for asthma and the highest age adjusted Emergency Department Visit Rate for asthma. For example, the age adjusted ED visit rate for asthma in Essex County (1370 visits per 100,000 population) was more than 6 times higher than the Hunterdon County rate (215 per 100,000 population) in 2004.

As mentioned before, in addition to schools and child care providers, PACNJ is working with physicians, communities, health insurers and environmental agencies for statewide system changes. It is this approach that is aimed at reducing emergency room visits.

Physician Education for System Change

This past year PACNJ worked with the New Jersey Chapter of the American Academy of Pediatrics to develop an asthma education program for system change in physician's offices. This program is being piloted in Trenton with 11 physician practices and involves all office personnel and medical staff in the establishment of systems that improve asthma care. This requires a shift from an acute care perspective to a chronic care model and can be expanded to other cities with appropriate funding.

The National Heart, Lung and Blood Institute identified in their Guidelines for Best Practice in asthma management the importance of an asthma action plan for communicating between physician and patient. This tool has been developed by PACNJ and tracked for effectiveness through the school nurses. It has now been revised in response to the school nurse survey that identified problems with physicians in implementation. PACNJ has partnered with the New Jersey Primary Care Association to link with the New Jersey Federally Qualified Health Centers participating in the Asthma Collaborative to test this tool with their patients.

Communities for Change:

New Jersey was selected as one of six states to participate in a national initiative by the Agency for Healthcare Research and Quality (AHRQ) to address disparities in asthma. PACNJ has participated on the AHRQ team and as a result, all the PACNJ asthma educational materials were reviewed for cultural competency. Currently the AHRQ is developing guidelines PACNJ and others in the state can use for developing asthma tools that are culturally competent for the

diverse populations in New Jersey. The tools will include patient cultural beliefs and folk remedies associated with asthma that can be a barrier to patient compliance. The AHRQ is also developing a protocol for convening focus groups on asthma from the target populations hardest hit by the disease. PACNJ has a unique opportunity to implement these tools through our Community Task Force and revise our current materials to more fully meet the needs of the children and their families with asthma.

The New Jersey AHRQ team is also looking at asthma morbidity at the city level and is finding that certain cities experience disproportionate hospitalization and Emergency Department visit rates for asthma. The team is planning an Emergency Department intervention to target Trenton and Camden with the hopes of raising awareness, garnering support, and extending the program to other affected cities including Newark.

PACNJ has maintained a website that increasingly serves as a statewide resource for all our materials and links to many resources statewide. We anticipate that soon it will be necessary to revise our materials to stay current with changes in asthma management including cultural competency, changes in the NHLBI Guidelines, and changes in medication.

We need your help to sustain our statewide coalition that targets communities most in need with new programs and then expands those programs for statewide change. Funding allocated annually to continue the work with schools, child care, communities, physicians and environmental agencies is needed. And as stated before, policies need to be established to offer those schools who are recognized as complying with the Law and being asthma friendly to get priority when state funding is made available to schools.

Thank you again for the invitation to speak with you about the burden of asthma, PACNJ's effort to impact statewide with sustainable system change for managing asthma and the need for funding to support this effort.

New Jersey Asthma Statistics

Asthma is a one of the most common chronic diseases affecting children:

- Results from the 2003 National Survey of Children's Health suggest that about 255,484 children in New Jersey (12% of the pediatric population) have a history of asthma.
- Results from the 2003 National Survey of Children's Health also suggest that about 180,159 New Jersey children (9% of the pediatric population) currently have asthma.

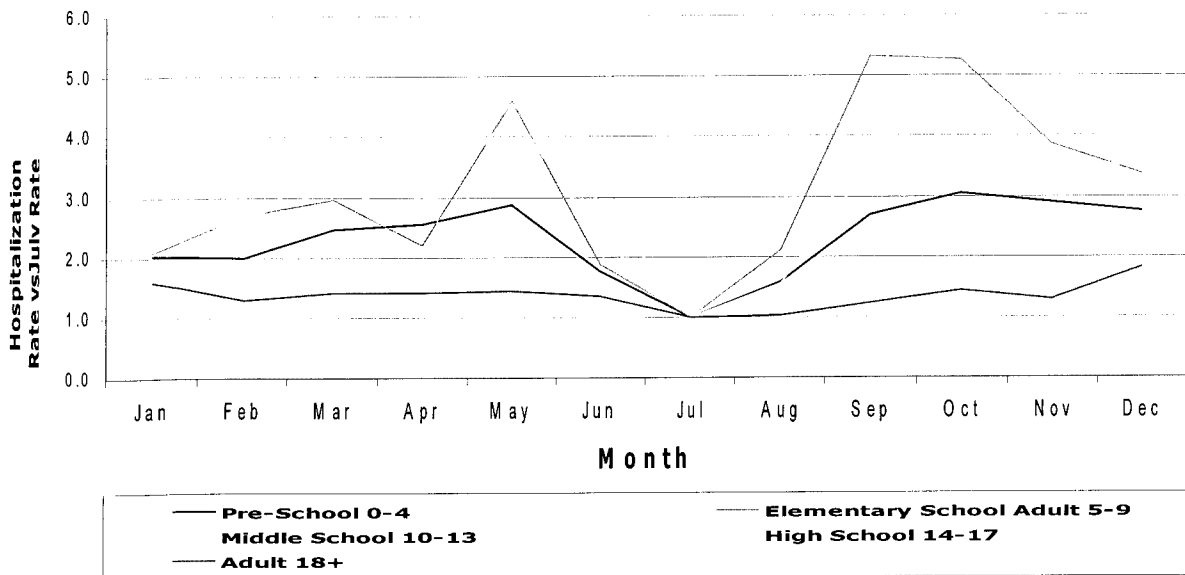
Asthma has a widespread impact on children:

- When uncontrolled, asthma can result in activity limitations, missed school days, emergency department visits, hospitalizations and even death.
- According to national estimates from CDC, asthma accounts for about 14 million lost days of school annually.
- National data from the 2005 Youth Risk Behavior Surveillance System suggest that about 38% of high school students with current asthma experienced an episode of asthma or asthma attack in the prior year.
- Children are more likely to be hospitalized with asthma than adults. In 2004, there were 5,175 asthma hospitalizations for children in New Jersey.

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- Children are more likely to visit the emergency department for asthma when compared to adults. In 2004 alone, there were 19,160 emergency department visits for asthma among children in New Jersey.
- Hospitalizations for asthma demonstrate distinct seasonal patterns among children in New Jersey. Rates are lowest during the summer and highest during the spring and fall months. These seasonal peaks are most apparent among school age children. For example among elementary school age children, the May asthma hospitalization rate is 4.6 times the July asthma hospitalization rate and the September and October rates are 5.3 times the July asthma hospitalization rate.

**Seasonal Hospital Discharges for Asthma,
New Jersey 2003-2004**



Black and Hispanic residents are disproportionately affected by asthma:

- Childhood asthma prevalence varies by race/ethnicity with Hispanic and black children experiencing higher rates when compared to non-Hispanic and white children.
- In 2004, black children in New Jersey were over 3 times more likely to be hospitalized with asthma when compared to white children. In the same year, Hispanic children in New Jersey were more than 1 ½ times more likely than non-Hispanic children to be hospitalized for asthma.
- In 2004, black children in New Jersey were over 3 times more likely to visit the ED with asthma when compared to white children. In the same year, Hispanic children in New Jersey were more than 1 ½ times more likely than non-Hispanic children to be hospitalized for asthma.

Geographic disparities exist throughout the state:

- The burden of asthma is disproportionately distributed throughout the state with Essex County experiencing the highest age adjusted hospital discharge rate for asthma and the highest age adjusted Emergency Department Visit Rate for asthma. For example, the age adjusted ED visit rate for asthma in Essex County (1370 visits per 100,000 population) was more than 6 times higher than the Hunterdon County rate (215 per 100,000 population) in 2004.

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- The New Jersey AHRQ team is looking at asthma morbidity at the city level and is finding that certain cities experience disproportionate hospitalization and ED visit rates for asthma. The team is planning an ED intervention to target Trenton and Camden with the hopes of raising awareness, garnering support, and extending the program to other affected cities including Newark.

Respectfully Submitted by,
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Testimony of Linda Holmes
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New Jersey Department of Health and Senior Services
Assembly Regulatory Oversight Committee
Thursday, December 6, 2007

Issue: Health Disparities

Good Morning Mr. Chairman and members of the Assembly Regulatory Oversight Committee. I appreciate the opportunity to provide the Committee information on the important issue of health disparities.

Last spring, when providing testimony to this committee, I indicated that the Department had developed a plan to address health disparities and had begun implementation. Since the release of the ***Strategic Plan to Eliminate Health Disparities in New Jersey*** in March 2007, the New Jersey Department of Health and Senior Services (NJDHSS) has made some strides in its efforts to address health disparities. The plan covers several areas where steps to strengthen and expand efforts already in place are listed as objectives for accomplishing the major goal of eliminating health disparities in New Jersey.

Health disparities are complex and longstanding; addressing them requires many comprehensive approaches. We know that in order to measure the impact a health disparities initiative may have on health outcomes requires time and an understanding of these complexities.

Progress is being made in meeting objectives in medical priority areas from asthma to obesity. Our partnerships with Federally Qualified Health Centers and community based organizations are making a difference in linking minority communities with needed health care services in the areas of asthma and diabetes. In the area of obesity, Dr. Fred Jacobs, NJDHSS Commissioner, recently joined with the Commissioners of Education and Agriculture in a statewide awareness campaign to emphasize the importance of obesity prevention among children.

We are also seeing progress in accomplishing objectives in the infrastructure areas where NJDHSS is reaching short term objectives. The infrastructure areas—language access, data, minorities in the health professions and community links—strengthen the department's ability to set examples in critical components of the Eliminating Health Disparities Initiative.

NJDHSS major new initiatives include work in the areas of language access and data. In the infrastructural area of language access, the department has made several significant steps in improving its ability to provide culturally competent resources for New Jersey's diverse population.

Through collaborative projects with the New Jersey Hospital Association, the NJDHSS implemented a demonstration project to train bilingual staff as medical interpreters. Shore Memorial Hospital, South Jersey Hospital, and AtlantiCare will be the first hospitals in the state where bilingual staff will be trained through this project.

For the first time, medical interpreters are making use of a communication picture board distributed widely by NJDHSS. Two thousand five hundred boards were distributed to hospitals and Federally Qualified Health Centers (FQHCs) this spring.

The Department has also created an invaluable resource by adding a Spanish portal to its Office of Minority and Multicultural Health (OMMH) website. This portal provides health education resources and information in Spanish.

In addition, OMMH provided a training seminar in health literacy to make certain that health education materials produced by NJDHSS are easy to read and understand. Far too often, health information is so filled with technical jargon that key messages that could make our communities healthier are missed or misunderstood.

In the area of data, NJDHSS has made significant policy changes to standardize statewide practices in collecting and reporting racial and ethnic data. The Department has established policy to require all hospitals to report data on race and ethnicity as well as primary language spoken in uniform categories. In the future, all health care providers, local health departments, grantees, and other entities reporting to the State will be required to use the standardized categories. Because collecting data is critical to tracking and monitoring progress in addressing health disparities, implementation of policy to standardize the collection of data is an important step in the overall initiative to eliminate health disparities.

This fall the Department took steps to meet its objective to increase minorities in the health professions by launching its mentoring program. Human Resources enlisted volunteers to serve as mentors and identified protégées. A training for potential mentors was held in September.

In the area of community outreach, the NJDHSS continues to support initiatives to empower communities with education and resources to manage their health. The Office of Minority and Multicultural Health remains convinced that minority community based organizations that have the trust of the communities they serve have a pivotal role in educating and linking hard to reach populations to needed services. Most recently, a program to manage chronic diseases has been established and is being monitored by both the OMMH and the Division of Aging and Community Services (DACS). Seven minority community-based agencies were granted funding to be trained and then to offer the training in the

communities they serve. For the first time in New Jersey, the training will also be offered in Spanish.

The importance of tapping respected community resources has also been identified in the medical area of cancer. The Barbershop Initiative is a program that has been noted for its success in recruiting African American men for prostate cancer screening. Because of its success in two counties, this initiative will be replicated in all of New Jersey's 21 counties.

In the overall effort to raise awareness of health disparities and to encourage effective DHSS initiatives, the OMMH continues to host the annual Commissioner's Health Disparities Symposium, which brings together public health practitioners, health care providers, academicians and policy-makers from the national arena to identify best practices to address the complex issues contributing to racial/ethnic health disparities. In a meeting that included NJDHSS senior management and OMMH advisors, this year's focus was "Understanding social determinants of disparities: translating what we know into action." That roundtable took place at The Robert Wood Foundation on Tuesday, December 4.

This meeting highlighted the importance of strengthening collaboration across state agencies to understand and address some of the root causes of differences in health outcome. National public health experts agree that environment, housing, education, jobs, incarceration rates, segregation, insurance coverage all contribute to the causal web of health disparities.

New Jersey continues to receive national recognition for its work in developing a comprehensive health disparities plan. New Jersey's health disparities plan was noted as a model at the National Conference of State Legislatures (NCSL) in Boston, Mass., as well as at the National Committee for Quality Assurance (NCQA) conference in Washington, DC, "Breakthroughs in Reducing Health Care Disparities."

As the plan was released as a three-year endeavor, the Department intends to continue several of the initiatives already in place and develop new strategies. The OMMH will continue the Commissioner's Health Disparities Symposium; the Department intends to expand the medical interpretation training to additional counties as well as expand access to other language services and resources; and, new departmental reports which are expected to reflect the standardized categories will expand knowledge on the effectiveness of New Jersey health disparities initiatives focusing on specific health areas highlighted in the Plan.

Most importantly, data will track whether the initiatives in the medical priority areas are making a difference for African Americans, Latinos, South Asians and other minority groups. Data will also point to best practices; some of which we have already identified.

This progress report, while focusing on a span of only nine months, affirms the benefits of having established such a comprehensive plan. This blueprint is being used to track the continued progress of the Department and the state in eliminating health disparities.