

Strategic Plan to Eliminate Health Disparities in New Jersey: Update & Addendum

2010

New Jersey Department of Health & Senior Services,
Office of Minority and Multicultural Health



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Strategic Plan to Eliminate Health Disparities
Update and Addendum

June 2010

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Introduction

The 2004 *Eliminating Health Disparities Initiative* was established through legislation (NJSA 26:2-167) within the Department of Health and Senior Services (DHSS). A major component of the Initiative was to develop the *Strategic Plan to Eliminate Health Disparities in New Jersey* (Disparities Plan), which was released in March 2007. The Disparities Plan outlines the DHSS' current activities in addressing racial and ethnic health disparities in New Jersey. Further, it lists departmental goals for eliminating disparities together with an action plan for achieving set goals and measuring outcomes.

Through the 2007 Disparities Plan, DHSS programs established timelines and outcome measures for closing gaps in health particularly within specific medical areas. The Plan also outlines actions required to strengthen DHSS' infrastructure in four areas - language access, collection and report of race/ethnicity data, minorities in health professions and community outreach. Seven of the medical areas of emphasis - asthma, cancer, cardiovascular disease, diabetes, HIV/AIDS, infant mortality and unintentional injuries – were included in the 2007 Plan. An update to the March 2007 Plan was published in December of 2007. The update provided a progress report on the status of objectives outlined in the initial Disparities Plan. It is available online together with the *Strategic Plan to Eliminate Health Disparities* on the OMMH website at www.nj.gov/health/omh.

This Disparities Plan Addendum provides an update of progress made within DHSS in both medical and infrastructure areas since the Plan's release and also adds the medical areas which were required by the 2004 legislation. The added health areas are kidney disease, hepatitis C, sexually transmitted diseases, immunization and violence.

Using the same format as the previous edition, the Addendum examines the medical areas of emphasis, using available data and programmatic information provided by DHSS staff. These data are meant to describe the problem and identify higher risk groups in each area. Information on DHSS existing programs in place to address these conditions, and goals for eliminating disparities noted are provided. Steps for achieving set goals and methods

for measuring the actual outcomes are also specified. In addition, this Addendum includes an update on the status of DHSS actions on eliminating health disparities since the most recent update in December 2007.

I. Update on DHSS Activities

A. Office of Minority and Multicultural Health Initiatives

Language Access - Medical Interpreters Training Program Pilot Project

The Department has improved its ability to provide culturally competent resources for New Jersey's diverse population through continued collaboration with the Health Research and Educational Trust of New Jersey (HRET), a nonprofit affiliate of the New Jersey Hospital Association. This collaboration includes a demonstration project to train bilingual hospital staff to be medical interpreters. In 2009, 56 medical interpreters were trained in five South Jersey hospitals. In addition, OMMH supported training for 24 community based leaders to function as guides to help interpret or act as liaisons for minority clients navigating the health care system.

Minorities in Health Professions – Dental Tool Kit

One aim of the OMMH is to support and develop initiatives to increase the number of minorities in health professions. With collaboration from the New Jersey Dental Association, the OMMH created a tool kit, *Exposing Diverse Students to Oral Health Professions*, that would help high school guidance counselors attract minority students to learn more about careers in oral health professions.

The tool kit gives general information about the highlighted professions – dental laboratory technician, dental assistant, dental hygienist and dentist – and academic requirements for completing programs leading to those careers. It also provides detailed instruction on how to invite an oral health professional to the schools to describe the careers in dentistry in greater detail. In addition, oral health statistics and statewide resources are described within the Tool Kit. The OMMH hopes to inspire minority students to pursue oral health professional career programs. The Tool Kit was published in November 2009.

Community Outreach - Expansion of NJ FamilyCare

NJ FamilyCare is a federal and state-funded health insurance program created so that New Jersey's uninsured children and qualifying parents and guardians can have affordable health coverage.

The OMMH has linked minority serving community-based organizations (CBOs) to the *NJ FamilyCare* enrollment and retention campaign. These CBOs will be targeting minority populations to enroll those who qualify into the state-run health insurance program. Collaborating with the Department of Human Services (DHS), the OMMH channeled DHS funds to six minority-serving, community-based agencies to participate in the outreach and recruitment initiative of *NJ FamilyCare*. Each agency received \$30,000 for recruitment and training. This project covered outreach, including local advertising and enrollment activity, and provided direct application assistance for the enrollment of uninsured children under age 19 in the *NJ FamilyCare* program.

Community Outreach - Community Health Mobilization Grants

The OMMH continues to provide leadership in addressing health disparities through the *Community Health Mobilization Grants: Reducing Asthma and Diabetes Disparities* awarded to community-based minority serving or faith-based organizations. These CBOs and FBOs work from within the community to improve self management and quality of care in diabetes and asthma treatment and prevention. Evidence based strategies including education, local outreach and self evaluation are implemented to (1) reduce pediatric emergency department visits and school absences for asthma in minority communities by reducing exposure to asthma triggers and by improving ability to self-manage asthma symptoms and (2) improve diabetes outcomes in minority communities by increasing diabetes awareness and screening, access to care, and available self-management resources.

Currently, eight agencies participate in the grant program, and they target the African American, Latino and Asian American communities. Also, for the first time, an agency serving the American Indian community in New Jersey has received an award for this grant program. OMMH partners with the Division of Family Health Services to administer the grants.

During Fiscal Year 2008-09 the OMMH Pediatric Asthma Intervention Grants accomplished the following positive outcomes:

- The asthma grants facilitated 2,705 outreach encounters with minority children with asthma or with high risk for developing asthma.
- About 22% (586) of these children were screened and found they had been diagnosed asthma.
- The number of visits to the emergency rooms was reduced by 88% in 25 children that participated in the asthma management programs of these grants.
- The number of school absences in 32 children who participated in the asthma management programs was reduced to 45 percent.

In Fiscal Year 2008-09, OMMH Diabetes Intervention Grants accomplished the following positive outcomes:

- OMMH Diabetes Grants facilitated 5,127 minority outreach encounters. From this figure 2,109 or 41% were found to be at risk for developing diabetes when they were screened with the American Diabetes Association Risk Test (ADART) in their communities.
- About 4 percent or 81 of the ADART screened patients were referred for medical screening. From this number, 14% had a previous diagnosis of diabetes but showed a poor diabetes management and 63% were diagnosed with diabetes for first time. Another 23% were diagnosed with Pre-Diabetes after the clinical glucose screening.
- A 100% of the referred patients had no health insurance.

Community Outreach - Chronic Disease Self Management Program – *Take Control of Your Health!*

In 2006, the Division of Aging and Community Services (DACS) within the Department of Health and Senior Services, received a grant from the U.S. Administration on Aging to implement an initiative designed to provide people with chronic conditions (e.g., asthma, heart disease, diabetes, obesity) and their caregivers the knowledge, skills and confidence to take a more active part in their health care. This Chronic Disease Management Program was developed by the School of Medicine at Stanford University in California

and is recognized as a premiere, evidence-based health promotion and disease prevention program. Researchers who studied the program found that participants with heart disease, lung disease, stroke or arthritis experienced major improvements in their overall health. They reported improved ability to exercise, manage their symptoms, and talk with their healthcare professional. Program participants also reported spending fewer days in the hospital.

In 2007, OMMH collaborated with DACS to implement this program within racial/ethnic communities. OMMH identified minority serving community based and faith-based agencies that worked within Latino, Asian and African American communities. The partnership began with funding seven agencies in 2007, added five more in 2008, and another five in 2009. These agencies were awarded mini-grant funding to implement the *Take Control of Your Health* program to New Jersey residents from African-American, Latino, Asian (Chinese, Korean, South Asian) and Haitian communities. To date, \$560,000 in funding has been awarded to 18 agencies.

When *Take Control of Your Health* was first implemented in New Jersey, only 3% of the participants were racial/ethnic minorities. However, with the collaborative efforts of OMMH and DACS, the percentage rose to 42% (27% Hispanic, 43% African American, 13% Asian and 3% American Indian). In addition, New Jersey residents can now attend workshops in their native languages of Spanish, Korean, Cantonese, Mandarin, Haitian Creole, and Hindi. The benefits of the program have been repeatedly demonstrated by reports of fewer hospitalization days, significant improvements in physical activity and cognitive symptom management, and a reduced number of outpatient visits made by those who have completed it.

Community Outreach – Community Round Tables

During the spring of 2008, the OMMH sponsored community roundtable discussion groups —*Speak Up About Health for Your Community*—in Atlantic City and Newark. These roundtables gave community members an opportunity to voice their concerns and give suggestions for addressing health disparities statewide. Roundtable participants

reported that there were many barriers to improved health including limited proximity to grocery stores that sell fresh produce, lack of the availability of convenient health services and access to safe places to exercise. These particular concerns highlight the importance of recognizing the importance of less obvious social determinants of health when addressing health disparities. The report on the roundtable discussions, *We Hear You: Community Voices on Health Disparities*, is available on the OMMH website.

Commissioner's Health Disparities Symposium

In September 2009, OMMH held its the third annual New Jersey Department of Health and Senior Services Commissioner's Symposium, "Closing the Gap in Health Access and Quality: A Focus on Best Practices." Attendees included the DHSS senior staff, DHSS grantees and their invited guests, and a small number of invited academic and medical health disparities researchers.

This full day program was designed to share DHSS and its grantees' successes in addressing health disparities, and to review existing national and state frameworks for eliminating health disparities. A discussion on how to fully integrate health disparities initiatives throughout the Department, particularly through Healthy People 2020 planning was facilitated by the Commissioner.

Common themes have emerged in the evaluation of various programs and initiatives executed within the DHSS since the Disparities Plan was published in 2007. Numerous successful collaborations within the Department have increased public health efforts directed to racial/ethnic minority communities statewide. These efforts should be continued and expanded whenever possible. DHSS self assessment initiatives have forced those implementing policies and interventions to consider more culturally competent methods of accessing minority populations, and to use evidence-based, best practice approaches to address persistent barriers to health equity. Concentrated, continuous and multi-faceted efforts are required to attain DHSS' goal of eliminating health disparities. OMMH will continue to monitor health disparities statewide, and to report on the successes and challenges of methods employed.

B. Additional DHSS Health Disparities Initiatives

Several initiatives in other divisions and programs within the Department of Health and Senior Services exemplify promising practices in addressing health disparities. Recent and ongoing activities are described below.

Blue Ribbon Panel on Immigrant Health

In August 2007, New Jersey issued an executive order creating the *Governor's Blue Ribbon Advisory Panel on Immigrant Policy*. The *Panel* was charged with developing recommendations for a comprehensive and strategic statewide approach to successfully integrate the rapidly growing immigrant population in New Jersey.

The Department of Health and Senior Services was assigned to the social services subcommittee, which focused on two major areas: cultural competency/language access and access to services. The social services subcommittee made recommendations based on two goals: (1) ensuring access to needed social and health services; and (2) ensuring that those services are delivered in a culturally and linguistically competent manner. The committee advised that several strategies could be employed to reach these goals including: increasing the number of medical interpreters; training and certification of medical interpreters; increasing the use of patient navigators; providing more comprehensive primary care in safety net settings; and expanding health insurance coverage.

Immigrant Health Report

The publication of the Immigrant Health in New Jersey report is currently scheduled for release in 2010. This report provides an overview of demographic and geographic trends of the state's foreign-born population, and examines the impact of nativity and race/ethnicity on the health status of New Jersey residents. It provides a comparison of health behaviors and outcomes between US born and Foreign-born New Jersey residents

and also some analyses on the impact of acculturation on the health of New Jersey's foreign-born population.

The report was prepared by the staff of the Center for Health Statistics and earlier drafts were reviewed and commented on by the OMMH Advisory Commission. The report provides relevant data on a growing minority population in New Jersey, opening the dialogue for addressing health concerns among this group.

Bureau of Vital Statistics Language Access Services

The Bureau of Vital Statistics (BVS) within DHSS' Office of the State Registrar provides vital statistics information for the state. BVS found that many of the requests received from consumers were coming from individuals whose primary language spoken is Spanish. BVS began planning to make its services more accessible to New Jersey's Spanish-speaking population.

BVS hired bilingual staff and made key changes in services provided. The Bureau of Vital Statistics' website was completely translated into Spanish. The Customer Service Telephone Line added a Spanish speaking representative and many BVS forms were also translated into Spanish.

Prenatal Care Task Force

When a 2007 study ranked New Jersey 40th in the nation in the percentage of women receiving first trimester prenatal care, the New Jersey Department of Health and Senior Services, made this issue a priority. Then Commissioner Heather Howard convened the *Prenatal Care Task Force* in February 2008.

The charge of the *Task Force* was to review data related to prenatal care access, including racial and ethnic disparities and to make recommendations for effective policies and strategies that improve access to early prenatal care and increase the number of women

seeking and receiving care. The *Task Force* was also charged with reviewing the adequacy of the provider network and identifying any regional or geographic barriers to care; reviewing best practices and identifying successful programs to increase prenatal care; reviewing current support for improved pregnancy outcome activities; and making recommendations to improve first trimester prenatal care rates in New Jersey.

The *Task Force* was comprised of leaders and experts in the field of maternal and child health who made recommendations to the Commissioner. The recommendations include increasing public awareness of preconceptional health; ensuring the availability of ongoing early prenatal care services for women in areas affected by hospital closures and reductions in obstetric services; and promoting equity in birth outcomes. The report is available on the DHSS website at:

www.state.nj.us/health/fhs/documents/task_force_report.pdf.

II. Medical Areas of Emphasis & Action Plans

Addendum 2010 Priority Areas - Summary of Disparities

Priority Area	Summary of Disparities
<i>Hepatitis C</i>	Among deaths for which hepatitis C is a contributing factor, Blacks have 3 times higher death rates compared to Whites.
<i>Chronic Kidney Disease</i>	<p>Mortality from kidney disease is highest among Blacks. Death rates among Blacks are more than 2 times higher compared to Whites.</p> <p>The incidence rate of end-stage renal disease among adults diagnosed with diabetes is nearly 2 times higher among Blacks.</p>
<i>Sexually Transmitted Diseases</i>	<p>Blacks and Hispanics have the highest rates of sexually transmitted diseases.</p> <p>Non-white New Jersey residents have syphilis incidence rates that are 3 times higher than white residents.</p>
<i>Immunizations</i>	<p>Blacks aged 65 and older are significantly less likely to receive influenza and pneumococcal vaccines compared to Whites.</p> <p>Deaths due to pneumonia or influenza are highest among Blacks.</p> <p>Minority children younger than 2 years old are less likely to obtain all the recommended vaccinations compared to Whites.</p>
<i>Violence</i>	<p>Homicide rates are nearly 12 times higher among Blacks, and 2 times higher among Hispanics compared to Whites in New Jersey.</p> <p>Among males 15 to 19 years old and 20 to 34 years, rates among Blacks are 10 times and 4 times higher respectively, compared to all males.</p> <p>Hispanic homicide rates are 4 times higher compared to Whites.</p> <p>Among 15 to 19 year old Hispanic males, homicide rates are 27% higher than compared to the total New Jersey population.</p>

A. Area of Emphasis: HEPATITIS C

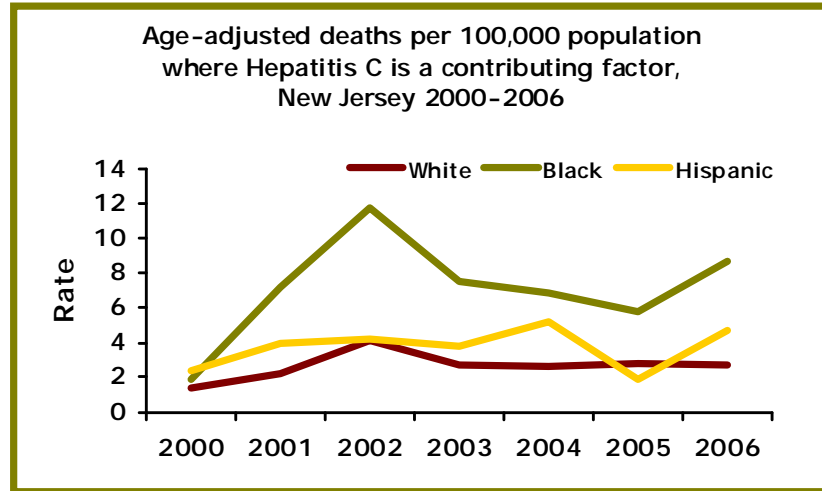
Background Data

Hepatitis C Viral (HCV) infection occurs among persons of all ages, with the highest incidence of acute HCV (new cases) occurring among persons aged 20 to 39 years. The virus is spread from person to person through exposure to contaminated blood and blood products. The most common mode of transmission is sharing needles or syringes to inject drugs. Sexual transmission of HCV does occur, but is not common. HCV is not spread via casual contact, kissing, sneezing, hugging, sharing glasses or eating utensils or breast milk. People at greatest risk of infection are injection drug users, patients with hemophilia or long-term dialysis, prisoners and people who received blood or organ products prior to June 1992. An estimated 160,000 New Jersey residents live with hepatitis C. There is no vaccine available for hepatitis C.

In 2007, approximately 7,200 new hepatitis C cases (acute and chronic) were confirmed in the state (2007 New Jersey Reportable Communicable Disease Report). This figure represents a large increase in the number of new cases reported, however, that is due to a sharp increase in reporting of HCV infection in New Jersey. Most of these newly reported cases are not people with new (acute) disease, but previously undiagnosed people who were only recently reported.

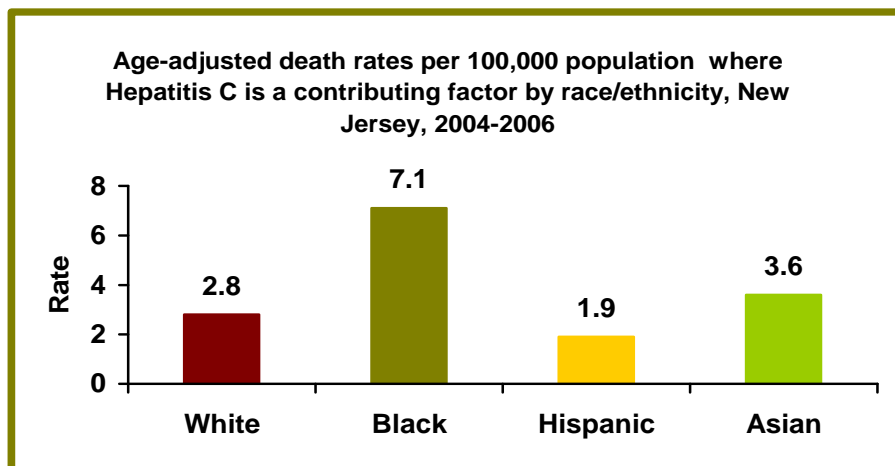
A blood test is the only way to determine if a person is infected with the hepatitis C virus. The virus can usually be detected in the blood within 1 to 3 weeks after the initial exposure. HCV infections are typically classified in two ways: acute (or new infection) or chronic (infected a while ago). Most people are asymptomatic during the first decade or two of chronic hepatitis C. Some people experience a range of symptoms including fatigue, headaches, joint aches, muscle aches, nausea, jaundice (yellowing of the skin and eyes), loss of appetite and/or abdominal pain. Of those chronically infected, about 10 to 20 percent may eventually develop cirrhosis or cancer of the liver. Cirrhosis can lead to liver failure in some people and put them at higher risk for developing liver cancer.

Mortality



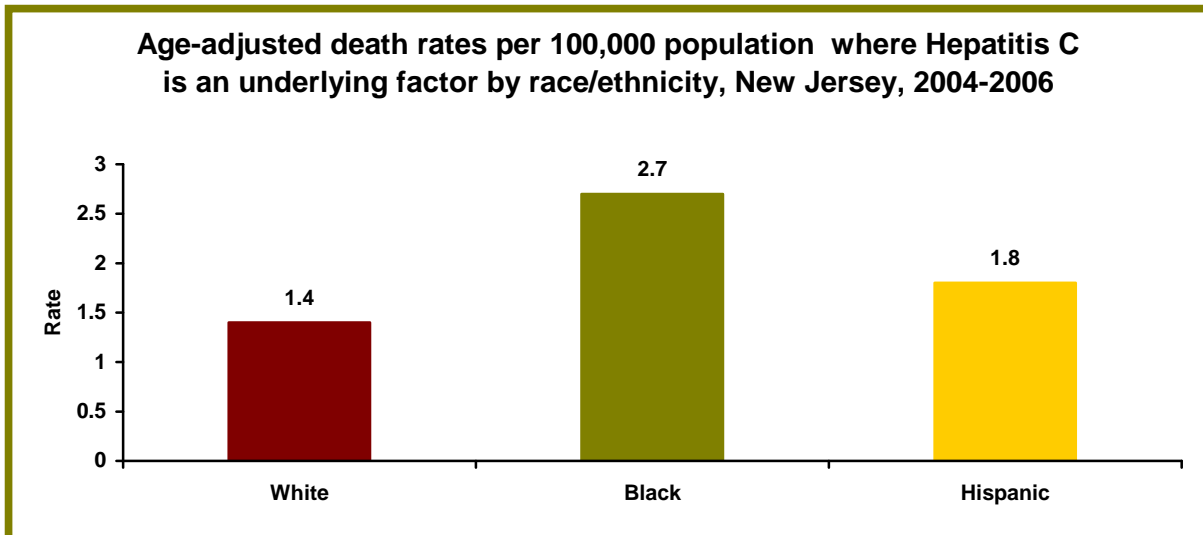
Source: DHSS, Center for Health Statistics, Vital Statistics Data

Hepatitis C is categorized as having been either a *contributing factor* of death (a major component in the cause of death) or an *underlying factor* (the disease which initiated the chain of events leading directly to death). Deaths with HCV as a contributing factor have increased nearly 25% since 2000. During this period from 2000 to 2006, there were a total of 2,027 deaths among New Jersey residents for this cause. Hepatitis C was the primary contributing factor in 77 percent of these deaths and it was the secondary factor in another 20 percent; the 2006 death rate with this contributing cause is 3.2 per 100,000 U.S. standard population.



Source: DHSS, Center for Health Statistics, Vital Statistics Data

Death rates with hepatitis C as a contributing factor were highest among Blacks and were more than three times higher from this cause compared to Whites. Asian death rates were nearly 30% higher. Deaths from this cause are lowest among Hispanics, 47% lower in comparison to Whites.



Source: DHSS, Center for Health Statistics, Vital Statistics Data

Due to the fact that each death may have several contributing causes but only one underlying cause, 2006 death rates where hepatitis C is an underlying cause of death are lower overall (1.8 per 100,000 population) compared to deaths where hepatitis C is a contributing factor. Rates with hepatitis C as an underlying cause are still highest among Blacks (2.7 per 100,000). There are too few deaths among Asians to compute a reliable rate.

Building on Success

- The Communicable Disease Service (CDS) is collaborating with the Division of HIV/AIDS and Addiction Services to incorporate information about HCV into existing training curricula. HIV, Sexually Transmitted Disease (STD), Syringe Exchange and Addictions counselors receive additional training about prevention and testing to increase their knowledge about the disease so that they can inform their clients and other high-risk individuals. As a result of this collaboration, health professionals are able to incorporate harm reduction principles concerning the hepatitis C virus into existing counseling and outreach efforts. Since there is no

vaccine for HCV, preventing the spread of disease and stopping infection is an important part of harm reduction.

- DHSS is working with public health partners to offer available hepatitis A and B vaccines to those infected with HCV. Partnering with primary care centers, STD clinics and methadone maintenance facilities to offer the vaccine increases the likelihood that high-risk persons already infected with HCV will not contract other viruses which are vaccine-preventable.
- As required by legislation passed in 2008, DHSS convened an advisory board of health professionals. Clinical and research professionals were identified and recruited to the board. The goal of the Hepatitis C Advisory Board is to provide advice and recommendations to the Commissioner regarding matters relating to hepatitis C. The board has met and begun discussion of the development of a guidebook that will provide the public with health education resources as well as information on support groups and clinical, vaccine and screening resources.
- May is Hepatitis Awareness Month. DHSS is leading efforts to increase the awareness of the disease to reduce infection rates in the state. The DHSS submitted a proclamation in 2007 and the State recognized hepatitis as a serious public health issue for New Jerseyans. In 2009, another proclamation was approved by the State to continue to promote awareness and understanding of viral hepatitis and prevention efforts.
- DHSS and Department of Corrections staff developed and filmed a video about HCV prevention. The video featured clinical staff from both state agencies and provided background information tailored to the incarcerated population. After filming was completed, inmates edited the video and added graphics. The video was distributed to prisons in the state and to other interested facilities.

Goal: To promote awareness of and educate the general public, especially high-risk groups, about hepatitis C and offer strategies to reduce the occurrence of new infections.

Action Plan

Steps and Timeline:

- Continue to create linkages with public health partners and other state agencies to promote knowledge and understanding of hepatitis C prevention and screening.
- Integrate information on hepatitis C into existing HIV and STD training curricula to increase awareness.
- Update and maintain the viral hepatitis webpage on the DHSS Communicable Disease Service website.
- Conduct a focus group with New Jersey prisoners to obtain feedback on the hepatitis C video.
- Revise the New Jersey Hepatitis Strategic Plan with the assistance of the Hepatitis C Advisory Board.

Outcome Measures

- Increase the number of primary care centers, STD clinics and methadone maintenance facilities that offer HAV/HBV vaccine to high-risk persons.
- Increase awareness of viral hepatitis by New Jersey public health and healthcare professionals with the integration of viral hepatitis information in education curricula and training materials.
- Provide ongoing viral hepatitis education to public health and healthcare professionals.
- Receive comments and usable feedback from prisoners regarding DHSS HCV education video.
- With the assistance of the Hepatitis C Advisory Board, revise the hepatitis C state plan submit it to the Commissioner of Health and Senior Services and post to the DHSS CDS website.

B. Area of Emphasis: CHRONIC KIDNEY DISEASE

Background Data

Recent professional guidelines classify levels of Chronic Kidney Disease (CKD) in five stages, with stage 1 the mildest, and usually causing few symptoms, and stage 5 the most severe, with poor life expectancy if untreated. Stage 5 CKD is also called established chronic kidney disease and is synonymous with the older known terms such as end-stage renal disease (ESRD), chronic kidney failure (CKF) or chronic renal failure (CRF). CKD or ESRD is the condition of progressive loss of renal function over a period of months or years. It can result in the total inability of the kidneys to function. The loss of kidney function results in the build-up of toxic substances in the body and bloodstream, which if untreated, leads to death. The main risk factors for complete kidney failure are a history of diabetes, hypertension, glomerulo-nephritis or polycystic disease.

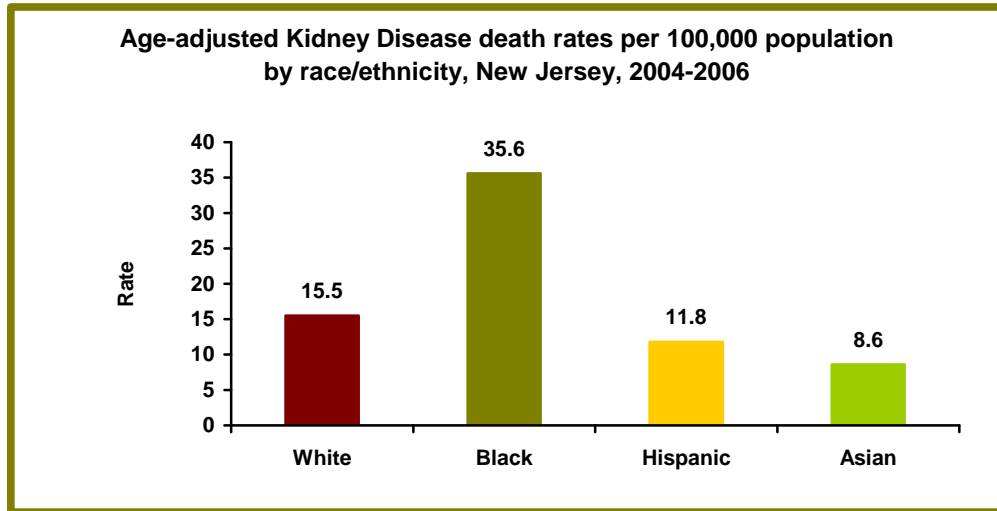
Incidence

According to the *Transatlantic Renal Council 2007 Annual Report*, consumers receiving dialysis in New Jersey were 57% male and 43% female. Forty-two percent of the population on dialysis was Black, 52% White, with other racial groups constituting the remainder. Thirty-eight percent of the consumers receiving chronic dialysis in New Jersey during 2007 were 70 years or older; 61% were aged 60 years or older. The senior population continues to be the fastest growing segment both receiving long-term chronic care and initiating treatment. Diabetes was the most frequently reported risk factor of all prevalent consumers on dialysis at 42%. The mean age of the prevalent patient population in 1980 was 49.6, in 1990 it was 53.4, in 2000 it was 56.9 and in 2004 it was 57.8 showing a steady progression toward an older population.

Mortality

In 2006, kidney disease was the tenth leading cause of death in New Jersey. The overall age-adjusted death rate from kidney disease is 17.0 per 100,000 population. Death rates from the disease were significantly higher among Blacks compared to Whites, whose rates were second highest compared to other racial/ethnic groups. Hispanic and Asian mortality from this cause is significantly lower compared to Whites. Chronic kidney

disease deaths are much higher among men compared to women. Black males have the highest rate of death from this cause of all race/gender groups.



Source: DHSS, Center for Health Statistics, State Health Assessment Data Query System (NJSHAD)

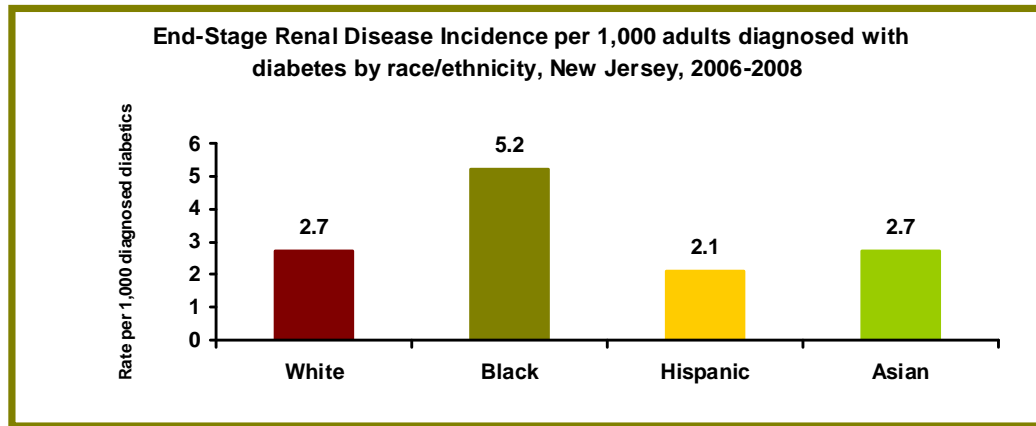
New Jersey Chronic Kidney Disease/End-Stage Renal Disease (CKD/ESRD) Consumer Reports

Death notification reports for New Jersey CKD/ESRD consumers were analyzed by sex, race, and cause of death. The primary cause of death reported in 2007 continued to be cardiac (47%), which reflected national data. Infection was reported as the primary cause in 17% of the 2,535 death records received. Of all deaths reported in 2007, 65% were White, 31% Black and 56% were male, 44% female. Primary diagnoses among deaths reported were diabetes (43%), hypertension (32%), and glomerulonephritis (7%).

End Stage Renal Disease

One Healthy New Jersey (HNJ) 2010 objective is to lower the incidence rate of ESRD per 1,000 diabetic persons aged 18 and older. Two major causes of ESRD are diabetes and hypertension. Since 1999, ESRD rates have declined steadily among all racial/ethnic groups but most significantly among Hispanics and Blacks. ESRD among Hispanics dropped more than 60 percent from 1999 to 2006. Among Blacks, the rate dropped 33

percent. Still, data from DHSS' Diabetes Control and Prevention Program reveal that ESRD rates are more than 90% higher among Blacks compared to Whites.



Source: DHSS, Center for Health Statistics, Diabetes Control and Prevention Program

Building on Success

The New Jersey Department of Health and Senior Services provides grant funds to the Trans-Atlantic Renal Council (TARC) for financial assistance to dialysis centers so that more than 1,500 low-income, chronic renal dialysis patients and other patients with (ESRD) can receive medications and nutritional supplements when there is no other source of payment. TARC's Chronic Renal Disease Program provides the professional framework within which the provision of quality care to consumers of end-stage renal disease are met by monitoring over 113 service provider facilities throughout New Jersey. The TARC's mission is to monitor service delivery; interact with consumers; collect and analyze data; work with other interested agencies; and promote the maximum rehabilitation potential in consumers. TARC monitors these services by conducting regular site visits, maintaining phone contact and providing approval for needed medications and supplements for diverse populations across New Jersey.

The TARC is in its ninth year of funding, which was utilized by 87 facilities in New Jersey with 94.2% of those funds disbursed for products such as nutritional supplements, cardiovascular and gastrointestinal agents as well as antidiabetic medications. Over 1,840 patients were serviced within these groups in 2008.

Goal:

- **To improve the quality and safety of dialysis related services provided for individuals with CKD/ESRD;**
- **Improve the independence, quality of life, and rehabilitation (to the extent possible) of individuals with CKD/ESRD through transplantation, use of self-care modalities, as medically appropriate, through the end of life;**
- **Improve patient perception of care and experience of care and resolve patient complaints and grievances; and**
- **To improve the collection, reliability, timeliness, and use of data to measure processes of care and outcomes; and to maintain the patient registry.**

Action Plan***Steps and Timeline:***

- Continue to work with the service provider facilities to ensure improvement in the quality of life among patients in underserved communities.
- Participate in a newly established Chronic Disease Advisory Council (CDAC) to provide expertise to the New Jersey community on the needs of patients experiencing Chronic Kidney Disease.
- Provide quality assurance among all the service provider facilities to ensure adequate service delivery; access to care and access to necessary supplements and medication for disparate communities and patients with CKD/ESRD.
- Convene the DHSS Chronic Kidney Disease Task Force to make recommendations on the implementation of a cost effective plan for preventing CKD and increasing early screening, diagnosis and treatment of Chronic Kidney Disease Statewide.
- The Chronic Kidney Disease Task Force will publish a set of recommendations on what strategies should be employed to reduce health disparities in the treatment and diagnosis of CKD within one year of its first meeting in 2010.

Outcome Measures

- Increase the number of patients served and number of facilities serving patients pending funding.
- Implement efficient computerized financial reimbursement system to minimize staff time and foster timely payment.
- Analyze nutritional and pharmaceutical products used by patients and facilities to determine marginal clinical use and eliminate these medications to incorporate new ones.
- Analyze medications by type and aggregate data to yield descriptive information concerning usage. The formulary will then be examined for relevance and usefulness.
- Provide instruction to facilities on the reimbursement tracking system.
- Maintain quality control system for financial disbursements.

C. Area of Emphasis: Sexually Transmitted Diseases

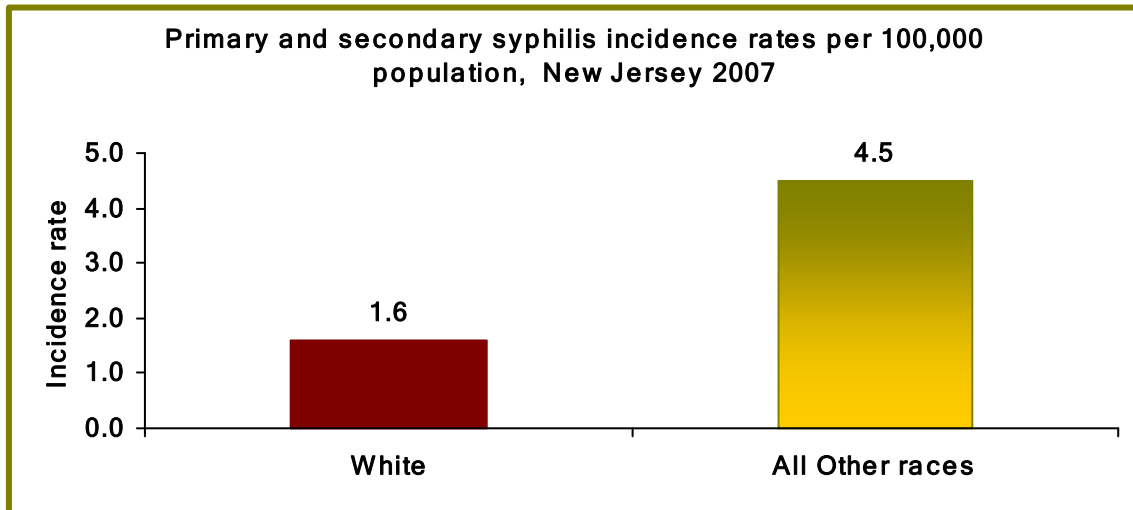
Background Data

Sexually transmitted diseases (STDs) continue to be a major public health issue throughout New Jersey. The most commonly reported sexually transmitted diseases in the state and nationwide are chlamydia, gonorrhea, and syphilis. There were 22,405 new chlamydia cases, 5,298 new gonorrhea cases, and 1,010 new syphilis cases in New Jersey during 2008. Several Healthy New Jersey (HNJ) 2010 objectives are dedicated to reducing the incidence and prevalence of these diseases. While racial/ethnic STD data for New Jersey is limited, huge differences in the incidence and prevalence of sexually transmitted diseases between racial/ethnic groups have been documented nationwide.

Primary & Secondary Syphilis

Overall the number of new syphilis (all stages combined) cases have declined an average of 25 percent since 2002. However, the STD surveillance data provided by the Centers for Disease Control and Prevention (CDC) reveals that primary and secondary syphilis rates are 7 times higher among Blacks compared to Whites and nearly 3 times higher for Hispanics nationwide. Asians have the lowest rates compared to all groups. One HNJ 2010 objective shows that the syphilis incidence rate among non-Whites in the state is nearly twice the rate among Whites. In 2007, New Jersey's primary and secondary syphilis rate was 2.6 per 100,000 (up from 2.0 per 100,000 population in 2006) and greatly exceeds the Healthy People 2010 objective of 0.2 per 100,000 population.

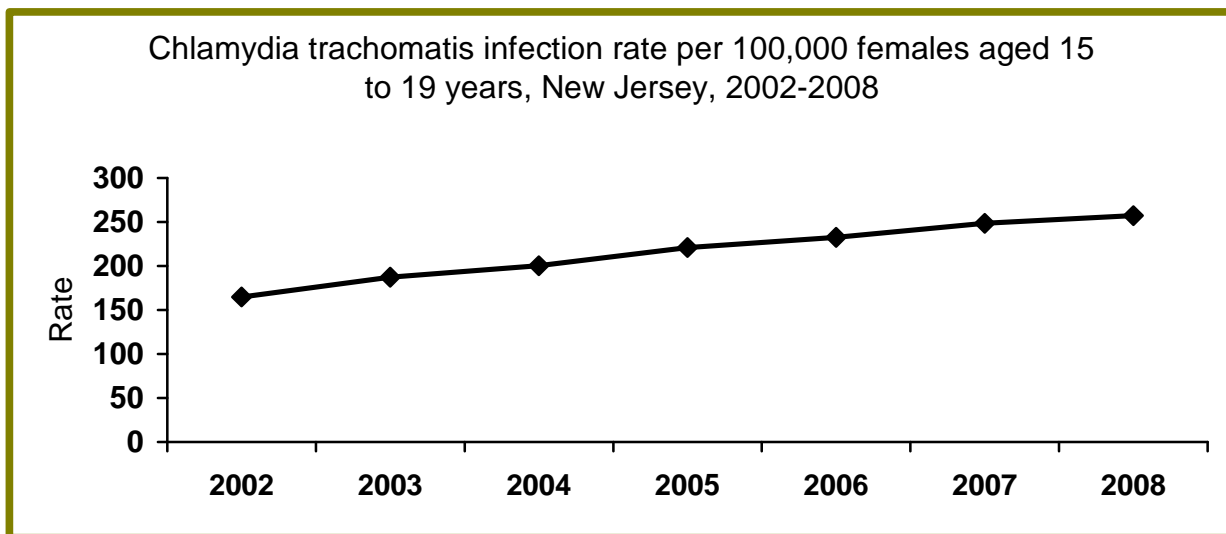
Forty percent of new cases of primary and secondary syphilis occurred among Blacks in New Jersey in 2008. The second highest percentage of new syphilis cases was among Whites with 31%, followed by Hispanics with 27%. Only 2% of cases occurred among Asians in the state.



Source: DHSS, Communicable Disease Service, Sexually Transmitted Disease Program

Chlamydia

Chlamydia incidence rates have increased steadily in New Jersey since 2002. Overall incidence rates for 2008 were 257.3 cases per 100,000 population (up 56% from 232.0 per 100,000 population in 2006). Among 15 to 19 year old females, rates are especially high with incidence rates at 2,130.6 per 100,000 age- and sex-specific population. This represents a nearly 15% increase from the HNJ 2010 baseline rate for this population of 1,873.8 per 100,000 population, and the target rate for this population is 950. It will not be achieved by 2010.



Source: DHSS, Communicable Disease Service, Sexually Transmitted Disease Program

Another HNJ 2010 objective seeks to reduce chlamydia prevalence among persons aged 15 to 24 years tested at family planning and STD clinics. Prevalence has increased 37% since the HNJ 2010 baseline in 1998 (from 5% to 8%) among family planning patients in the state.

Analysis of five-year trends of chlamydia prevalence show an overall increase in morbidity of 28% with 16,169 cases reported in 2003 and 22,405 reported in 2008. A total of 139,300 cases of chlamydia were reported to the Sexually Transmitted Disease Program (STDP) between 2003 and 2007.

Blacks comprised 32% of the total chlamydia cases reported in 2008 with the next highest percentage, 15%, coming from Hispanics. Whites comprised 8% of the total cases. Less than 1% of new chlamydia cases were reported among Asians and American Indian/Alaska Natives combined. It is also important to note that 80% of all new cases in 2008 occurred among women alone (STDP, Reported Chlamydia Cases in New Jersey, 2008)

Gonorrhea

The gonorrhea incidence rate in New Jersey was 69.8 per 100,000 population in 2007 (up from 63.1 per 100,000 in 2006). One HNJ 2010 objective is to reduce the incidence to 30.0 per 100,000 for the total population and to 325.0 among 15 to 19 year olds. The 2007 rate among females aged 15 to 19 years is 5 times higher than the total state population incidence (70.0) at 388 per 100,000 female population. (*Sexually Transmitted Disease Program Reported Gonorrhea Cases in New Jersey Report, 2008*).

Among new cases of gonorrhea reported in 2008, 56% were among Blacks. Only 7% and 5%, respectively were reported among Hispanics and Whites in the state. However, it is important to note that the race/ethnicity was unknown for 30% of the reported gonorrhea cases.

Building on Success

- The New Jersey Department of Health and Senior Services, Sexually Transmitted Disease Program (NJDHSS/STDP) provides Health Service Grants to STD programs in counties that have the highest rates of STD. The Health Service Grants assist these STD clinics with funding to enhance STD clinic operations, outreach services, screening activities, counseling and interviewing of STD patients, counseling, testing and treatment of STD contacts, and standards for mandatory reporting of STDs.
- The NJDHSS/STDP collaborates with major community health care providers through the Infertility Prevention Program (IPP) to provide increased screening of patients younger than age 26 years in family planning clinics and younger than age 29 years in STD clinics. The IPP Program has a coordinator that ensures screening is provided for targeted populations in underserved communities.
- The NJDHSS/STDP collaborates with schools and juvenile detention centers in affected communities to provide screening and treatment for teenagers at risk for STD.

Goal: Ensure that populations at risk for STD have access (availability and close proximity) to quality clinical and laboratory services.

Action Plan

Steps and Timeline:

- Continue to provide technical assistance to the STDP priority external partners located in high morbidity areas (Newark, Paterson, Jersey City, Trenton, Camden, Elizabeth, Atlantic City, Middlesex, Monmouth and Union counties).
- The STDP Manager and the IPP Coordinator will continue to collaborate with family planning sites and directors at the Health Service Grant sites as well as IPP funded sites to ensure adherence to Program Guidelines. All the sites will be visited and self assessment protocols will be developed for each site for submission to the STDP on a quarterly basis.
- The Office of Minority and Multicultural Health will conduct in-depth interviews with staff from the Sexually Transmitted Disease Program to assess barriers to

- Increase comprehensive services provided for patients served at the Health Service Grant (HSG) sites.
- Ensure STD education is being provided for health care providers as well as patients in (priority & non-priority areas).
- Enhance screening and reporting activities in HSG and IPP sites.
- Ensure that infected patients are re-screened within six months after treatment for an STD.
- Increase STD screening in juvenile detention centers and school-based clinics.
- Increase STD screening in prisons and local jails.
- Increase reporting of STD statistics by racial/ethnic groups so that intervention efforts may be better assessed.

Outcome Measures

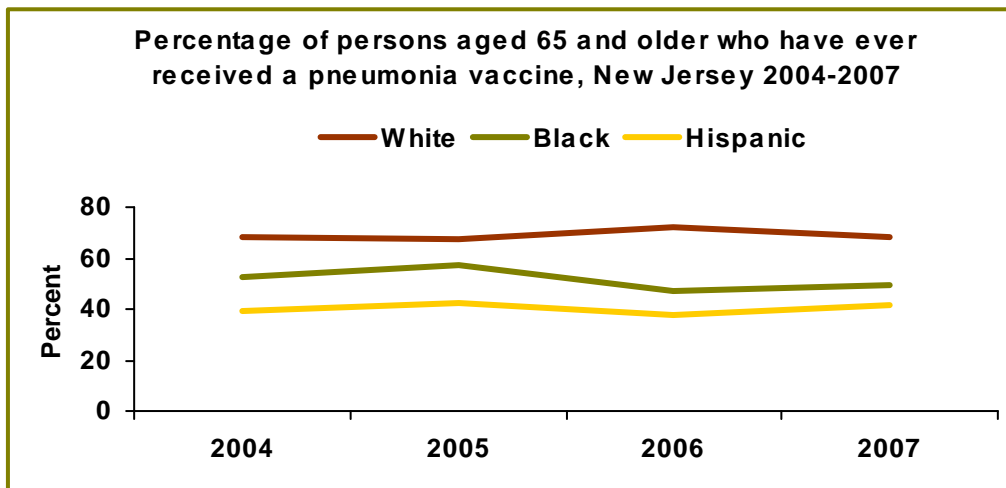
- Increase the percentage of pregnant patients in high risk populations that receive screening for all STD.
- Increase the number of STD data entered into the STD Management Information System within 24 hours of receipt to ensure prompt initiation of high-priority investigations and appropriate follow-up, diagnosis, and treatment of infected individuals and their partners.
- STDP field staff will conduct annual site visits to 100% of priority licensed laboratories that perform tests for priority STDs in high incidence areas.
- The STDP will work with Internet Sexuality Intervention Services, Inc (ISIS, Inc.) to implement an STD partner notification and an informational web site to help agencies develop behavior change intervention efforts.
- By the end of this project period (2009-2013) increase the percentage of STD clinics that provide comprehensive services (HIV, HPV vaccines, Hepatitis vaccines) to high risk populations.
- By the release of Healthy New Jersey 2020 objectives, increase the proportion which can be measured by racial/ethnic group.

D. Area of Emphasis: Adult & Child Immunizations

Background Data

Adult Immunization

Two HNJ 2010 objectives focus on increasing flu and pneumonia immunization rates among the elderly, aged 65 and older, in New Jersey. New Jersey Behavioral Risk Factor Survey (NJBRFS) 2007 data show that significant differences exist in flu and pneumonia immunization levels by race/ethnicity in this age group. White seniors are significantly more likely to have ever received either an influenza (72%) or pneumonia vaccination (68%) than Black seniors (60%, 50%, respectively). The Hispanic elderly are also significantly less likely and the least likely to have ever received the pneumonia (42%) or the flu (59%) vaccine as compared to all racial/ethnic groups.

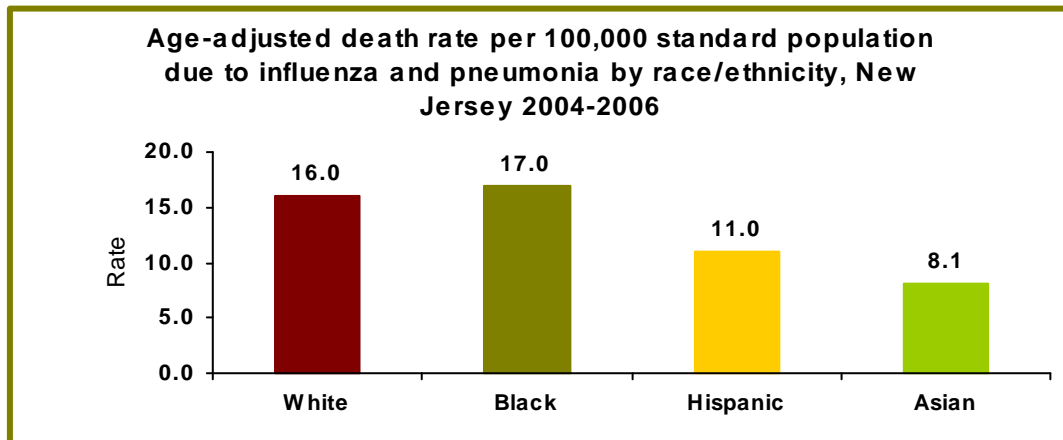


Source: DHSS, Center for Health Statistics, Behavioral Risk Factor Survey

Mortality

In 2006, influenza and pneumonia were the ninth leading causes of death for New Jerseyans with eighty percent of the deaths occurring among the elderly, ages 75 and older. Differences also exist in the age adjusted death rates due to influenza and pneumonia by race/ethnicity. Death rates among Blacks were slightly higher compared to Whites. However, Hispanic death rates from this cause were 30% lower than Whites,

and Asian death rates were the lowest compared to all groups, nearly 50% lower than Whites.

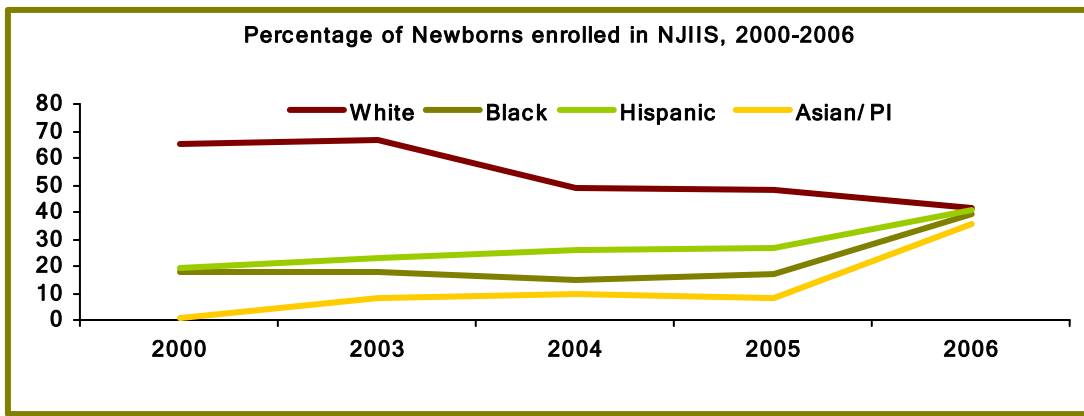


Source: DHSS, Center for Health Statistics, NJ Behavioral Risk Factor Survey

Childhood Immunization

Two HNJ 2010 objectives reference childhood immunization in the State. One seeks to increase the percentage of 2 years old receiving the Centers for Disease Control and Prevention's (CDC) recommended 4:3:1 series immunization recommendation for children aged 18 months and younger. Vaccinations for the following diseases are included: diphtheria/tetanus/acellular pertussis (DTaP), polio, measles/ mumps/ rubella (MMR), Haemophilus influenza type b (Hib), and hepatitis B. These data are not available by race/ethnicity for the state. However, overall vaccination levels have increased with 84% of children in this age group vaccinated in 2007 (*NJ Vaccine Preventable Disease Program*).

Another HNJ 2010 objective is to increase percentage of newborns enrolled in the New Jersey Immunization Information System (NJIS). The NJIS is a web based registry system that was officially recognized in 2004 to track statewide immunization data. NJIS enrollment is increasing overall and within each racial/ethnic group except Whites, for whom enrollment levels have been decreasing since 2003.



Source: DHSS, Vaccine Preventable Disease Program, NJ Immunization Information System

The Immunization Program’s vaccination progress is evaluated and assessed annually by the CDC National Immunization Survey (NIS). Its rates for each vaccine antigen are compared against the United States national average. The report provides a view of the antigens for which progress has been made in reaching the national Healthy People 2010 objectives. With that information, an immunization program is able to determine the areas that require greater or lesser focus. The most recent year, 2007, NIS results reported that the vaccination rate among New Jersey children ages 19 to 35 months of age for the period (Q3/2006 – Q2/2007) was 80.3 percent.

Over the past 3 years, the NIS immunization rates have reached a plateau nationally. Due to significant improvements, as of 2008, the CDC decided that the NIS would no longer report the coverage level for Newark which had previously been an area of greater focus. However, recognizing efforts to increase immunization rates were still warranted in Newark. The Newark Health Department and the DHSS Vaccine Preventable Disease (VPD) program partnered to create the New Immunization Strategic Workgroup (NISW). Newark’s current NIS vaccination average is 72%, below the state average. The NISW will establish a method to electronically calculate the city’s immunization coverage rate using the New Jersey Immunization Information System (NJIIS).

Building on Success

- The Vaccine Preventable Disease Program is able to reach and provide services to all persons in the state who are within the CDC's Advisory Council on Immunization Practices (ACIP) immunization schedules for recommended vaccinations. Multiple VPD program initiatives and projects provide access to immunizations. For example, the Vaccines for Children (VFC) Program makes vaccines available at no cost to medical providers who enroll in the program for vaccinating children ages 0 through 18 years. The vaccine recipient eligibility requirements are one of the following: American Indian/Alaskan Native, uninsured, Medicaid, or underinsured. Children of all racial/ethnic groups in New Jersey who meet the criteria can be vaccinated with VFC vaccine.
- VPD collaborates with external as well as internal partners. There are fifteen grantees funded by the VPD Program's CDC immunization grant. Six of the grantees from throughout the state perform outreach and immunization education, immunization registry recruitment, training and quality assurance. Nine grantees conduct outreach and immunization education activities and help connect children to immunization services.
- During the 2008-2009 influenza season, the VFC Program provided over 300,000 doses of influenza vaccine to children statewide in compliance with the Immunization of Pupils in Schools 8:57-4 influenza vaccination mandate. The changes in the Immunization of Pupils in Schools rules that mandate the receipt of influenza vaccine for children entering licensed child care and preschool facilities will result in increased coverage levels for the state during the next two NIS reporting cycles. Additionally, the "On Time Every Time: Keys to Prevention" (OTET) project focuses on increasing the immunization coverage rate for the fourth Diphtheria, Tetanus, and acellular Pertussis (DTaP) immunization. OTET also encourages providers to administer the third and fourth doses of the pneumococcal conjugate vaccine.

Goal:

- **Increase the influenza and pneumococcal conjugate immunization coverage rate of minority children 0 to 59 months who attend a licensed day care or preschool. Increase the annual pneumococcal and influenza vaccination rate for adults ages 65 and older.**

Action Plan

Steps and Timeline:

- The VPDP will increase the amount of influenza vaccine that is available for children eligible for the VFC Program and vaccinated at local health departments, federally qualified health centers and private medical providers who enroll in the VFC program.
- Increase the amount of pneumococcal conjugate vaccine that is also available for children eligible for the VFC Program and vaccinated at local health departments, federally qualified health centers and medical providers who enroll in the VFC program.
- Increase the percent of children ages 2 and younger who received the 4:3:1 series vaccination.
- Increase the number of children enrolled in the New Jersey Immunization Information system.
- Increase community outreach to racial/ethnic minority communities to improve vaccination rates for this population.

Outcome Measures

- The number of children between the ages 6 and 59 months who are immunized with influenza vaccine. School audits that will be performed by nurses at the local health departments and reported annually to the Vaccine Preventable Disease Program.
- The increase in the number of children immunized with pneumococcal conjugate vaccine in compliance with the NJ Immunization of Pupils in Schools rules, N.J.A.C. 8:57-4. These statistics will also be obtained through the School Audit report that is conducted by the local health departments of the day-care and preschools in their jurisdiction and reported to the Vaccine Preventable Disease Program.
- Data will be available through the Vaccine Preventable Disease Program annually and presented graphically to demonstrate an increase in compliance with the influenza and pneumococcal conjugate vaccines.
- The number of adults ages 65 and older who are immunized with influenza vaccine and pneumococcal vaccine.

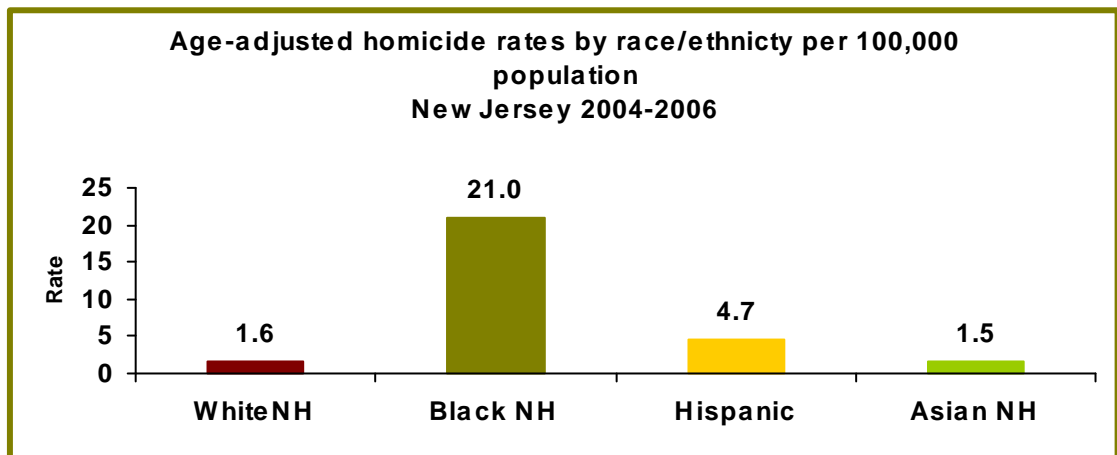
E. Area of Emphasis: Violence

Background Data

The World Health Organization (WHO) defines violence as “the intentional use of physical force or power against oneself, another person, or against a group or a community.” Homicide is the 13th leading cause of death in New Jersey (NJ Vital Statistics data, 2006). Though these rates are lower than national ones, they are cause for great concern particularly among adolescents in the state; homicide is the second leading cause of death among New Jersey residents aged 15 to 24 years. Black males in this age group have significantly higher homicide rates compared to other racial/ethnic groups in the state.

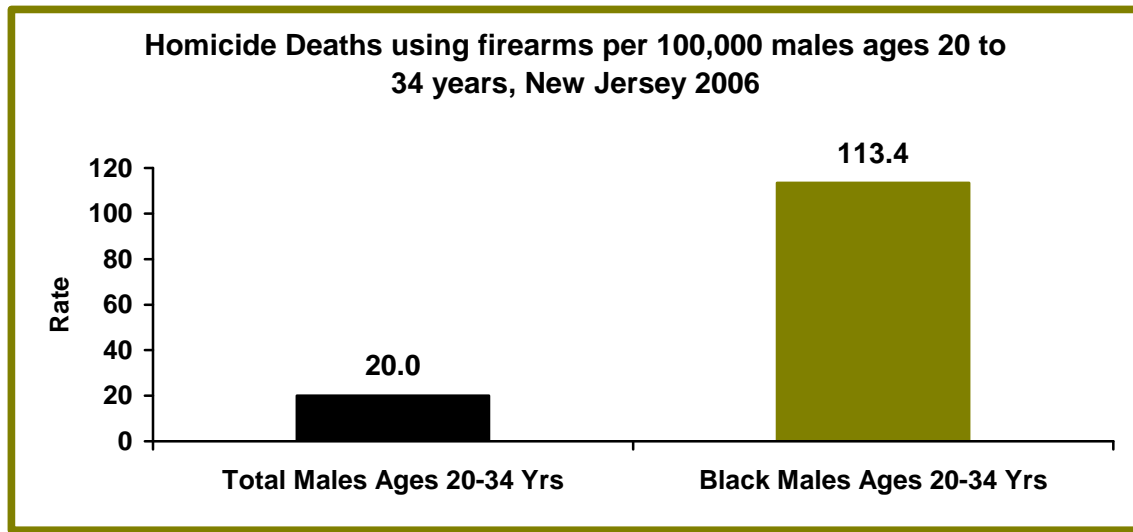
Homicide

Deaths due to homicide in New Jersey occur at the rate of 5.2 per 100,000 standard population (CHS, Vital Statistics data, 2006). The nationwide homicide rate is 10.4 per 100,000 population. There are considerable differences between homicide rates by gender and by race/ethnicity. Males have 4 times higher age-adjusted homicide rates (8.3 per 100,000 males) compared to women (1.7 per 100,000 females). Overall, compared to Whites, the age-adjusted homicide rate is nearly 12 times higher among Blacks and 2 times higher among Hispanics (NJSHAD, Vital Statistics, 2006). The annual homicide rate among Asians in New Jersey is as low as that among Whites.



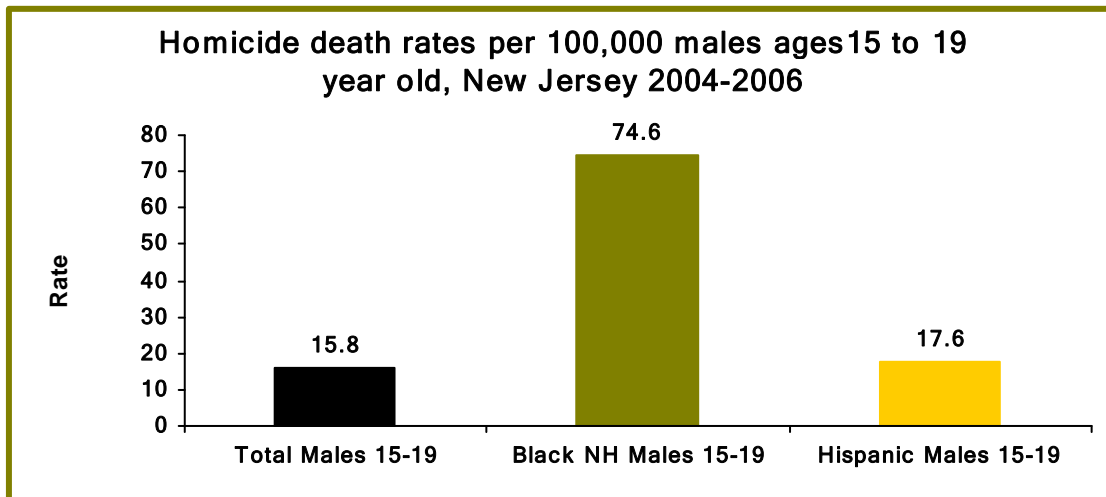
Source: DHSS, Center for Health Statistics, Vital Statistics Data

There are four HNJ 2010 objectives related to the reduction of homicide in New Jersey. Two focus on homicides caused by firearms. Homicides due to firearms among 20 to 34-year-old black males occur at rates that are 5 times higher compared to all racial/ethnic groups combined. Among other racial/ethnic groups, there are very few firearm homicides each year, so rates are not calculated.



Source: DHSS, Center for Health Statistics, Vital Statistics Data

Another two HNJ 2010 objectives focus on all homicides that occur among 15 to 19-year-olds and 20 to 34-year-olds; the highest rate of homicide in the state occurs among these two age groups, with 20 to 34-year-old males having the highest death rate at 20.0 per 100,000 population. The homicide rate among 15 to 19-year-old males is 4 times higher among Blacks (74.6 per 100,000 males) compared to the overall rate (15.8) for males in that age group.



Source: DHSS, Center for Health Statistics, Vital Statistics Data

Building on Success

- The Office of Injury Surveillance and Prevention (OISP) was established within NJDHSS's Center for Health Statistics (CHS) in 2005. OISP is a central source for injury statistics as well as home to several special injury projects including central nervous injury (CNS) surveillance, violent death surveillance, development of a state trauma registry, and the setting of statewide priorities for preventing injuries.
- OISP maintains the CDC-funded New Jersey Violent Death Reporting System (NJVDRS), which is a detailed database on violent fatalities in the state. Coordination of report submission from the medical examiners, local police departments, and county prosecutor's offices is conducted by OISP and the data are entered into the NJVDRS database and transmitted regularly to the National Violent Death Reporting System at CDC. Building a comprehensive data set on the circumstances and risk factors for all violent deaths that occur within the state aids researchers and prevention efforts.
- In 2008, OISP published, *Preventing Injury in New Jersey: Priorities for Action*, a collection of data and recommendations on strategies for reducing the ten leading causes of injury statewide; one chapter was dedicated to violence.

Goal: Decrease homicide rates in the state overall.

Action Plan

Steps and Timeline:

CHS will collect violence surveillance data for inclusion in the NJVDRS.

- CHS will print and distribute copies of the publication, *Preventing Injuries in New Jersey: Priorities for Action*. This Plan's violence reduction recommendations include:
 - Expand promising programs designed to prevent youth violence.
 - Increase the use of intelligence-led policing by state and local law enforcement agencies in combating gang and gun crime.
 - Promote comprehensive public education about the risks of firearms.

Outcome Measures

- Reduce the mortality rate from homicide among 15 through 19-year-old males per 100,000 population to 4.0 among Whites, 12.0 among Hispanics, and to 28.2 among Blacks.
- Reduce the mortality rate from homicide due to firearms among 15 through 19-year-old males per 100,000 population to 4.8 for the total population and to 21.3 among Blacks.
- Reduce the mortality rate from homicide among 20 through 34-year-olds per 100,000 population to 6.0 for the total population, 3.6 among Whites and to 33.2 among Blacks.
- Reduce the mortality rate from homicide due to firearms among 20 through 34-year-old males per 100,000 population to 7.4 among the total population and to 28.8 among Blacks.

III. Technical Notes

Race/Ethnicity Groups

Throughout this report the following mutually exclusive race and ethnicity groups are used: White, Black, Hispanic, and Asian. Data for White, Black, and Asian do not include Hispanics and Hispanics may be of any race. Race and ethnicity are reported as separate characteristics on most of the forms used to collect data reported in this document. Among these are birth and death certificates, the New Jersey Behavioral Risk Factor Survey, the UB-92 hospital discharge file, and the Cancer Registry. The HIV registry collects race/ethnicity as one characteristic: non-Hispanic White, non-Hispanic black, non-Hispanic other race, and Hispanic.

The reporting of Hispanic ethnicity on some major data systems is problematic due to a relatively large percentage of records with ethnicity not stated. Additionally, Asians, Native Hawaiians/and Pacific Islanders are sometimes misreported. Efforts are underway to improve the reporting of Hispanic ethnicity and Asian, Native Hawaiians and Pacific Islander races on the health data collected by the New Jersey Department of Health and Senior Services. For now, data presented for these groups should be used with caution as they may understate the true rates.

Definitions

Cause of Death Classification -- a system of specification of the diseases and/or injuries which led to death and the sequential order of their occurrence. The version of the system in use since 1999 is the *International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)*, sponsored by the World Health Organization

Chronic Kidney Disease -- Chronic Kidney disease is a collection of kidney conditions through which gradual and usually permanent loss of kidney function occurs over time - usually over months to years. Chronic kidney disease is divided into five stages of increasing severity. Stage 5 chronic kidney failure is also referred to as end-stage renal disease, wherein there is total or near-total loss of kidney function and patients need dialysis or transplantation to stay alive. The term "renal" refers to the kidney, so another name for kidney failure is "renal failure." Mild kidney disease is often called renal insufficiency.

Chlamydia -- is a common sexually transmitted disease (STD) caused by the bacterium, *Chlamydia trachomatis*, which can damage a woman's reproductive organs. Even though symptoms of chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia also can cause discharge from the penis of an infected man.

Contributing factor of death – a disease or injury which is a major component in the cause of death.

Gonorrhea -- is a sexually transmitted disease (STD). Gonorrhea is caused by *Neisseria gonorrhoea*, a bacterium that can grow and multiply easily in the warm, moist areas of the reproductive tract, including the cervix (opening to the womb), uterus (womb), and fallopian tubes (egg canals) in women, and in the urethra (urine canal) in women and men. The bacterium can also grow in the mouth, throat, eyes, and anus.

Immunization -- Vaccination. Immunizations work by stimulating the immune system, the natural disease-fighting system of the body. The healthy immune system is able to recognize invading bacteria and viruses and produce substances (antibodies) to destroy or disable them. Immunizations prepare the immune system to ward off a disease.

Incidence – The number of new occurrences of disease, injury, or death in a study population during a specific time period.

Pneumococcal conjugate vaccine -- Pneumococcal conjugate vaccine is a shot for infants and toddlers. It helps prevent pneumococcal disease, and it also helps stop the disease from spreading from person to person.

Prevalence – The number of persons in a defined population who have a specified disease or condition in a particular point in time.

Syphilis -- a sexually transmitted disease (STD) caused by the bacterium *Treponema pallidum*. It has often been called “the great imitator” because so many of the signs and symptoms are indistinguishable from those of other diseases.

Underlying Cause of Death -- the disease or injury which initiated the train of events leading directly to death or the circumstances of the unintentional injury or violence which produced the fatal injury.

Rates and Ratios

The presentation of statistics in the form of rates facilitates comparisons between political subdivisions with populations of different sizes or between subgroups of a population. Age-adjusted rates are used to compare the mortality and morbidity experience among groups with differing age distributions. The definitions of rates used in this report follow. Caution should be exercised in the interpretation of rates based on small numbers. Death rates based on fewer than 20 deaths do not meet National Center for Health Statistics standards for reliability and precision.

Age-Adjusted Incidence or Death Rate -- the application of age-specific rates to a standard population to arrive at the theoretical number of events that would occur in the standard population at the rates prevailing in the actual population. The number of events is divided by the total number of persons in the standard population to arrive at the

adjusted rate. The resulting age-adjusted rate is an index number and can only be compared to other rates age-adjusted using the same standard population and cannot be compared to crude or other actual rates. The standard population used in this report for age-adjustment of rates is the United States 2000 standard million, derived from projected 2000 decennial census counts.

Ratio – an expression of the quantity of one outcome in relation to that of another. For example, for the age-adjusted death rate due to breast cancer among Blacks as compared to Whites, the ratio for Whites as the reference group is 1.0 and for Blacks, it is 1.24. In this example, the age-adjusted death rate among Blacks is 24 percent higher than the rate among Whites.

ICD-10 Codes

<i>Cause of Death</i>	<i>ICD-10 Codes</i>
Assault	X85 – X92, X96 - Y09
Hepatitis C	K70, K73 – K74
Homicide	X85 – Y09, Y87.1
Homicide by firearms	X93 – X95
Influenza & pneumonia	J10 – J18
Kidney Disease	N00 – N07, N17 – N19, N25 – N27
Sexually Transmitted Diseases	A50 – A53
Suicide	X60 – X84, Y87.0
Viral hepatitis	B15 – B19

Population Estimates

Population estimates used to calculate various rates in this report were derived from the bridged-race postcensal population estimates prepared by the National Center for Health Statistics (NCHS) in collaboration with the U.S. Bureau of the Census. These estimates result from bridging the 31 race categories used in the 2000 Census, as specified in the 1997 federal OMB standards for the collection of data on race and ethnicity, to the four race categories specified under the 1977 standards. Many data systems are continuing to use the 1977 standards during the transition to full implementation of the 1997 standards. Population estimates as of April 1, 2000 were used with 2000 data, Vintage 2006 estimates were used.

The estimates presented below have not been rounded. However, it should not be presumed that they have the degree of accuracy which such precise figures might imply.

Bridged-Race Population Estimates, New Jersey, 2000-2006									
Year	White		Black		Hispanic		Asian/ Pacific Islander		
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
2000	5,638,028	66.9	1,142,607	13.6	1,127,601	13.4	508,367	6.0	
2001	5,633,473	66.2	1,155,691	13.6	1,169,737	13.8	529,435	6.2	
2002	5,625,887	65.6	1,168,045	13.6	1,213,478	14.2	551,943	6.4	
2003	5,613,438	65.0	1,178,980	13.6	1,254,466	14.5	575,423	6.7	
2004	5,588,490	64.2	1,181,060	13.6	1,294,422	14.9	618,705	7.1	
2005	5,551,291	63.7	1,181,540	13.6	1,327,413	15.2	641,502	7.4	
2006	5,472,178	63%	1,165,592	13%	1,345,475	16%	640,193	7%	
Bridged-Race Population Estimates by County, New Jersey, 2006									
County	Total	White		Black		Hispanic		Asian/Pacific Islander	
		#	%	#	%	#	%	#	%
Atlantic	271,015	170,374	62.9	44,895	16.6	37,765	13.9	17,315	6.4
Bergen	902,561	608,783	67.5	48,964	5.4	119,814	13.3	123,874	13.7
Burlington	450,743	334,938	74.3	74,688	16.6	22,370	5.0	17,696	3.9
Camden	518,249	336,516	64.9	98,051	18.9	58,771	11.3	23,695	4.6
Cape May	99,286	89,663	90.3	4,770	4.8	3,942	4.0	776	0.8
Cumberland	153,252	85,635	55.9	30,985	20.2	33,810	22.1	1,711	1.1
Essex	791,057	290,390	36.7	325,712	41.2	138,755	17.5	34,416	4.4
Gloucester	276,910	234,673	84.7	27,265	9.8	8,677	3.1	5,778	2.1
Hudson	603,521	211,507	35.0	76,165	12.6	247,682	41.0	66,779	11.1
Hunterdon	130,404	118,028	90.5	3,473	2.7	4,751	3.6	4,003	3.1
Mercer	366,256	220,623	60.2	73,497	20.1	43,201	11.8	28,299	7.7
Middlesex	789,516	440,385	55.8	73,698	9.3	128,282	16.2	145,644	18.4
Monmouth	635,952	504,675	79.4	49,853	7.8	48,629	7.6	31,863	5.0
Morris	490,593	387,392	79.0	14,527	3.0	47,654	9.7	40,427	8.2
Ocean	558,341	494,958	88.6	17,901	3.2	35,303	6.3	9,417	1.7
Passaic	499,060	246,105	49.3	60,885	12.2	168,962	33.9	22,125	4.4
Salem	66,346	52,645	79.3	9,805	14.8	3,171	4.8	516	0.8
Somerset	319,900	219,135	68.5	26,865	8.4	35,641	11.1	37,951	11.9
Sussex	153,130	140,061	91.5	2,300	1.5	7,865	5.1	2,752	1.8
Union	531,457	266,390	50.1	114,048	21.5	126,219	23.7	23,925	4.5
Warren	110,376	98,415	89.2	3,193	2.9	6,149	5.6	2,540	2.3

Data Sources

Data	Source
Adult immunization	NJDHSS, Center for Health Statistics, NJ Behavioral Risk Factor Survey
Death rates	NJDHSS, Center for Health Statistics NJ Resident Death Certificates
Hospitalization and amputation rates	NJDHSS, Center for Health Statistics NJ Uniform Billing Hospital Discharge File
Sexually transmitted diseases	NJDHSS, Communicable Disease Services
Child immunization	NJDHSS, CDS, Vaccine Prevention Disease Program