

# Strategic Plan to Eliminate Health Disparities in New Jersey 2007

New Jersey Department of Health & Senior Services



Jon S. Corzine  
Governor



Fred M. Jacobs, M.D., J.D.  
Commissioner





## State of New Jersey

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JON S. CORZINE  
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March 6, 2007

All New Jersey residents have a right to equal access to high quality health care.

Unfortunately, vast differences persist in health outcomes among our diverse communities. Members of minority and multicultural communities have disproportionately higher incidence and mortality rates for diseases including asthma, diabetes, infant mortality, HIV/AIDS, cancer, cardiovascular diseases and obesity.

We simply are not making enough progress in closing the disparities gap for more than one third of our residents.

We can and we must do better.

We need new approaches, new ideas. We need to know which strategies are working and which strategies are missing the mark. We have to answer some fundamental questions to create a plan that will have real, tangible results.

That's why this Strategic Plan for Eliminating Disparities is so important. It examines the programs and services within the Department of Health and Senior Services that address racial and ethnic disparities, and it makes recommendations for strengthening these programs and developing new initiatives that will help the Department work toward the elimination of disparities.

Health and Senior Services Commissioner Dr. Fred Jacobs frequently says that there is no more important mission for the Department of Health and Senior Services than reducing health disparities.

I could not agree more.

This plan is a call to action and I know it will guide the Department of Health and Senior Services in improving health outcomes for all New Jersey citizens.

Sincerely,

A handwritten signature in black ink, appearing to read "Jon S. Corzine".

JON S. CORZINE  
Governor



## State of New Jersey

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March 2007

New Jersey is rich in ethnic, racial and cultural diversity. With a population of more than eight million, almost 64 percent are white, more than 13 percent are black, just over 15 percent are Hispanic, nearly seven and a half percent are Asian or Pacific Islander and .02 percent are American Indian or Alaskan native. With this racial and cultural diversity comes many languages. Twenty-six percent of New Jersey's population—or more than two million residents—speak a language other than English at home and 11 percent of the population has limited English proficiency.

This wealth of cultural diversity presents us with great health care challenges not only because of language barriers, but also because of the vast and increasing differences in the incidence, prevalence and death rates of diseases among different populations in this state.

In New Jersey, like the rest of the nation, these health disparities are pervasive and long-standing. Some of the biggest disparities exist in the areas of asthma, cervical and prostate cancer, cardiovascular disease, obesity, diabetes, HIV/AIDS and infant mortality. These and other health disparities result from a complex set of factors including education, environment, language barriers, lack of health insurance, income and other socioeconomic factors.

Reducing and ultimately eliminating these disparities is a core mission of the Department of Health and Senior Services and it has been my top priority since I became commissioner in December of 2004. Since that time, the Department has sustained and launched programs targeted to minority communities.

However, disparities persist. In the wealthiest state in the nation, I know that we can do better. Hence, the Department is continually considering promising strategies. For the first time, the Department of Health and Senior Services has developed a *Strategic Plan to Eliminate Health Disparities*—a comprehensive plan of action to improve the health of racial and ethnic minorities in this state. This document—which will continue to evolve—is our roadmap to reduce health disparities over the next three years.

We will measure our progress against the benchmarks outlined in this document. We look forward to collaborating with academia, community-based organizations, health care and other public health professionals as we work together to achieve our goal of eliminating health disparities in New Jersey.

A handwritten signature in black ink, appearing to read "Fred M. Jacobs".

Fred M. Jacobs, M.D., J.D.  
Commissioner

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## Executive Summary

In September 2004, the New Jersey Legislature authorized the Commissioner of the Department of Health and Senior Services (the Department) to establish the *Eliminating Health Disparities Initiative* in the Office on Minority and Multicultural Health (OMMH). Public Law 2004, c. 137, required the OMMH to develop and implement a comprehensive, coordinated plan to improve the health of racial and ethnic minorities within the State. In New Jersey, like throughout the nation, health disparities are deep, persistent and complex.

The *Eliminating Health Disparities Initiative* provides an opportunity to examine the Department's programs that target specific minority populations, identifies strengths of the Department's programs and proposes new strategies. The NJDHSS Plan to Eliminate Health Disparities (the Plan) is the Department's strategy book on a comprehensive and targeted effort to address some of the major issues that contribute to racial and ethnic health disparities in New Jersey.

In addition to examining the Department's model programs, the Plan summarizes the Department's efforts to improve its capacity to address health disparities as part of its ongoing activities. The Plan creates a synergistic approach by supporting intradepartmental collaboration specifically on eliminating health disparities. The NJDHSS Health Disparities Work Group examined existing programs and initiatives addressing health disparities, which provided the basis for the Plan and formalized the Department's efforts to build on successful initiatives to address health disparities. The Plan delineates overall progress through goals, action plans and outcome measures.

The Plan maintains its focus in certain priority areas of medical emphasis that disproportionately impact minority communities and are identified in the legislation: asthma, breast, cervical, colorectal and prostate cancer, cardiovascular disease, diabetes, HIV disease, infant mortality and unintentional injuries. In addition, the Plan addresses the impact of obesity on the health of minority populations. Succeeding versions of the

Plan will focus on other priority health areas including: kidney disease, hepatitis C, sexually transmitted infections, immunizations, and violence.

The specific areas of internal development that the Plan focuses on are improving the standards for collecting and reporting race/ethnicity data; increasing the availability of culturally and linguistically sensitive materials and services; increasing minorities in management positions; enhancing community outreach; and increasing programs that exemplify promising practices.

The NJDHSS recognizes that disparities result from a complex set of factors including education, environment, gender, income and other socioeconomic factors, and behavioral patterns. There is also growing evidence that provider behavior, including a lack of cultural competency, contributes to disparities in care. While some information on the contributing factors to this problem is known, more research and documentation of outcomes is required to appropriately institute policies and programs that will help close the gaps in health care access and quality that are persistent.

Developing an agenda for addressing health disparities is challenging and requires funding and resources. In addition to state and federal aid, NJDHSS continues to seek funding from private foundations and other sources to support new health disparities initiatives. Next steps include creating a process that involves community partners, funders, advocates and health care professionals to implement the Plan.

While the Plan projects a strategic approach to addressing health disparities over the next three years, the recommendation is that these strategies continue to be re-examined and re-evaluated during and even beyond the three-year implementation period. The Plan should be treated as a working document, such that it will continue to evolve, expand and be updated with the most current information and resources that can contribute to eliminating health disparities.

## Introduction

In the United States, there have always been wide gaps between the health of whites and racial and ethnic minorities. Data indicate that blacks have experienced disproportionately higher rates of morbidity and mortality in nearly all of the medical areas addressed in this Plan. New Jersey is like the nation in that minorities in this State are at greater risk than Whites for premature death and preventable disease. Disparities in health, health care and access across racial, ethnic, and socioeconomic backgrounds in the United States are well documented.

### *Background*

In 1985, addressing gaps in health care and health status became a priority on a national level and as a result, the U.S. Department of Health and Human Services (HHS) established the Office of Minority Health.<sup>1</sup> State offices of minority health were subsequently established as were numerous initiatives to address health disparities. In New Jersey, the Governor signed into law P.L. 1991, Chapter 401 which permanently established the Office of Minority Health in 1992—one of the first states to create such an office. In 1979, the first set of national health objectives was published by HHS. In September 1990, the HHS released the most recent version, *Healthy People 2000*—a national strategy for improving the health of Americans. This initiative sets goals to improve health nationwide by the end of the marked decade. New Jersey has published its own set of objectives based on the national agenda beginning in 1990. With *Healthy People 2010*, the HHS set a goal to eliminate health disparities nationally by 2010.

*Healthy New Jersey 2010* (HNJ 2010 - [www.state.nj.us/health/chs/hnj2010u05/index.shtml](http://www.state.nj.us/health/chs/hnj2010u05/index.shtml)) is this State's equivalent of that federal program, setting goals for New Jersey to improve health in specific areas and measuring progress toward accomplishing those goals. HNJ 2010 is an integral document to the Department's efforts to address health disparities. This document focuses on many health indicators and establishes goals for reducing and ultimately ending health disparities in New Jersey. It is available on the Department's website at [www.nj.gov/health/chs/hnj.htm](http://www.nj.gov/health/chs/hnj.htm).

Most recently, the Department and the Office of Minority and Multicultural Health collaborated with the Policy Research Institute for the Region at the Woodrow Wilson School of Public and International Affairs at Princeton University to conduct a roundtable of public health researchers, practitioners and scholars to discuss promising practices in addressing health disparities. A summary of that roundtable can be obtained directly from the Institute. Key public health stakeholders in the New Jersey/New York/Pennsylvania region agreed on one key idea in addressing health disparities: “Even with the right data, the right definitions, and the right indicators, initiating a successful program to address a particular disparity in health care requires three other elements: the will to make change, meaningful partnerships, and the implementation of targeted and effective programs, with an eye toward installing systems that will outlast changes in priority and staff at both health departments and provider institutions.”<sup>ii</sup>

The Plan reflects the research literature, as well as the internal discussions and extensive work of the Department to address health disparities. There are several strategies that can be implemented to contribute to eliminating racial and ethnic health disparities in New Jersey.

Throughout its history, the OMMH has held summits, sponsored studies and supported community-based efforts that focus attention on eliminating health disparities. From this work, there have been “lessons learned” that have helped OMMH identify and highlight several crosscutting issues. They are:

- the need to improve and standardize data collection methods for gathering race/ethnicity and primary language spoken information;
- the need to develop and support cultural competency training programs for health care providers;
- the need to develop strategies that increase access to care;
- the need to increase the numbers of minorities entering the health professions; and
- the need to establish measurable outcomes for health disparities initiatives.

The OMMH established recommendations for addressing health disparities in New Jersey based on these cross-cutting issues. These recommendations have been supported by the Department and OMMH's Advisory Commission.

### *Need for a Plan*

While there have been numerous initiatives at national and state levels to address health disparities, racial and ethnic health disparities remain persistent. In 2002, The Institute of Medicine (IOM) documented deep and pervasive disparities in health and health care for minorities in its report, *Unequal Treatment*. This is a critical reason why key stakeholders, public health experts and advocates, affected communities and community leaders and legislators have called for a comprehensive effort to coordinate health disparities initiatives—to provide guidance, set standards and be a foundation for a cohesive, targeted effort to eliminate health disparities. Hence, the development of the Plan to strengthen internal efforts that ultimately contribute to reducing health disparities. The Plan provides a framework for putting the discussions, recommendations and policies around health disparities into one coordinated Plan. The Department is committed to addressing health disparities through the many programs that have been established provided that state and federal resources continue to sustain them.

### *Plan Design*

The Plan is organized on several focused health areas identified in N.J.S.A. 26:2-167.1 (asthma, breast, cervical, colorectal and prostate cancer, cardiovascular disease, obesity, diabetes, HIV/AIDS, infant mortality and unintentional injuries). It provides a snapshot of the Department's strengths to date in the specific areas of focus. Finally, the Plan outlines the Department's goals in those areas, the steps needed to accomplish the goals, and the benchmarks for measuring progress. Section I of the Plan consists of the following segments.

**Medical Area of Emphasis** – In this section, the Plan gives a synopsis of available health statistics on the health of New Jersey residents for each of the focus medical areas. These areas of emphasis were identified in the Eliminating Health Disparities legislation.

**Building on Success** – In this section, the Plan highlights existing or planned Department programs that have been effective or show promise in reducing health disparities within each specific health area.

**Goal** – In this section, the Plan states its main goal(s) as it relates to eliminating health disparities.

**Action Plan** – In this section, the Plan lists the strategic steps identified for reaching the set goals.

**Outcome Measures** – Here, the Plan lists specific outcomes which are also the foundation for evaluating the effectiveness of the program.

In conclusion, the **Summary of Actions** lists point-by-point the intended actions of the Department. The Department will use the Plan to guide and implement initiatives in a comprehensive effort to eliminate racial/ethnic health disparities in New Jersey. This is one component of a broader effort to address health disparities throughout the state.

## OVERVIEW: Demographic and socioeconomic circumstances

Healthy New Jersey 2010 (HNJ 2010) defines health disparities as substantial differences in health status within and among different populations in the State. To better understand why disparities exist, it is imperative that more data are collected by race and ethnicity and used to measure the differences seen between sub-populations of the State.

### Race/ethnicity

As of July 1, 2005, New Jersey's population was 8.7 million persons of whom 63.7% were white, 13.6% were black, 15.2% were Hispanic, 7.4% were Asian or Pacific Islander, and 0.2% were American Indian or Alaskan native. Throughout the Plan, data by race/ethnicity are mutually exclusive, meaning the white, black, and Asian/Pacific Islander groups do not include persons of Hispanic ethnicity and Hispanics may be of any race.

### Income

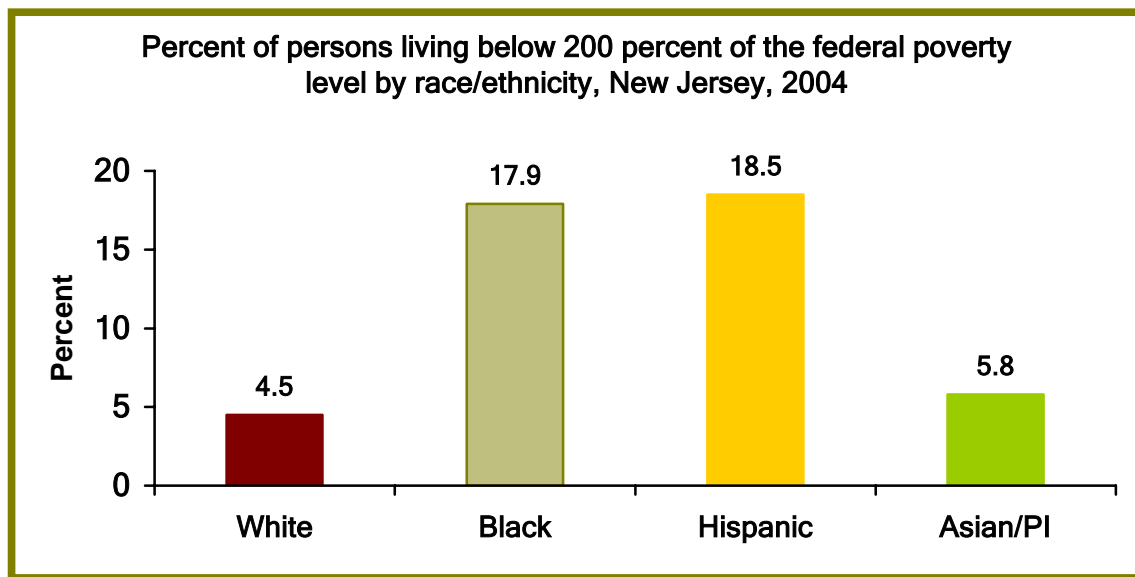
According to 2000 Census data, the difference in per capita income, by race/ethnicity in New Jersey is significant. The per capita income for whites is nearly two times that of blacks and more than double that of Hispanics. Similarly, whites have a greater median household income and also a greater median family income as compared to other racial/ethnic groups.

Per capita, median household, and median family income by race/ethnicity, New Jersey 1999			
Race/ethnicity	Per Capita Income	Median Household Income	Median Family Income
White	\$31,559	\$60,600	\$73,043
Black	\$17,049	\$38,513	\$44,056
Hispanic	\$14,804	\$39,609	\$40,105
Asian/Pacific Islander	\$25,663	\$92,192	\$71,487

Source: US Census 2000

## Poverty

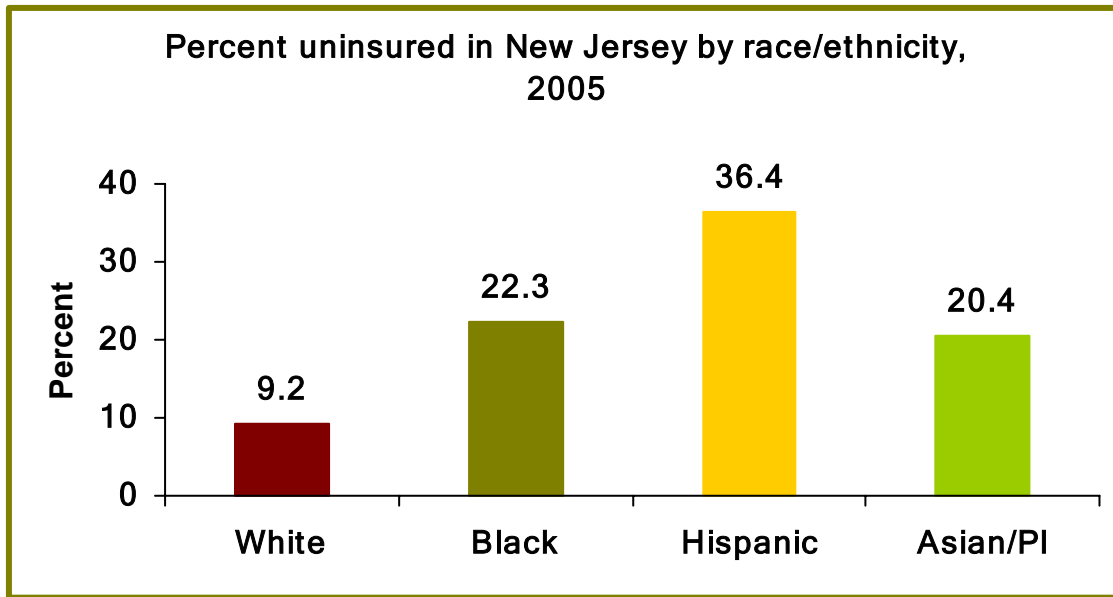
One-fifth of the State's residents live in poverty – below 200 percent of the 2004 federal poverty level (FPL) or at an annual income below \$30,438. Nine percent have an income that is less than \$15,219 (100% FPL) and another four percent live on an annual salary that is below \$7,610 (50% FPL). Poverty prevalence is higher among New Jersey's minorities than among whites. Blacks and Hispanics are more than four times as likely to live in poverty compared to whites. Asian and Pacific Islander poverty prevalence is only slightly higher than that of whites.



Source: Legal Services of New Jersey, Poverty Research Institute, 2005

## Health Insurance

In 2005, more than 15 percent of New Jersey's population was uninsured. Among residents under the age of 65, the uninsured rate is nearly 17 percent. Blacks and Asian/Pacific Islanders are three times more likely to be uninsured than whites. More than a third of New Jersey's Hispanic population does not have health insurance.



Source: Current Population Survey, Annual Demographic file, 2001-6 US Census Bureau

Foreign born whites, blacks, and Hispanics are much more likely than their native born counterparts to be uninsured. Within the Asian/Pacific Islander population, foreign born New Jersey residents are as likely as native born to be have no source of health insurance.

Race/ethnicity	Native born (%)	Foreign born (%)
White	8.5	19.2
Black	19.5	41.4
Hispanic	23.6	48.9
Asian/Pacific Islander	20.2	20.5

Source: Current Population Survey: Annual Demographic File, 2001-6, US Census Bureau

No single demographic and socioeconomic factor above explains the differences in health outcomes that are recognized among racial/ethnic groups throughout the State. Additional research is required to better understand the causal factors. Still, the following data are an essential starting point for all interested in taking appropriate action to eliminate health disparities.

## Summary of Medical Areas Examined

Priority Area	Summary of disparities
<i>Asthma</i>	Hospitalization rates are 3 times higher for blacks and 1.8 times higher for Hispanics. Black death rates are four times higher. For Hispanics, the rate is twice as high when compared to whites.
<i>Breast Cancer</i>	Hispanics and Asian/Pacific Islanders have lower screening rates than whites and blacks; the age adjusted death rate due to cancer is 24 percent higher among black women.
<i>Cervical Cancer</i>	Screening rates among Asians and Pacific Islanders are lower when compared to all other groups. The incidence rate among blacks and Hispanics is about twice the rate of whites; the death rate from the disease is twice as high among blacks as compared to whites and Hispanics.
<i>Prostate Cancer</i>	Incidence rates among blacks are 1.5 times that of whites. Blacks die from the disease at 2.5 times the rate of whites.
<i>Colorectal Cancer</i>	Screening rates are lower among blacks, Hispanics and Asians and Pacific Islanders. Incidence and death rates are highest among blacks.
<i>Cardiovascular Disease</i>	Blacks have the highest death rates from heart disease and from stroke.
<i>Obesity</i>	Adult obesity is highest among blacks. Childhood obesity is highest among Hispanics; it is 2 times higher among blacks and Hispanics as compared to whites.
<i>Diabetes</i>	The prevalence of the disease is highest among blacks. Deaths are 2 times more likely among blacks and blacks are more likely than any other group to develop end stage renal disease or have a lower limb amputated as a result of the disease.
<i>HIV/AIDS</i>	Prevalence rates are significantly higher among blacks and Hispanics in the state. AIDS incidence rates are 16 times higher for blacks and 5 times higher for Hispanics than whites. HIV disease death rates are 19 and 6 times higher for blacks and Hispanics, respectively.
<i>Infant Mortality</i>	The black infant mortality rate is nearly 3 times that of whites.
<i>Unintentional Injury</i>	The highest rate of unintentional injury death occurs among blacks.

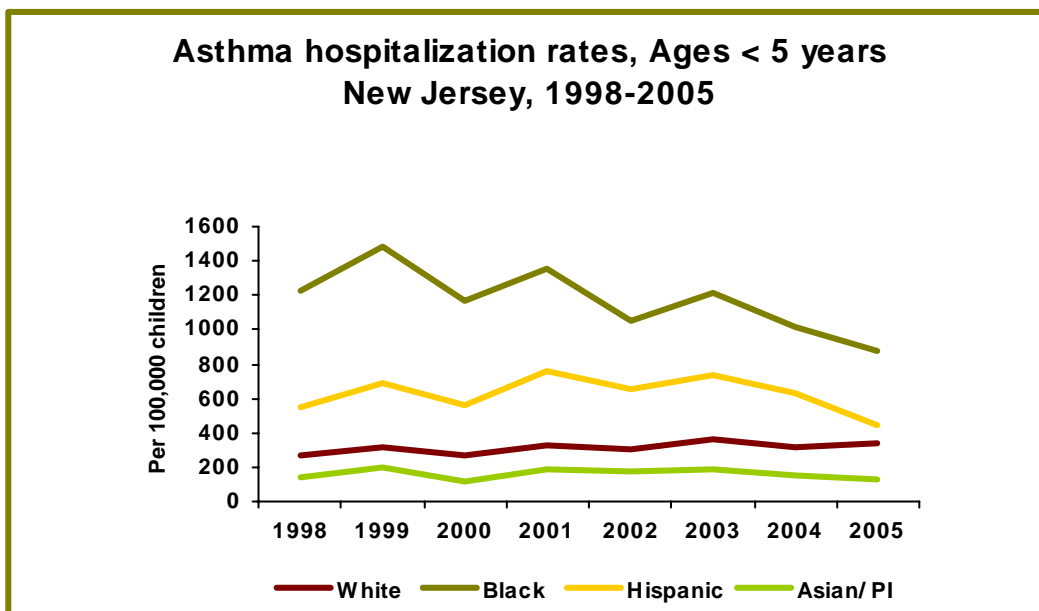
# I. Medical Areas of Emphasis

## A. Area of Emphasis: Asthma

### Background Data

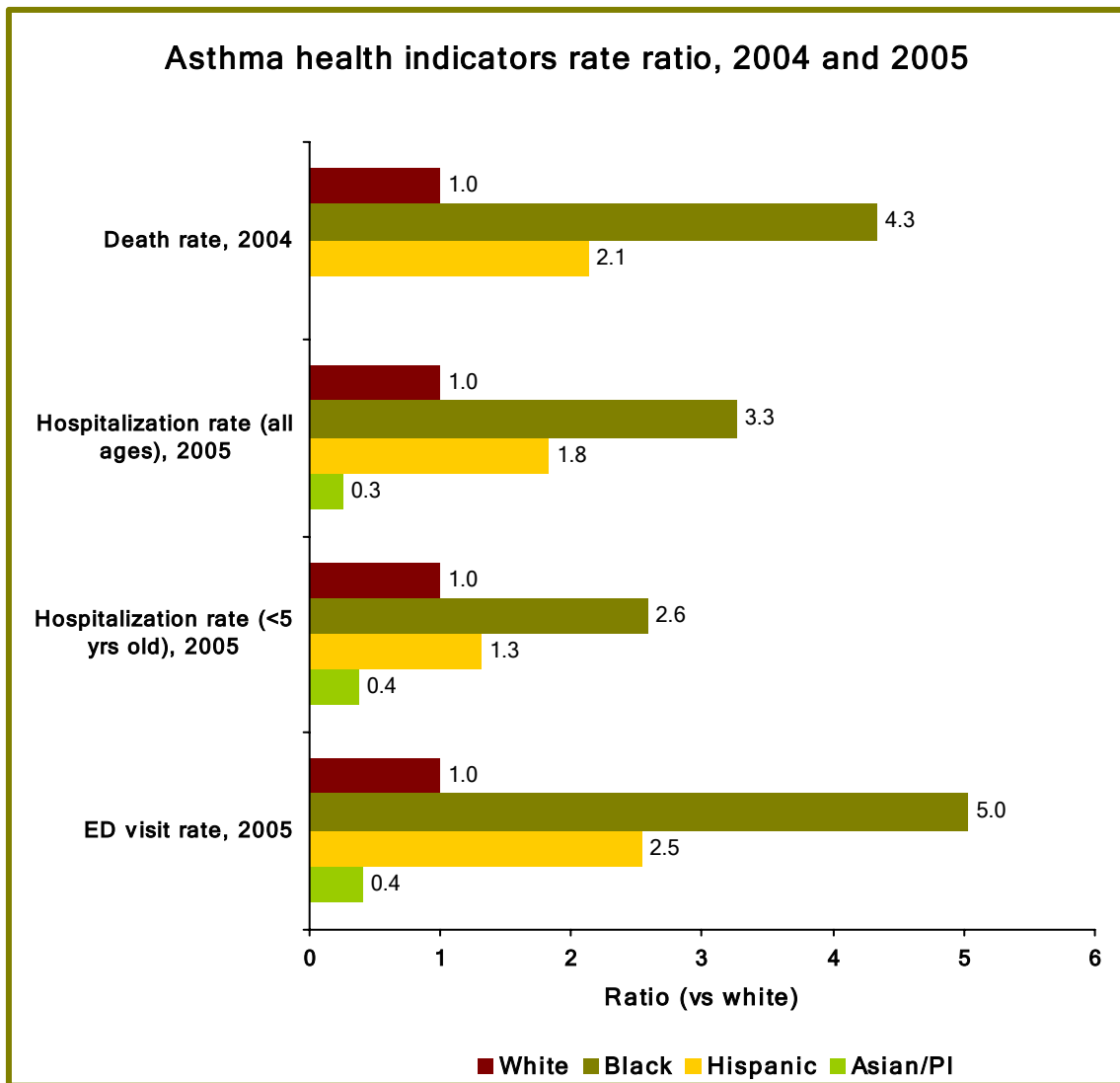
An estimated 11 percent of the New Jersey population suffers from asthma. Data from the New Jersey Behavioral Risk Factor Survey (NJBFRS) show that blacks report higher rates of asthma as compared to whites and other racial/ethnic groups in the State. In 2005, the NJBRFS results showed that 13 percent of blacks, 12 percent of whites, and 11 percent of Hispanics reported receiving an asthma diagnosis. More significant racial/ethnic differences are evident when asthma mortality and hospitalization data are examined.

In recent years, there has been virtually no change in mortality or all-age hospitalization rates due to asthma among any racial/ethnic group. However, from 2003 to 2005, there was a sharp decline in asthma-related hospitalization rates among children under five years old in all groups except whites. Emergency department (ED) data became available in 2004. ED visit rates increased between 2004 and 2005 for all groups except Hispanics.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

Asthma mortality and ED visit rates among blacks are four to five times that of whites while hospitalization rates are about three times higher. Among Hispanics, mortality and ED visit rates are more than twice that of whites, but hospitalization rates are less than double the white rate. Hospitalization and ED rates among Asians and Pacific Islanders are lower than among whites, and so few Asians and Pacific Islanders die due to asthma that reliable rates cannot be calculated.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

## Building on Success

- The Commissioner's Annual Asthma Summit has provided a forum to facilitate collaboration among national and local experts on the strategies and practices required to reduce asthma disparities in New Jersey. The targeted audience includes health care providers, community health workers, health educators, social workers, nurses, community and faith based organizations. At the conclusion of the first Summit in September 2005, health care providers were challenged to:
  - implement new asthma interventions to reduce the disproportionate impact of asthma in the pediatric and low-income population, and minority communities;
  - incorporate best practices as the basis of asthma management and decision-making; and
  - develop partnerships with public and community health systems to empower citizens to take actions to improve the health of individuals, families and communities.
  
- The Pediatric/Adult Asthma Coalition of New Jersey (PACNJ), partially supported by NJDHSS, continues to serve as the statewide coalition on asthma awareness. 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 and provide them with the most effective methods for managing their asthma. The PACNJ is undertaking the following initiatives:
  - School nurse asthma training;
  - Developing policies and practices for asthma friendly childcare settings;
  - Distribution of the *Asthma Action Plan*, that allows parents of school-age children, school nurses and pediatricians to personalize **the form**, which results in an individualized asthma management plan;
  - Train-the-trainer programs in three urban cities with the highest asthma hospitalization rates;

- Healthy School criteria (Asthma Friendly School Award); and
  - Annual media campaigns.
- The Educating Physicians in their Communities Asthma Curriculum Project partnered with the New Jersey Academy of Pediatrics to educate 10 pediatric practices in Trenton on proper asthma care and management for high-risk populations.
- A partnership with the Trenton Childhood Asthma Program, an asthma management and education program for children and families in the City of Trenton, includes case management and community education as well as an environmental assessment of homes.
- The Agency for Healthcare Research and Quality (AHRQ) selected New Jersey as one of six states to participate in the *Learning Partnership to Decrease Disparities in Pediatric Asthma* Project. AHRQ required each state to convene a team comprised of but not limited to state, local, faith-based, healthcare and coalition representatives. The primary focus of the initiative is the development of the State's Action Plan for Decreasing Disparities in Pediatric Asthma. The New Jersey Action Plan implements a comprehensive asthma outreach/education program in three cities with high-risk populations in order to improve the quality of care and life for children with asthma.

**Goal: Reduce the number of minorities with asthma who use hospital emergency departments as a main source of care, prevent asthma mortality and make it possible for children and adults to live healthier lives.**

## *Action Plan*

### *Steps and Timeline*

#### *FY 2007-2010*

- Collect Centers for Primary Health Care asthma collaborative data on quality of care.
- Increase the number of Centers for Primary Health Care participating in asthma collaboratives.
- Provide training to promote uniform, high quality asthma care among providers serving minorities at risk.
- Provide training to increase use among providers of the *Asthma Action Plan* which personalizes an asthma management program for school-age children.

### *Outcome Measures*

- By 2010, reduce the asthma age-adjusted mortality rate to 1.9 per 100,000 for the black population.
- By 2010, reduce the annual asthma hospital admission rate to 250 per 100,000 for the black population and to 150 per 100,000 for the Hispanic population.
- By 2010, reduce the annual asthma hospital admission rate for children under 5 years to 800 per 100,000 for the black population and to 340 per 100,000 for the Hispanic population.
- By 2010, reduce the annual asthma emergency department visit rate for black and Hispanic populations to reflect targets established in Healthy New Jersey 2010.

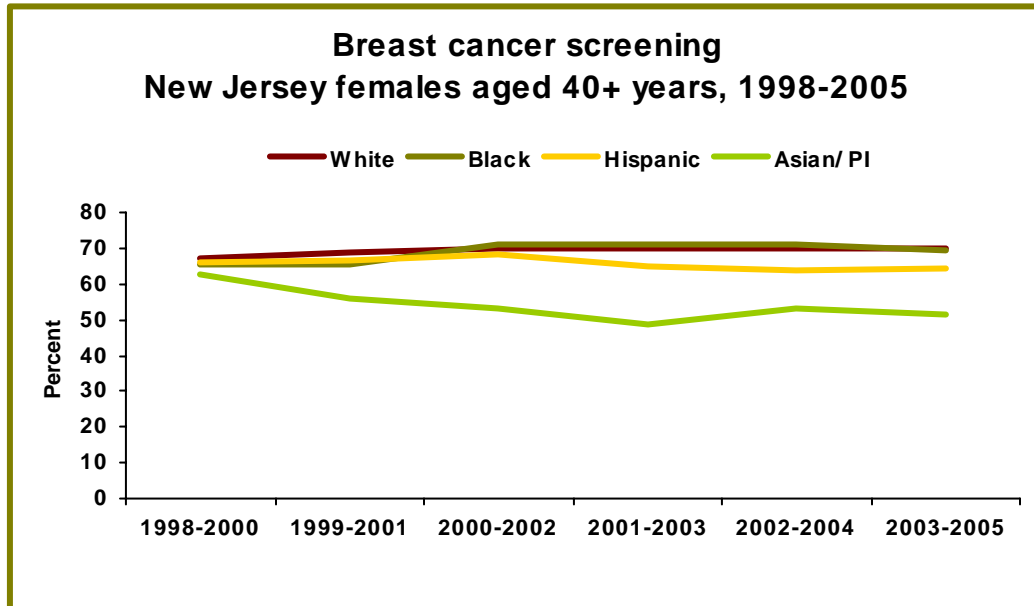
## B. Area of Emphasis: Cancer

### Background Data

#### *Breast Cancer*

Each year in New Jersey more than 6,000 women are diagnosed with invasive breast cancer and 1,500 women die from the disease. There are some significant racial/ethnic differences in mortality rates. Differences in screening rates are less distinctive, although Hispanic and Asian/Pacific Islander women have lower rates of completing the recommended screening schedule than whites and blacks.

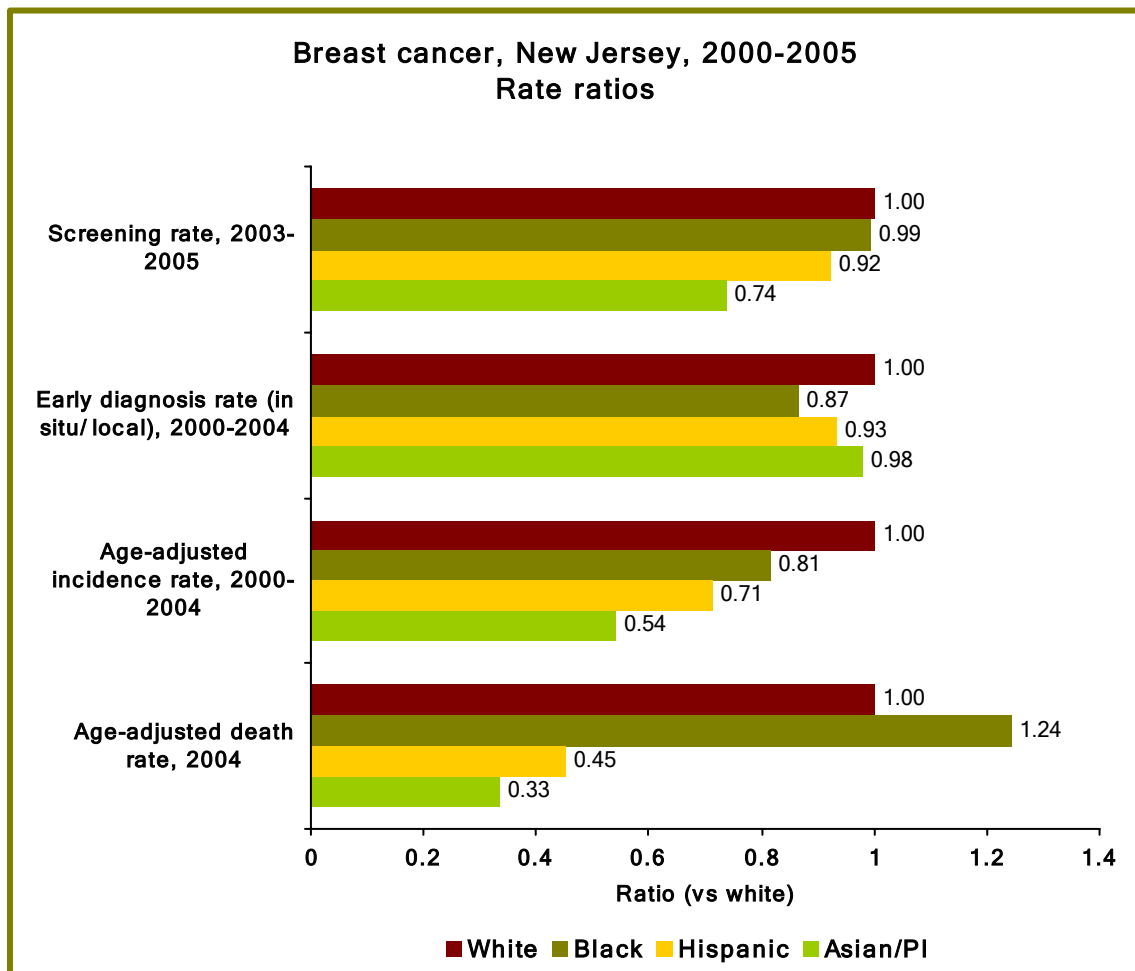
The NJBRFS asks women aged 40 years and over if they have received a clinical breast exam and a mammogram within the past two years. According to the survey, screening rates for white and black females are just below the Healthy New Jersey 2010 (HNJ 2010) target of 75 percent, while rates among Hispanic women lag behind slightly and rates among Asians and Pacific Islanders remain at about 50 percent.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

The age-adjusted breast cancer incidence rate among black and Hispanic women is 20 to 30 percent below that of white women and the rate among Asians and Pacific Islanders is about half the white rate. However, a higher percentage of breast cancers are diagnosed at an early (in situ/local) stage among whites and Asians/Pacific Islanders than among blacks and Hispanics.

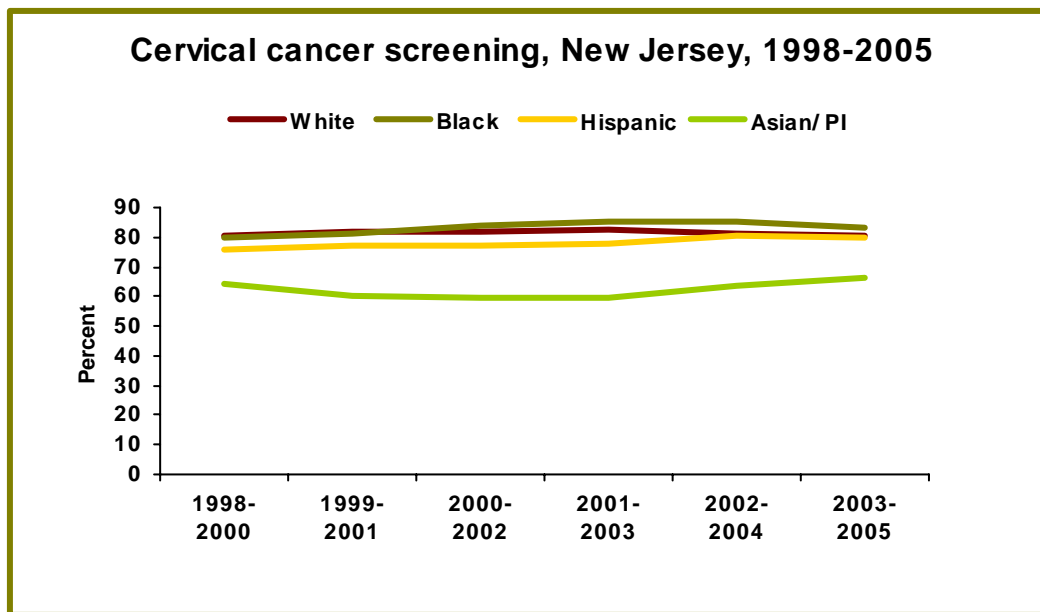
The age-adjusted death rate due to breast cancer among black women is 24 percent higher than the rate among white women. Rates for Hispanics and Asians/Pacific Islanders are one-half and one-third the white rate respectively, but some of the difference may be due to misreporting of race and ethnicity on death certificates, the healthy migrant effect, and other data artifacts.



*Sources: New Jersey Department of Health and Senior Services  
Center for Health Statistics and Cancer Epidemiology Services*

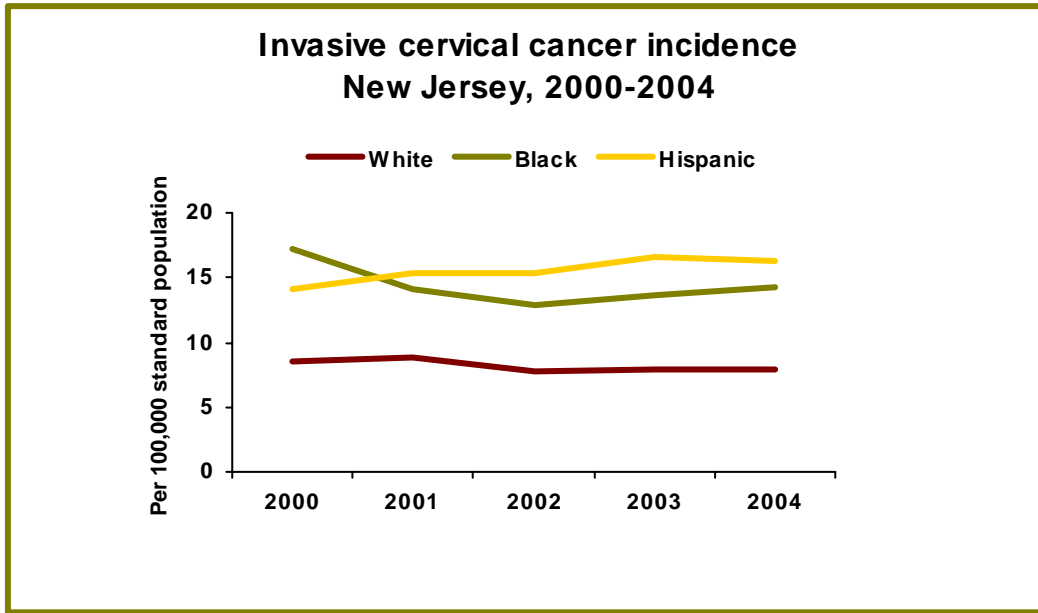
## *Cervical Cancer*

Even though cervical cancer screening rates among whites, blacks, and Hispanics are similar, this is not reflected in incidence or mortality rates due to cervical cancer. The NJBRFS asks females aged 18 years and over with an intact cervix whether they have had a Pap test within the past two years. Survey results for whites, blacks, and Hispanics hover at or just below the HNJ 2010 target of 85 percent. The rate among Asians and Pacific Islanders remains below that of the other groups.



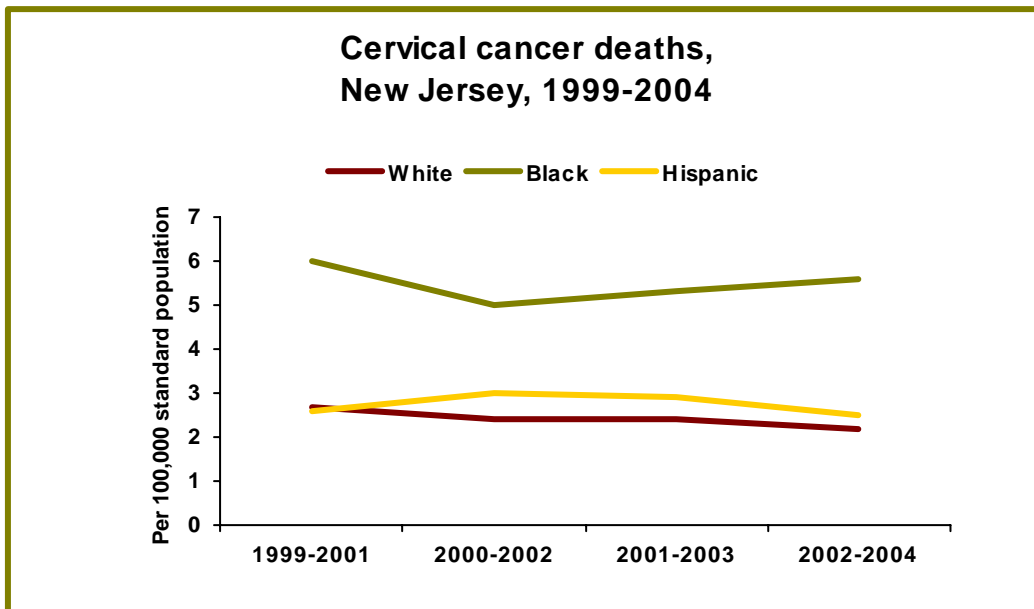
*Source: New Jersey Department of Health and Senior Services, Center for Health Statistics*

The age-adjusted incidence rate of invasive cervical cancer among blacks and Hispanics is about twice the rate among whites, even though blacks have a slightly higher screening rate and the screening rate among Hispanics is only slightly lower.



Source: New Jersey Department of Health and Senior Services, Cancer Epidemiology Services

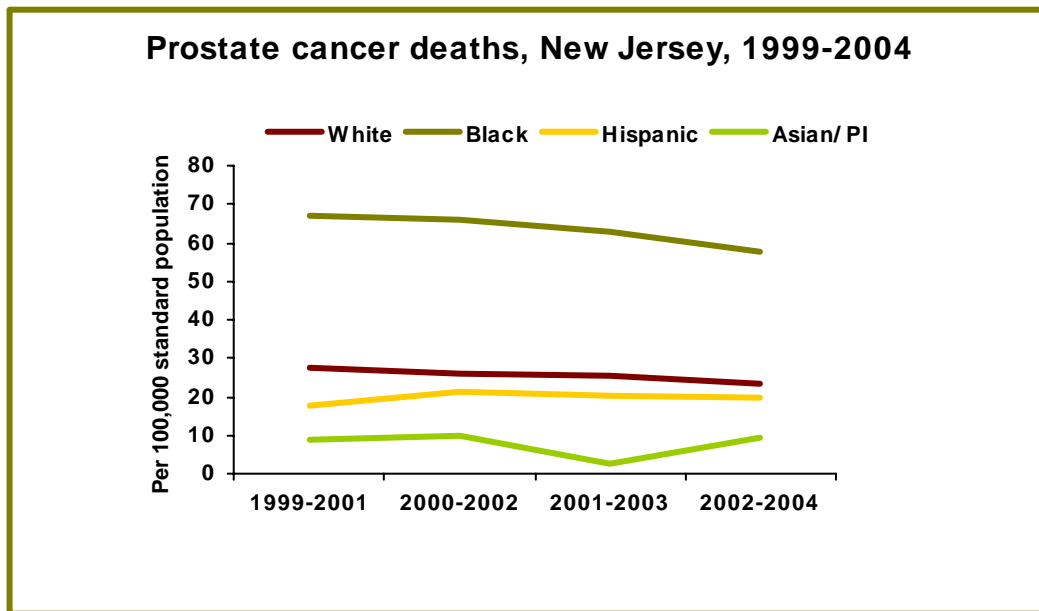
The mortality rate due to cervical cancer among blacks is more than twice the rate among whites while the rate among Hispanics is similar to the white rate. There are so few cases of and deaths due to cervical cancer among Asians and Pacific Islanders that reliable rates can not be computed.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

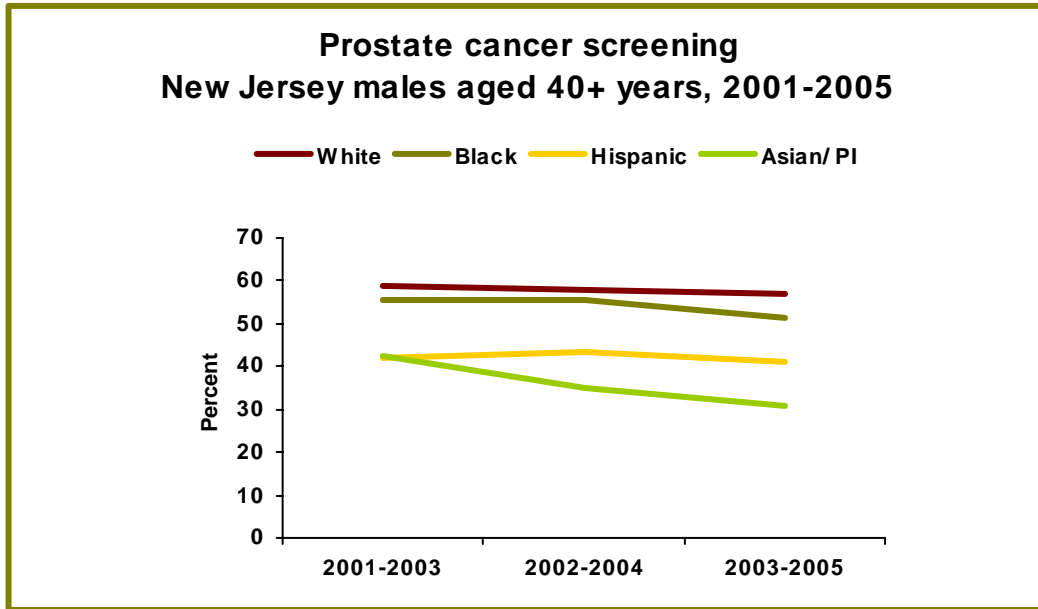
## Prostate Cancer

While prostate cancer death rates overall are declining in New Jersey and within all racial and ethnic groups, blacks have significantly higher mortality rates than other groups. The prostate cancer mortality rate among blacks remains 2.5 times the rate among whites. The rates among Hispanics and Asians/Pacific Islanders are slightly below the rate among whites.



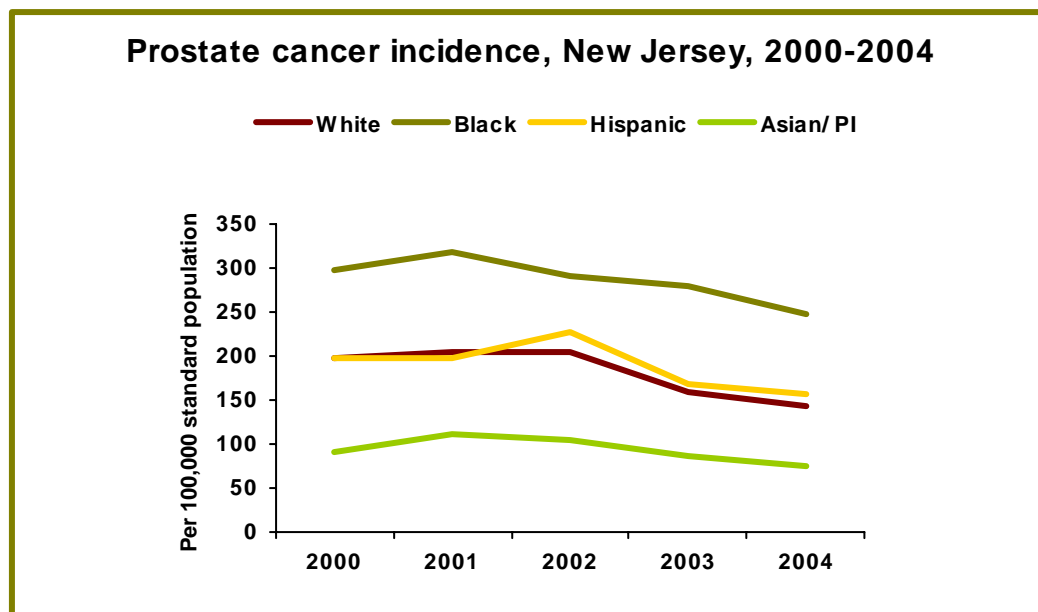
Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

The NJBRFS asks men aged 40 years and over whether they have had a prostate-specific antigen (PSA) blood test within the past two years. Survey results show that the prostate cancer screening rate among blacks only lags slightly behind that of whites. Rates among Hispanics and Asians/Pacific Islanders, however, are well below those of whites and blacks. For all races/ethnicities, screening rates are declining.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

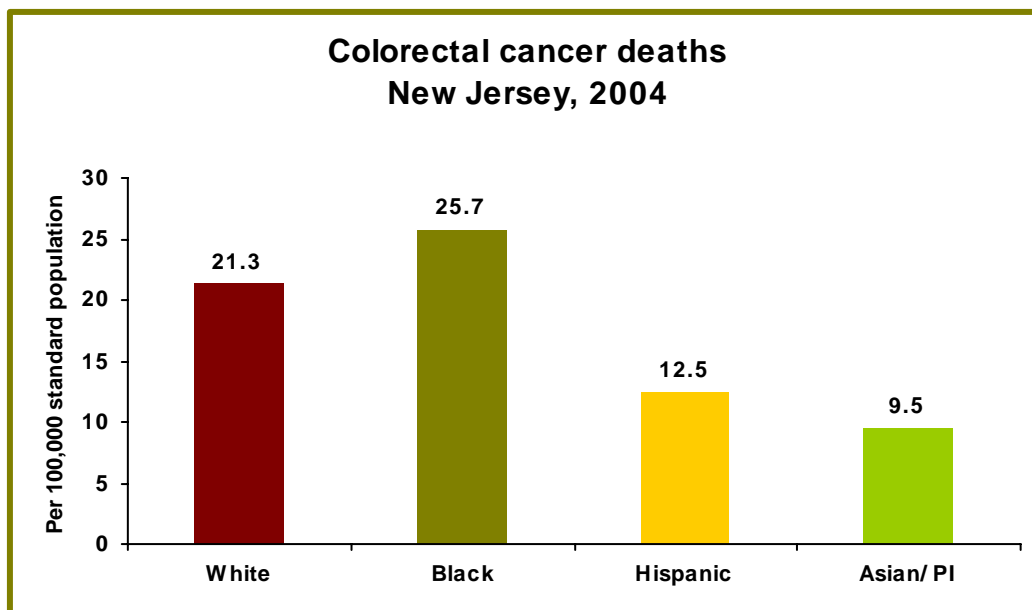
The incidence of invasive prostate cancer among blacks is 1.5 times the rate among whites and Hispanics, while the rate among Asians/Pacific Islanders is about half the white and Hispanic rates. Rates are decreasing among all racial/ethnic groups.



Source: New Jersey Department of Health and Senior Services, Cancer Epidemiology Services

## Colorectal Cancer

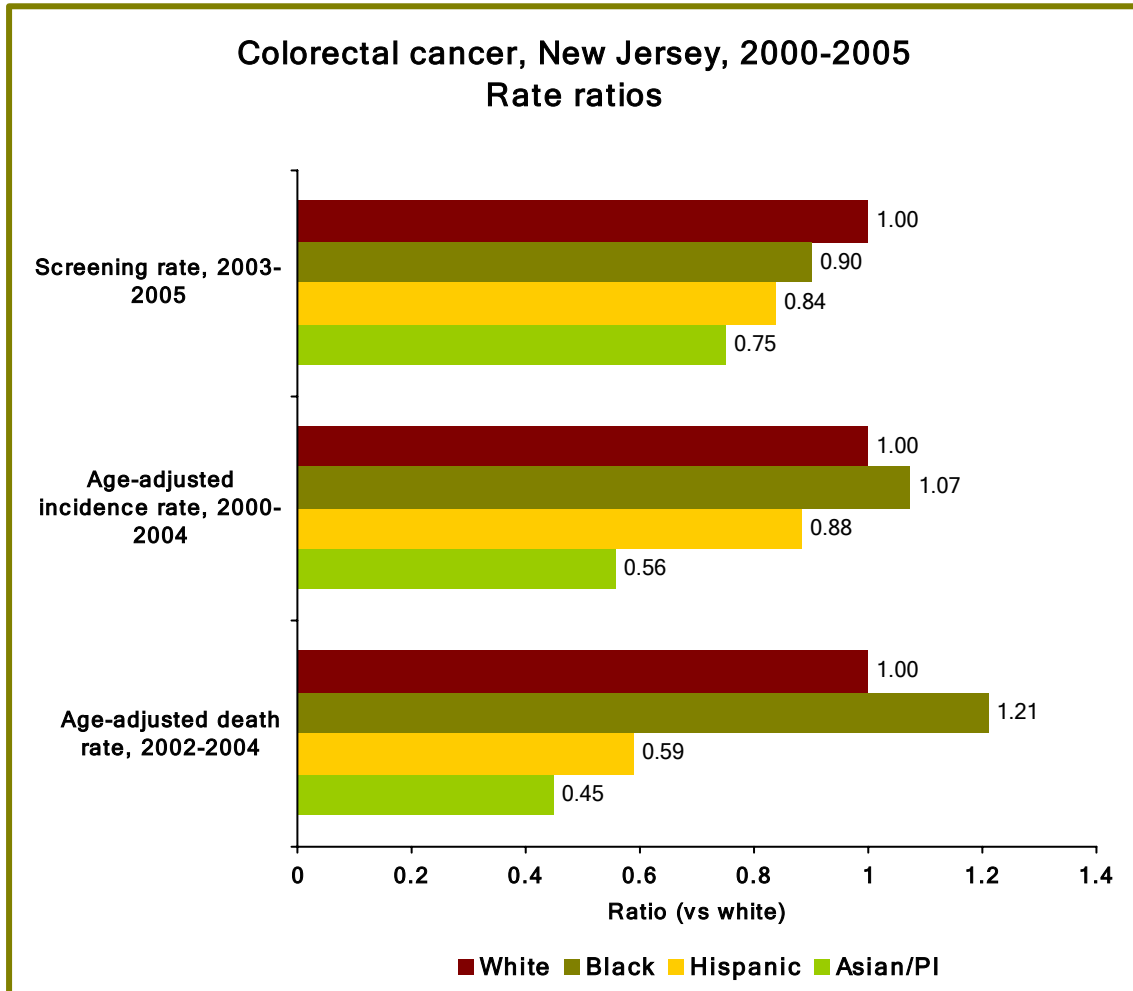
Colorectal cancer screening rates increased over the first part of the decade among all race/ethnicity groups. It appears likely that the rates will surpass the HNJ 2010 preferred endpoint of 75 percent of persons aged 50 and over receiving an annual fecal occult blood test and/or ever undergoing a sigmoidoscopy. Meanwhile, death rates are slowly decreasing among all groups except Asians and Pacific Islanders for whom rates are increasing. The incidence rate has also slowly decreased among whites but has not made much progress among blacks, Hispanics, and Asians and Pacific Islanders.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

Colorectal cancer screening rates among blacks, Hispanics, and Asians/Pacific Islanders are 10, 16, and 25 percent below that of whites, respectively. However, if current screening trends persist, the gap will continue to narrow and rates for blacks and Hispanics could meet or even surpass those for whites. The age-adjusted colorectal cancer incidence rate among blacks has been slightly above that of whites while the Hispanic rate has been slightly below, however most recent figures show the rates converging. The preliminary rate among Asians/Pacific Islanders was between 45 and 73 percent of the white rate between 2000 and 2004. The age-adjusted death rate due to

colorectal cancer among blacks is 21 percent higher than the white rate. Rates for Hispanics and Asians/Pacific Islanders are roughly half the white rate, but misreporting of race and ethnicity on death certificates, the healthy migrant effect, and other data artifacts may contribute to the low rates among those two groups.



Sources: New Jersey Department of Health and Senior Services  
Center for Health Statistics and Cancer Epidemiology Services

## *Building on Success*

The New Jersey Cancer Education and Early Detection (NJCEED) Program specifically seeks to screen underserved minority populations for breast, cervical, colorectal and prostate cancers.

- Local Lead Agencies (contractors that are funded to provide screening, education and case management services) employ ethnically diverse staff members and contract with minority community-based organizations to provide outreach and screening services to these minority populations.
- Since the goal of the NJCEED Program is to provide cancer awareness, education and screening services to underserved minority populations, including racial/ethnic minority populations, the Program has developed numerous awareness initiatives targeted to the black and Latino populations with regard to breast, cervical and prostate cancers.
- 13 counties in New Jersey have been targeted in a project entitled “2-1-1 Reach for Life,” for education and awareness messages for black women. Additionally, local Lead Agencies have created educational materials to target Asian (Chinese, Korean and Indian) audiences within their surrounding areas.

**Goal: Increase awareness of cancer initiatives and promote screenings for the New Jersey minority population.**

### *Action Plan*

#### *Steps and Timeline:*

*FY 2007-2010*

- Continue the work of NJCEED Lead Agencies together with cancer county coalitions' outreach initiatives and expand screening capacity for cervical and prostate cancer at the agencies to prevent instituting waiting lists.
- Continue to partner with numerous minority community-based organizations and existing social networks to raise awareness of the NJCEED Program and to provide education to the community at large regarding the importance of screening and early detection.
- Identify and address barriers to screening and follow-up care.
- Evaluate the data on the impact of screening programs on minority populations.

***Outcome Measures:***

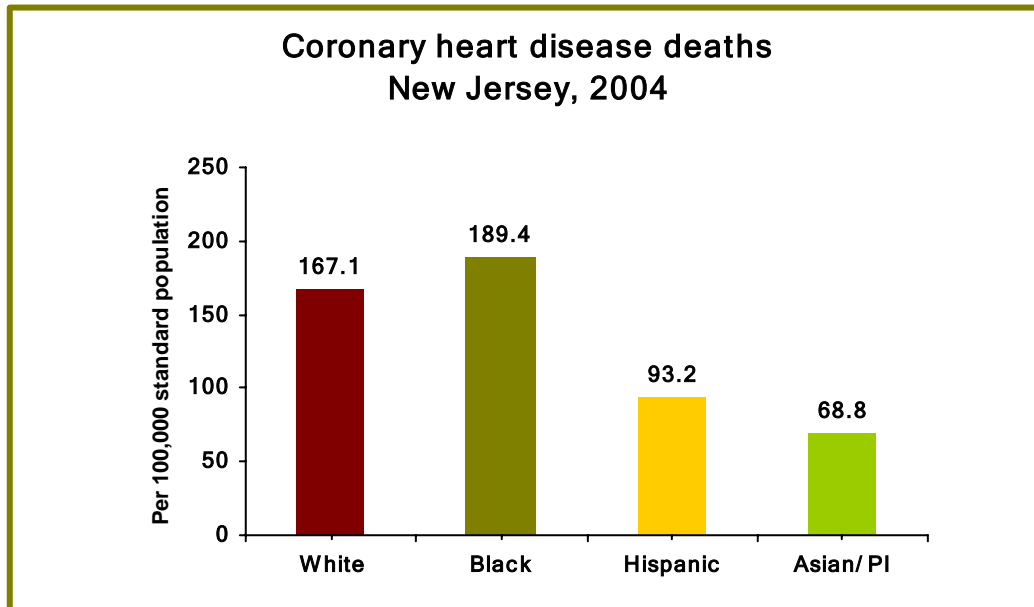
- An increase of 15% in the number of NJCEED eligible women aged 18-64 years (with intact cervix uteri) who have had a Pap test within the past 2 years.
- Increase in cancer-screening rates for all eligible women who have “never or rarely ever” been screened for cervical cancer.
- Based on prior year’s cervical and prostate cancer screening numbers for minority populations, demonstrate a 15% increase in the number of services to minority populations.
- Increase in the number of diagnosed early stage cancer cases by 15% for all cancers identified by the NJCEED.

## C. Area of Emphasis: Cardiovascular Disease

### Background Data

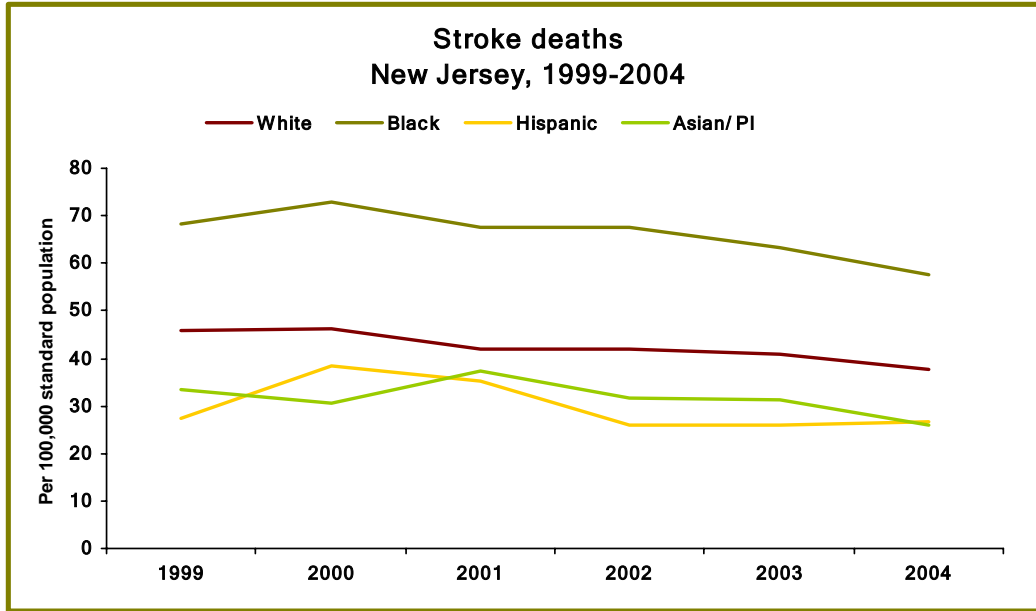
Heart disease is the leading cause of death in New Jersey. However, death rates due to coronary heart disease have been declining steadily in New Jersey for decades.

Differences in rates of death are apparent when comparing racial/ethnic groups and also when comparing age groups. Blacks and whites have much higher death rates than Hispanics and Asian/Pacific Islanders overall. The death rate for blacks is much higher in the 45-64 year old age group than for whites of the same age group. Among persons aged 65 and older, whites experience the highest rate of coronary heart disease deaths.



*Source: New Jersey Department of Health and Senior Services, Center for Health Statistics*

Stroke is the third leading cause of death among New Jerseyans. Blacks are more likely to die from stroke than whites, Hispanics, or Asian/Pacific Islanders. Though the rates are declining overall, whites have had the greatest percent decline as compared to other racial/ethnic groups. In recent years, Hispanics have had the lowest stroke death rates.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

The major risk factors for heart disease are overweight, physical inactivity, smoking, poor nutrition, high cholesterol, hypertension and diabetes. The NJBRFS collects data on each of these indicators by race/ethnicity. Blacks report higher levels for every risk area except for smoking and nutrition (eating less than five servings of fruits and vegetables per day) as compared to whites. Hispanics report lower rates of high cholesterol and high blood pressure diagnoses than whites.

Heart disease risk factors by race and ethnicity, NJBRFS, 2005				
Risk factor	Whites (%)	Blacks (%)	Hispanics (%)	Others (%)
Overweight	21.6	32.5	22.2	11.1
Physical Inactivity = less than 30+ minutes moderate physical activity for 5 or more days per week	50.0	58.3	62.8	61.2
Smoking	18.3	17.5	19.6	9.1
Nutrition=less than 5 fruits and vegetables per day	73.8	71.7	78.0	69.4
High Cholesterol	28.3	29.1	21.3	19.5
Hypertension	26.2	34.7	18.7	17.8
Diabetes	6.9	13.1	8.0	5.7

Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

## ***Building on Success***

- The Center for Health Statistics data systems provide vital information regarding the trends and patterns of cardiovascular disease and corresponding risk factors, thus effectively monitoring incidence and prevalence of cardiovascular disease as follows:
  - An interactive system called the *NJ State Health Assessment Data Query System* provides health data throughout the state;
  - The *NJ Health Statistics Report Series* summarizes deaths, births and population statistics; and
  - *Updated Healthy New Jersey 2010 (2005)* gives insight into the progress the State has made in addressing cardiovascular and other health issues.
  
- The New Jersey Comprehensive Tobacco Control Program encourages New Jerseyans to quit smoking while tracking their progress to date.
  
- The Office of Women’s Health is involved in a risk reduction 20-month initiative, “Take New Jersey Women to Heart,” a campaign that raises awareness and educates the general public about heart disease.

**Goal: Reduce the number of deaths due to cardiovascular disease through organized outreach and education efforts.**

## ***Action Plan***

### ***Steps and Timeline***

*FY 2007- 2010*

- Seek funding to create a centralized cardiovascular control program that addresses health disparities.
- Adopt administrative rules to implement licensing requirements for designation of stroke centers.

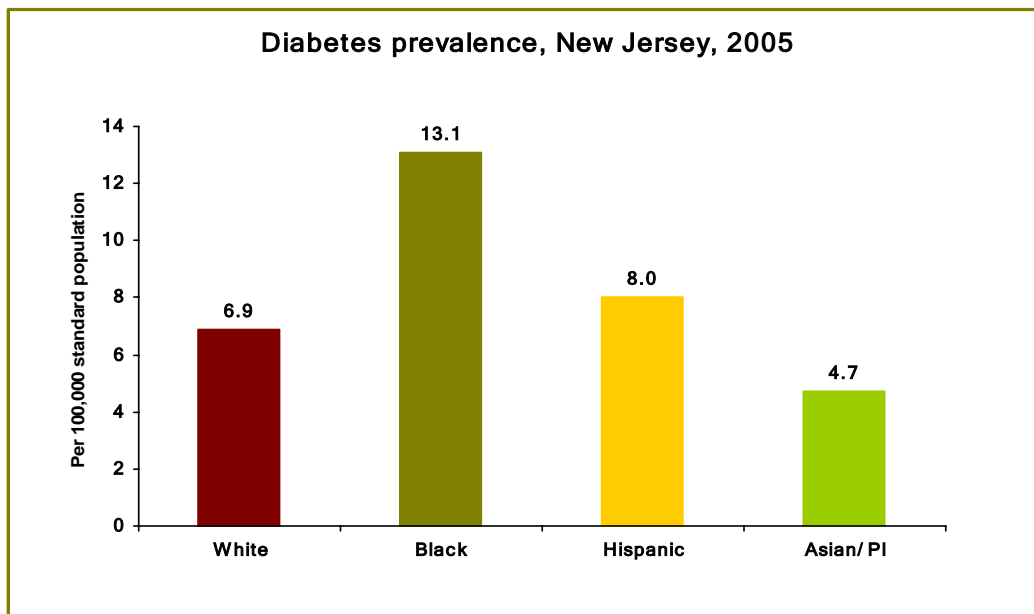
### *Outcome Measures*

- Funding obtained to create a cardiovascular control program that addresses health disparities.
- Monitor primary stroke centers data reporting as part of its quality improvement process.

## D. Area of Emphasis: Diabetes

### Background Data

An estimated 6.5 percent of adult New Jersey residents have been diagnosed with diabetes. The 2005 NJBFRS estimates blacks and Hispanics are significantly more likely than whites to suffer from the disease.

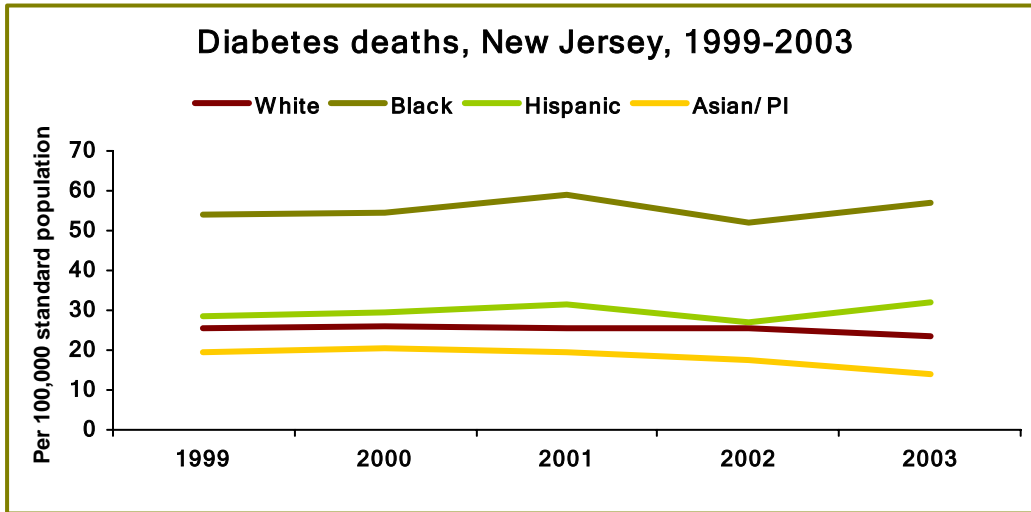


*Source: New Jersey Department of Health and Senior Services, Center for Health Statistics*

There are also racial/ethnic differences in the complications that result from diabetes. Though the incidence rate of end-stage renal disease (ESRD) due to diabetes per 1,000 persons diagnosed has slowly declined in recent years, blacks are still two times more likely than whites and Hispanics to develop ESRD.

Mortality rates for diabetes have also been decreasing among whites and Asians/Pacific Islanders yet they are increasing among blacks and Hispanics. Still, Asians and Pacific Islanders are two times less likely to die from diabetes than whites.

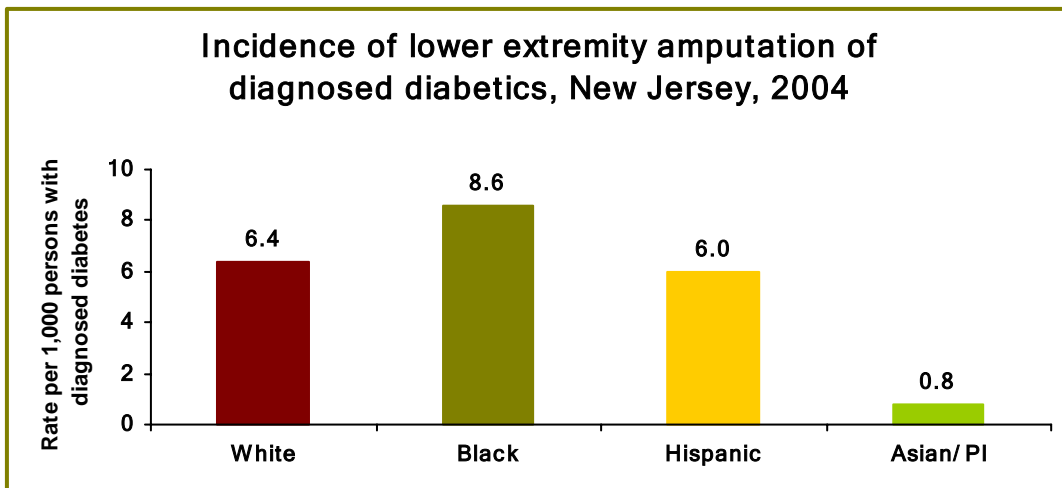
Blacks (56.9 per 100,000 population) are more than twice as likely as whites (23.6) to die from diabetes. Although the Hispanic death rate (31.9) is lower, this subpopulation is still more likely than whites to die from the disease. Asians/Pacific Islanders (13.8) have the lowest diabetes death rate of all.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

Lower extremity amputations may be required when diabetes causes damage to nerve endings or blood circulation to the feet or when foot ulcers occur. Significant differences in amputation rates between racial/ethnic groups have been documented nationwide.

These differences also exist in New Jersey. While blacks are most likely to have their lower limbs amputated, Asians/ Pacific Islanders are least likely as compared to all other racial/ethnic groups.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

## *Building on Success*

- The NJDHSS is linking community and faith-based organizations with health care providers, mainly Centers for Primary Health Care, to support early diagnosis and better management of diabetes in targeted minority communities. The increase in outreach and clinical encounters through diabetes screenings, education and self-management sessions in the black, Latino and Asian American communities are preventing unnecessary hospitalizations and deaths caused by diabetes. Also, these activities are increasing the number of individuals diagnosed with diabetes for the first time. Community-based organizations are partnering with Centers for Primary Health Care to increase referrals for clients identified as high risk or to link clients with services previously diagnosed with diabetes who are not receiving medical care. There are six NJDHSS diabetes health services grantees involved with aggressive outreach in minority communities, which includes administering the American Diabetes Association risk test at locations frequented by the populations such as churches, ethnic markets, health fairs, barbershops and beauty salons. As a result of this initiative, an increased number of minority individuals are linked to quality diabetes care where patients receive timely hemoglobin measurements, blood pressure measurements, lipid profile determinations, diabetic foot care, dilated eye examinations, immunizations, and lipid profile determinations. Community-based organizations also provide follow up and linkages to nutritional services, physical activity programs, and needed social supports.
- The Multicultural Health Disparities Task Force of the New Jersey Diabetes Council addresses barriers to care based on socioeconomic status and cultural diversity, and develops strategies to remove those barriers and increase the availability and quality of care to underserved segments of the New Jersey population. The Multicultural Health Disparities Task Force of the New Jersey Diabetes Council has created a framework for families to plot their relative risk for diabetes and other related chronic diseases.

- The New Jersey Diabetes Council Summit will be held on March 13, 2007. The conference will provide strategies for improving and achieving quality of diabetes care in a variety of practice settings. It will also demonstrate how electronic medical record systems can be used to enhance the quality of care in a clinical setting and will offer practical guidance on implementing such systems.

**Goal: To increase the number of minorities diagnosed with diabetes who receive high quality care and linkages to social supports.**

### *Action Plan*

#### *Steps and Timeline:*

##### *FY 2007-2010*

- NJDHSS diabetes grantees will collect diabetes outcome data.
- Additional Centers for Primary Health Care will participate in the Diabetes Collaboratives.
- Increase the number of minority clients who have access to needed pharmaceuticals through section 340B programs.
- Encourage diabetes grantees to explore funding opportunities from the Centers for Disease Control and Prevention and the American Diabetes Association.
- Encourage minority community-based organizations to participate in American Diabetes Association initiatives.

### *Outcome Measures*

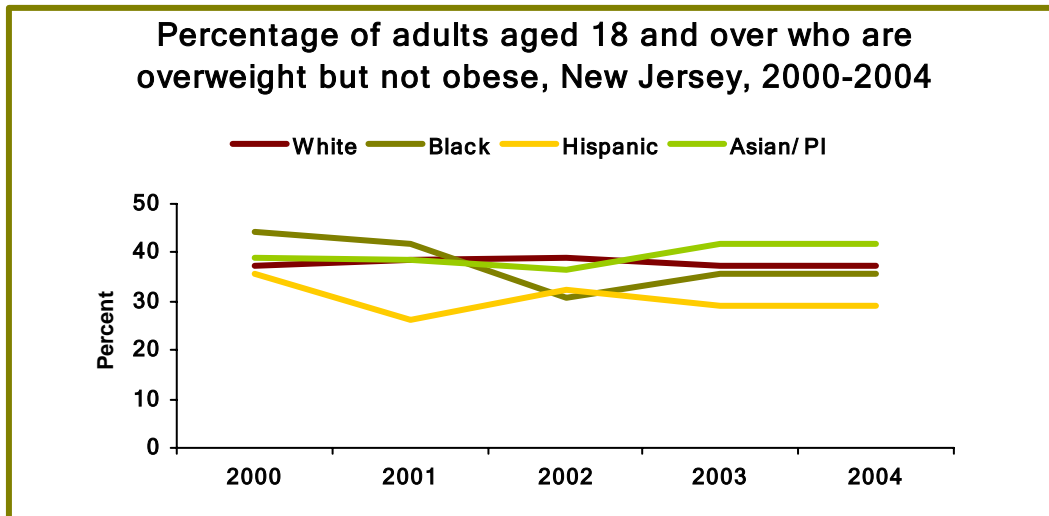
- Reduce the age-adjusted mortality rate from diabetes among blacks to 24.5 per 100,000 population and to 18.4 among Hispanics.
- Increase to 87 percent the proportion of minorities with diagnosed diabetes ages 18 and over who have had a dilated eye exam within the past year.
- Increase to 90 percent the proportion of minorities ages 18 and over with diagnosed diabetes who reported having a glycosylated hemoglobin measurement at least once a year.
- Increase the percentage of minority clients who have access to needed pharmaceuticals to better manage their diabetes through 340 B programs.
- Increase the percentage of Centers for Primary Health Care participating in the model Diabetes Collaboratives.
- Increase percentage of NJDHSS diabetes grantees who obtain funding from the American Diabetes Association, federal grants and foundations to continue programs currently supported by the State.

## E. Area of Emphasis: Obesity

### Background Data

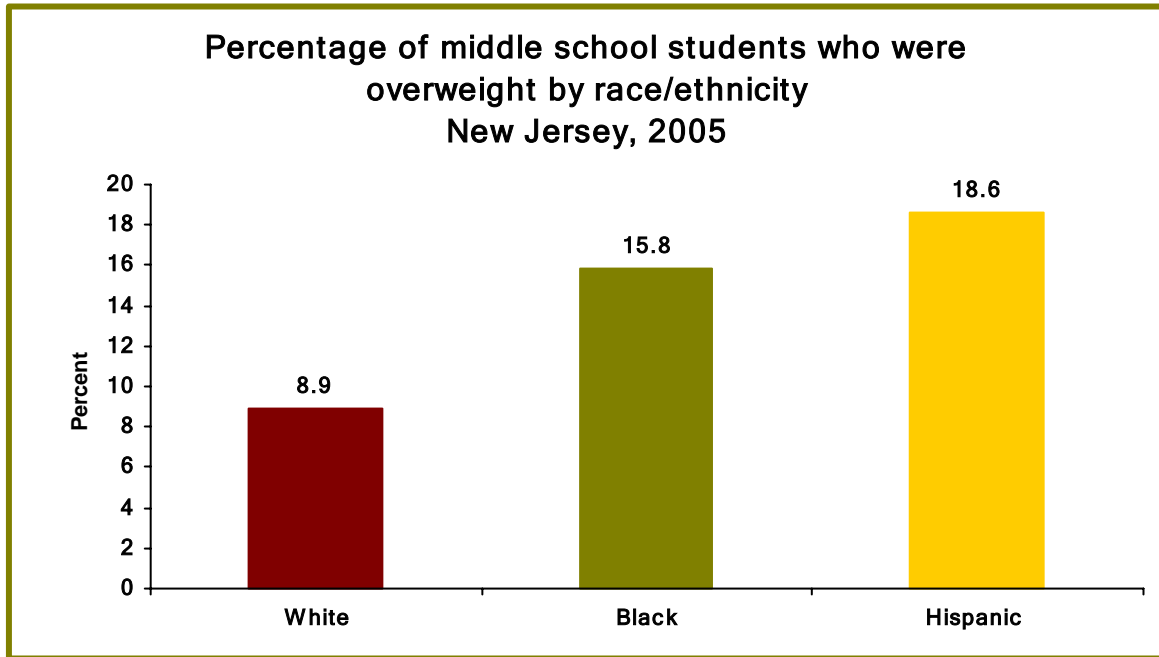
Obesity is a known risk factor for numerous chronic diseases including diabetes, heart disease, high blood pressure, gallbladder disease, arthritis, respiratory problems and some types of cancer. In 2004, New Jersey had the sixteenth lowest adult obesity prevalence in the nation (21.9%).

Several HNJ 2010 objectives aim to reduce the prevalence of overweight and obesity in New Jersey. The 2005 NJBRFS data show that more than half of New Jerseyans are either overweight or obese. Overall, the percentage of New Jerseyans who are overweight but not obese has declined slightly since 2000. Asian/Pacific Islanders had the highest prevalence of overweight but not obesity when compared to other groups.



*Source: New Jersey Department of Health and Senior Services, Center for Health Statistics*

This trend changes when we examine obesity prevalence by race/ethnicity. While the prevalence of obesity among New Jerseyans has been rising among all racial/ethnic groups since the early 1990s, the prevalence of obesity is significantly higher among blacks. Blacks are one and a half times more likely than whites and Hispanics, and three times more likely than other racial/ethnic groups to be obese.



*Source: NJ Department of Education, 2005 NJ Student Health Survey, YBRS*

New Jersey ranks number one in the nation for the percentage of overweight and obese low-income children aged two to five years old. According to a 2005 survey conducted by NJDHSS and the NJ Department of Education, 20 percent of the sixth-graders evaluated were obese, and another 18 percent were overweight.

Furthermore, the 2005 Youth Risk Behavior Survey (YBRS) of sixth to eighth-graders in New Jersey middle schools showed that 13 percent of the participating students were overweight (measuring for body mass index, by age and sex). Black and Hispanic students were up to two times more likely to be overweight than other racial/ethnic groups.

### **Diet and exercise**

Several factors contribute to obesity including lack of physical activity and poor nutrition. Two HNJ 2010 objectives track the level of physical activity (engagement in physical activity for at least 30 minutes per day) and the nutritional habits (eating at least five daily servings of fruits and vegetables) of New Jersey adults. The HNJ 2010 target

is to have 35 percent of New Jersey adults eating at least five daily servings of fruits and vegetables. Across all racial/ethnic groups approximately 26 percent meet this objective.

<b>Obesity risk factors by race/ethnicity, New Jersey, 2005</b>				
<b>Risk factor</b>	<b>White</b>	<b>Black</b>	<b>Hispanic</b>	<b>Other</b>
Percent eating 5+ servings of fruits and vegetables daily	26.2	28.3	22.0	30.6
Percent engaging in moderate physical activity 30 minutes or more daily	50.0	58.3	62.8	61.2

*Source: NJBRFS, 2005*

In tracking levels of moderate physical activity, there are greater differences between racial/ethnic groups. Blacks, Hispanics, and Asian/Pacific Islanders are less likely to meet the objective than whites who have achieved the HNJ 2010 target of reducing the number of persons who do not meet the objective to 50 percent.

### ***Building on Success***

In 2004, legislation was approved establishing the New Jersey Obesity Prevention Task Force. The purpose of the Task Force was to study, evaluate, and develop recommendations related to specific actionable measures to support and enhance obesity prevention among residents of the State, with particular attention to children and adolescents. In 2004, following the first meeting, three subcommittees were formed, Nutrition, Physical Activity, and Education. The subcommittees spent the next year researching, developing, and finalizing recommendations in their respective areas. These recommendations comprise the basis for a New Jersey Obesity Prevention Action Plan published in June 2006. Seven major themes serve as a framework: infrastructure, public/professional awareness, communities, schools, or workplace, health care system, and disparities.

- In January 2003, the Healthy Choices, Healthy Kids initiative to attack the obesity epidemic in New Jersey, was implemented. The mission was to combat childhood obesity and Type II diabetes and improve the overall health of New Jersey's schoolchildren by improving nutritional choices in schools, promoting greater

physical activity and encouraging healthy lifestyles, including the avoidance of cigarettes, drugs and alcohol. The target audience was children, parents, teachers, administrators, and school nurses. The NJ Department of Agriculture worked in cooperation with the Department of Health and Senior Services and the Department of Education to develop a comprehensive strategy to address the goals set forth in this initiative.

- As one component of this initiative, the Department of Agriculture adopted amendments to the state administrative code that deals with the Child Nutrition Programs requiring schools to adopt a local level nutrition policy that establishes nutritional standards for snacks and beverages sold or given out anywhere on school property. School nutrition policy will be based on the Department of Agriculture's model. The State Board of Education reviewed and readopted the New Jersey Core Curriculum Content Standards in Comprehensive Health and Physical Education in 2004 to include this model.

**Goal: Decrease disparities in obesity and increase healthy eating and physical activity across the lifespan among high risk groups (including black and Hispanic populations and those with low socioeconomic status) in New Jersey.**

### *Action Plan*

#### *Steps and Timeline:*

*FY 2007- 2010*

- Create a State Office of Obesity Prevention under the domain of the Department of Health and Senior Services that will utilize existing resources to address obesity prevention and reduction, especially among children.
- Appoint an Obesity Prevention Task Force to address the goals and objectives of the NJ Obesity Prevention Action Plan.
- Release the NJ Obesity Prevention Action Plan.
- Apply for external funding.

### *Outcome Measures*

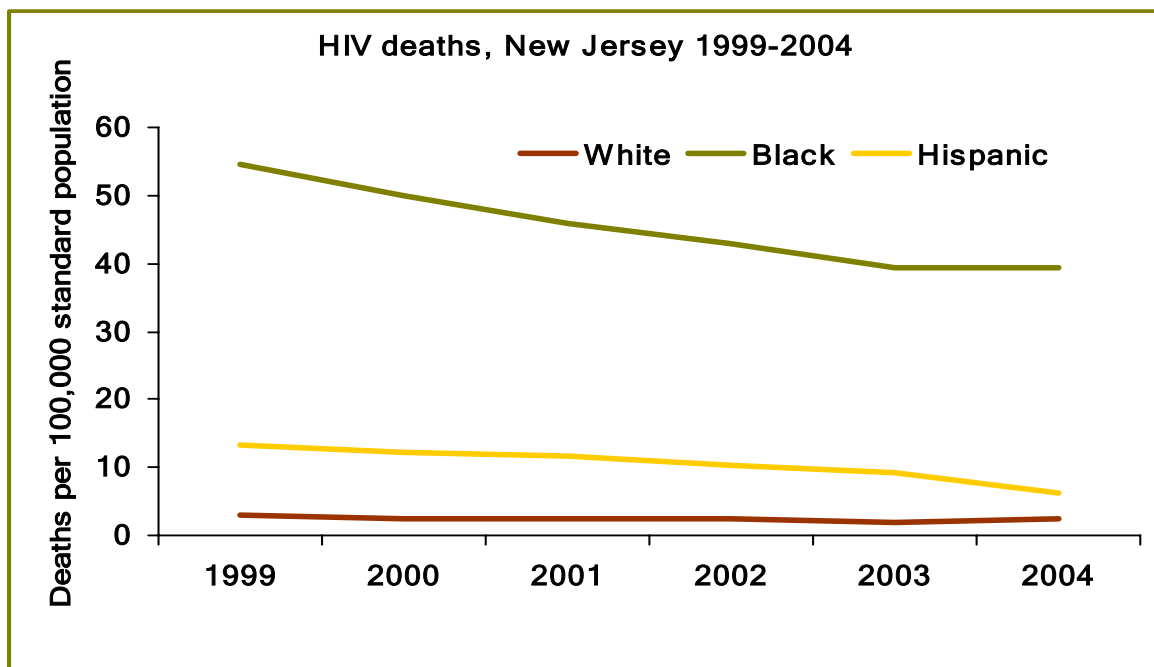
- Establish the state Office of Obesity Prevention under the domain of the Department of Health and Senior Services.
- Convene the first statewide conference to kick-off the Obesity Prevention Action Plan.
- Reconvene the Obesity Prevention Task Force.
- NJ Obesity Prevention Action Plan is implemented.
- Reduce the percentage of black and Hispanic adults ages 18 and older who are obese to 15, and 12 percent, respectively.
- Reduce the percentage of black and Hispanic adults ages 18 and older who are overweight but not obese to 28.4, and 32.4 percent, respectively.

## F. Area of Emphasis: HIV/AIDS

### Background Data

In 2006, nearly 34,000 New Jerseyans were reported to be living with HIV or AIDS. Racial/ethnic minorities in the State account for 78 percent of those living with the disease. Overall, one in 65 blacks in New Jersey is living with AIDS. For Hispanics, one in 185 is living with the disease. The prevalence among whites is much lower, with one in 783 living with the disease.

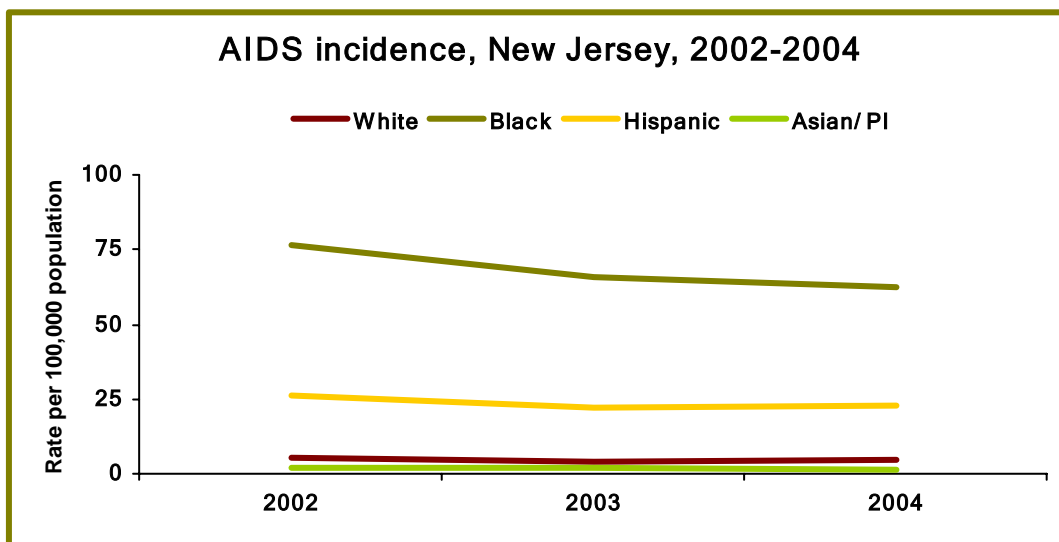
HIV disease is the third leading cause of death among black males, the fifth leading cause of death among black females and the number one cause of death among all blacks aged 25 to 44 years old. Among Hispanics in New Jersey, HIV disease is the ninth leading cause of death over all ages and the third leading cause among all Hispanics aged 25 to 44. It is the nineteenth leading cause of death among all whites and the twenty-fifth among Asian and Pacific Islanders.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

There are eight HNJ 2010 objectives which aim to reduce the prevalence, mortality, and incidence of HIV disease and AIDS in the state. For the total New Jersey population and across each racial/ethnic group, the State has met and surpassed the HNJ 2010 target for reducing the rate of deaths due to HIV disease. However, the mortality rate from HIV disease in New Jersey is still sixteen times higher for blacks than whites. The rate is three times higher for Hispanics when compared to whites.

The 2004 incidence of AIDS is also strikingly higher among blacks (62.1 per 100,000 standard population) and Hispanics (23.0) compared to whites (4.4). However, AIDS incidence rates have been declining overall and within racial/ethnic groups in New Jersey. The 2004 data suggest that the HNJ 2010 objective to reduce AIDS incidence to 4.3 per 100,000 population for whites and 21.3 for Hispanics will be met. Though declines in rates for blacks have been achieved, for this group a decrease in half the current rate is still required to achieve the HNJ 2010 target of 31.1. The AIDS incidence rate for blacks is fifteen times the white rate and three times the Hispanic rate. Among Asian/Pacific Islanders, AIDS incidence rates are so low (1.1 per 100,000 population) that no target was set in HNJ 2010.



Source: New Jersey Department of Health and Senior Services, Division of HIV/AIDS

Also in 2004, within the 15 to 44 year-old age group, black males had the highest HIV disease incidence rate in the state (153.9 per 100,000 standard population) as compared to white (14.5), Hispanic (64.3), and Asian/Pacific Islander (6.5) males of the same age. This pattern is consistent among new HIV disease cases for adolescents aged 13 to 24 years per 100,000 standard population and for persons at least 50 years old.

HIV disease and AIDS incidence rates <sup>†</sup> by age, gender and race/ethnicity New Jersey, 2004				
Sub-population per 100,000	White	Black	Hispanic	Asian/PI
HIV disease incidence, females 15-44	3.9	105.7	105.7	2.6
HIV disease incidence, males 15-44	14.5	153.9	153.9	6.5
HIV disease incidence, ages 50 +	4.7	75.8	75.8	1.5
HIV disease incidence, adolescents 13-24	2.5	55.0	55.0	1.1
AIDS incidence, total population	4.4	62.1	62.1	1.1

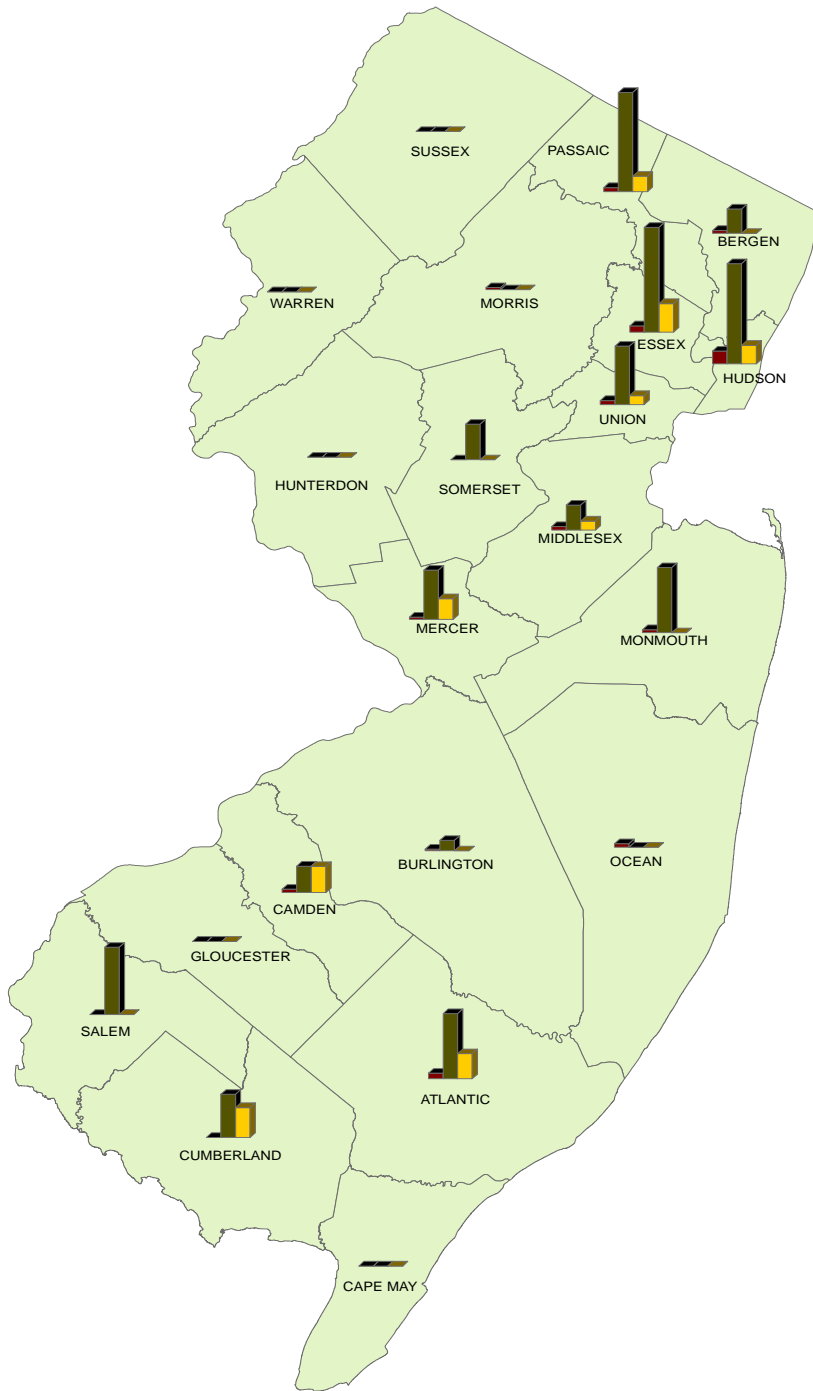
<sup>†</sup> Rates are per 100,000, US 2000 Census standard population

Source: NJDHSS, Division of HIV/AIDS Services

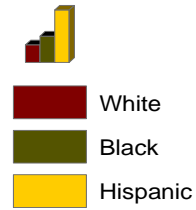
### County-specific HIV disease rates

HIV disease rates are concentrated in about 10 of New Jersey's counties. More than half of people living with HIV/AIDS reside in three counties (Essex (30%), Hudson (14%), and Passaic (8%). Another third live in 7 other counties: Atlantic, Bergen, Camden, Hudson, Mercer, Middlesex, Monmouth, and Union. Mortality rates from HIV disease among blacks in these counties occur at ten to nearly fifty times the rate of whites in the county. The map below shows the percentage of HIV/AIDS deaths as they occur by county and by racial/ethnic group.

## Death Rates from HIV per 100,000 Population By Race and Hispanic Origin New Jersey, 1999-2003



Death Rates per 100,000



COUNTY	WHITE	BLACK	HISPANIC
Atlantic	4.0	47.0	18.1
Bergen	2.0	17.6	0.0
Burlington	1.2	7.4	0.0
Camden	2.4	19.0	18.8
Cape May	0.0	0.0	0.0
Cumberland	0.0	31.2	21.6
Essex	4.5	75.6	20.5
Gloucester	0.0	0.0	0.0
Hudson	9.2	72.3	13.4
Hunterdon	0.0	0.0	0.0
Mercer	1.7	35.6	15.0
Middlesex	2.6	18.0	6.5
Monmouth	2.2	47.0	0.0
Morris	1.5	0.0	0.0
Ocean	2.5	0.0	0.0
Passaic	2.9	71.6	11.1
Salem	0.0	48.5	0.0
Somerset	0.0	25.6	0.0
Sussex	0.0	0.0	0.0
Union	2.9	42.2	6.5
Warren	0.0	0.0	0.0

Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

In addition, injecting drug use (IDU) continues to constitute the largest proportion of HIV/AIDS cases in New Jersey, comprising over 40 percent of all infections. This rate of infection related to IDU is almost twice the national average. While some studies indicate a relationship of IDU, sharing needles and HIV infections, syringe exchange programs remained elusive in New Jersey. Until late 2006, New Jersey was one of only two states that did not allow any form of sterile syringe access for injection drug users. In December 2006, Governor Jon Corzine signed a bill that permits the establishing of six demonstration sites for sterile syringe exchange programs.

### *Building on Success*

- The reduction in the HIV disease death rate is largely due to greater access to life prolonging and life sustaining medications. With the advent of antiretroviral therapies in the late 1990's, the incorporation of combination "cocktails" of various medications, and getting more HIV infected individuals into care sooner (as well as implementing better ways to assure that patients regularly take their medications), the overall death rate in New Jersey has been reduced. Much of this access to antiretroviral therapies is due to the existence of our AIDS Drug Distribution Program (ADDP), which provides a comprehensive formulary of medications to those eligible patients with HIV disease.
- Perinatal transmission of HIV declined by 27% from 1991 to 2005 and the rate of decline for blacks is steeper than that of whites.
- Rapid HIV testing is available throughout New Jersey at over 160 publicly funded HIV counseling and testing sites. From December 2003 through the middle of November 2006, almost 90,000 people were tested with the rapid testing technology.
- Of the estimated 1,500 people that have tested positive since 2003, almost 70% of them are "new" positives (i.e., people that have never been tested before, and are therefore new to our system).
- In 2006, Governor Jon Corzine signed a law authorizing a demonstration project allowing up to six New Jersey cities to implement syringe-exchange programs. Increasing sterile syringe availability through syringe exchange programs, pharmacy sales, and physician prescription will reduce needle sharing among injection drug

users, and subsequently decrease transmission of HIV/AIDS and hepatitis. Syringe exchange programs and pharmacy sale of syringes have also been shown to increase safe disposal of used syringes. In addition, these programs may refer injecting drug users to drug treatment, social services, and primary health care resources.

**Goal: Reduce the incidence of HIV/AIDS among minority populations through increased education and facilitation of greater access to care.**

### *Action Plan*

#### *Steps and Timeline:*

##### *FY 2007-2010*

- Increase percentage of HIV positive individuals receiving care.
- Increase percentage of individuals tested for HIV, and the number who receive their test results.
- Implement and evaluate syringe exchange programs over a three-year period.
- Encourage providers to discuss more routinely with their patients safe sex options, particularly condom usage.

#### *Outcome Measures*

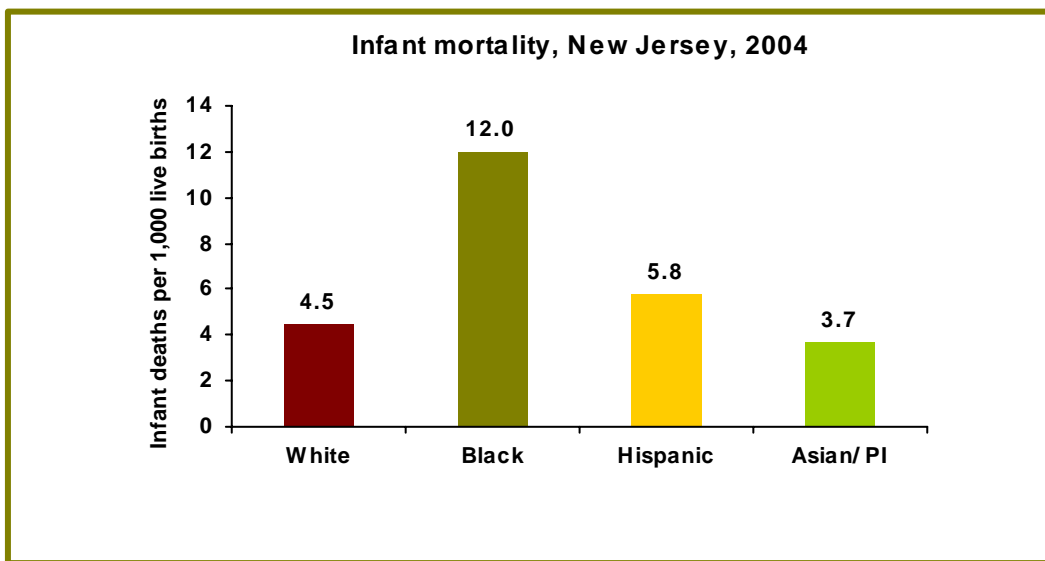
- Increase the percentage of HIV positive or AIDS patients receiving care, particularly African Americans and Latinos, each year by 10%.
- Increase the percentage of individuals tested with the rapid technology, and the number who receive their test results, by 10% each year.

- Increase the number of health care agencies who make HIV testing routine as outlined in CDC's "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings."
- Establish up to six (6) syringe exchange programs during the first year by (1/08); monitor progress through the second year ('09); and conduct evaluation by the third year ('10).
- Reduce new HIV infections by 25%.

## G. Area of Emphasis: Infant Mortality

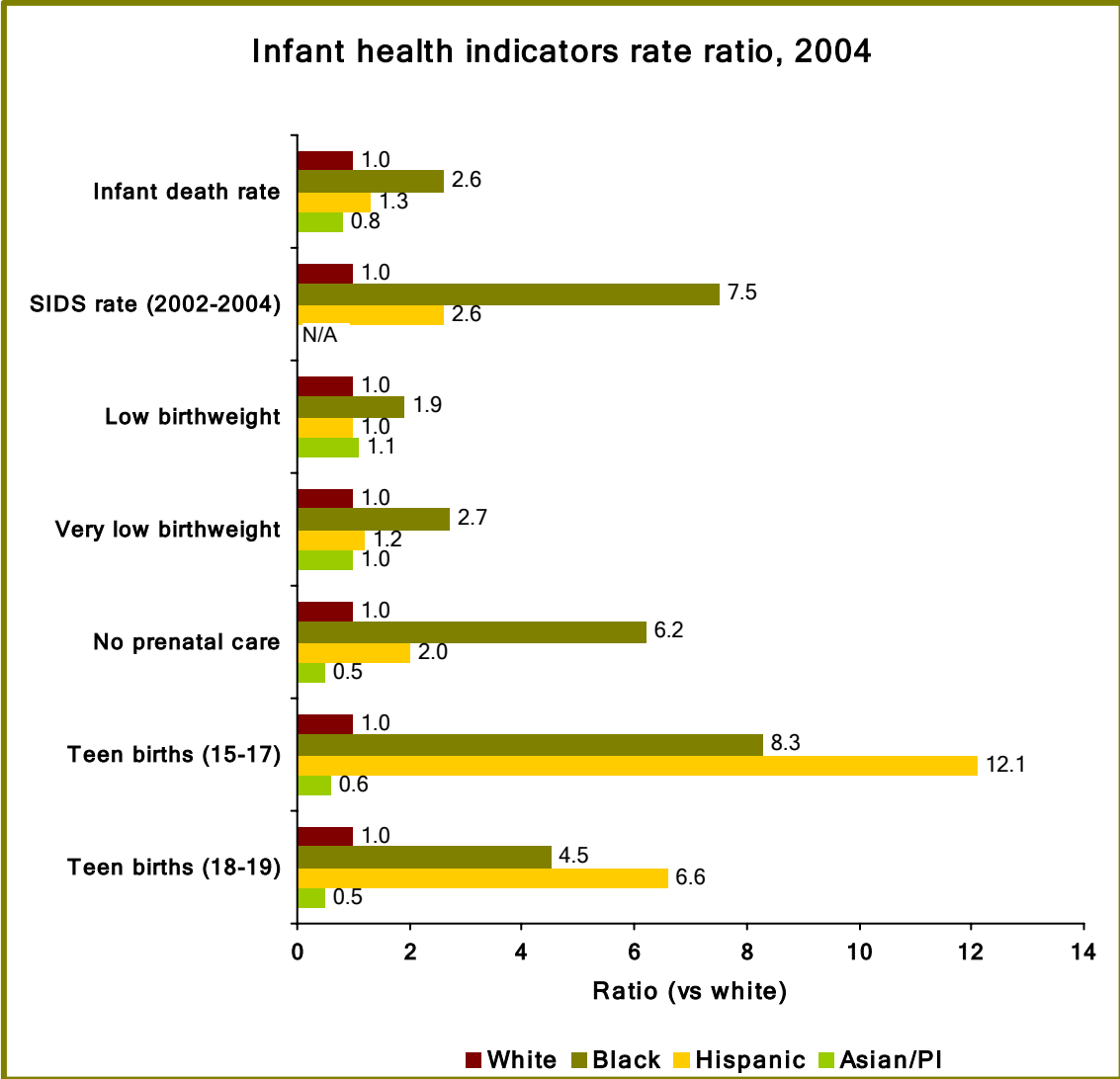
### Background Data

While infant mortality rates overall are declining in New Jersey and within all racial/ethnic groups, blacks have significantly higher infant mortality rates than other groups. The infant mortality rate among blacks remains nearly three times the rate among whites. The rate among Hispanics is 1.3 times the white rate, while the rate among Asian/Pacific Islanders has been about the same as for whites over the last few years.



*Source: New Jersey Department of Health and Senior Services, Center for Health Statistics*

Racial/ethnic disparities occur among many of the infant health indicators outlined in HNJ 2010. The following graph summarizes the ratios of infant health indicators for minority groups as compared to whites. For example, the Sudden Infant Death Syndrome (SIDS) rate is 7.5 times higher for blacks than for whites and the teen birth rate among Hispanics aged 15 to 17 years is 12.1 times the rate among whites. The birth rate to Asian/Pacific Islander teens aged 18 to 19 years, however, is half the rate among whites.



*Source: New Jersey Department of Health and Senior Services, Center for Health Statistics*

## *Building on Success*

- The Black Infant Mortality Reduction (BIMR) Initiative is long standing in New Jersey and involves the Maternal and Child Health Consortia, Healthy Mothers/Healthy Babies and Healthy Start grants. These projects successfully link black women and their infants to comprehensive maternity and pediatric services. Some programs provide case management support to mothers throughout the prenatal period. BIMR also promotes collaboration among churches, grassroots organizations, businesses and other community-based organizations, including the sponsorship of forums and presentations on black infant mortality.
- In 2006, a Request for Proposals was released focusing on modifying the behaviors, lifestyles and conditions that affect birth outcomes by improving the quality of care provided during the prenatal and infant period.
- Service providers and community-based organizations have partnered to improve black infant mortality rates in New Jersey. This collaborative approach addresses the behaviors, lifestyles, and conditions that affect black infant birth outcomes.
- The patient education brochure, *These Tests Could Save Your Baby's Life: Newborn Screening Tests*, as well as two of the 20 fact sheets on inheritable disorders, are available in English and Spanish. The brochures are routinely sent by the program to all birthing facilities for inclusion in their newborn information packets.
- Women, Infants, and Children (WIC), a multi-component, comprehensive, cost-saving public health nutrition program, addresses the specific health and nutrition needs of pregnant, postpartum, breastfeeding women in low socioeconomic status, infants and children. The ethnic distribution of New Jersey WIC participants is composed of 26% black (non-Hispanic), 52% Hispanic, 18% white (non-Hispanic), 3% Asian (non-Hispanic) and 1% other.

**Goal: Decrease disparities in birth outcomes between white and black infants.**

## *Action Plan*

### *Steps and Timeline*

*FY 2007- 2010*

- Provide cultural competency training for paraprofessional and professional health care staff.
- Increase outreach and basic education to the community on black infant mortality.
- Increase funding to support enhanced prenatal and pediatric services.
- Utilize newborn screening and genetic services follow-up programs to ensure that all infants born in New Jersey who have abnormal newborn screening test results receive appropriate and timely case management services.
- Inform appropriate parties including primary care physicians, medical specialists and parents of abnormal screening results.

### *Outcome Measures*

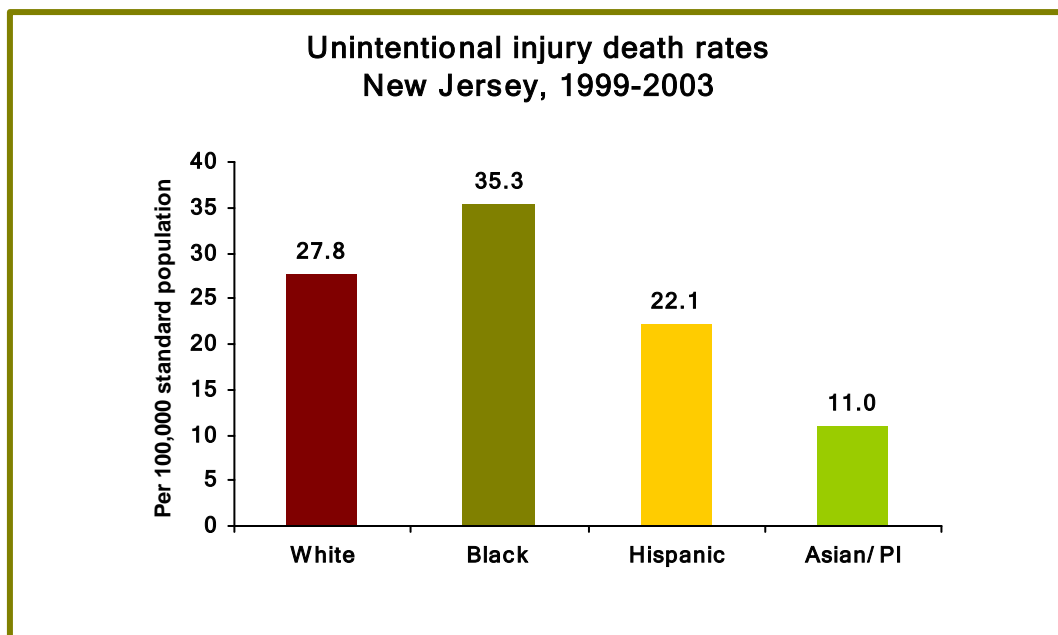
- Reduce the infant mortality rate to 7.5 per 1,000 live births for blacks and 6.4 for Hispanics.
- Reduce the percentage of infants with birth weight less than 2,500 grams to 7.5 percent for black and 6.0 percent for Hispanic and Asian/Pacific Islander populations.
- Increase the percentage of paraprofessionals and professional health care staff completing cultural competency training.
- Increase to 85 percent the proportion of black and Hispanic live births for which the mother received prenatal care in the first trimester of pregnancy.

## H. Area of Emphasis: Unintentional Injuries

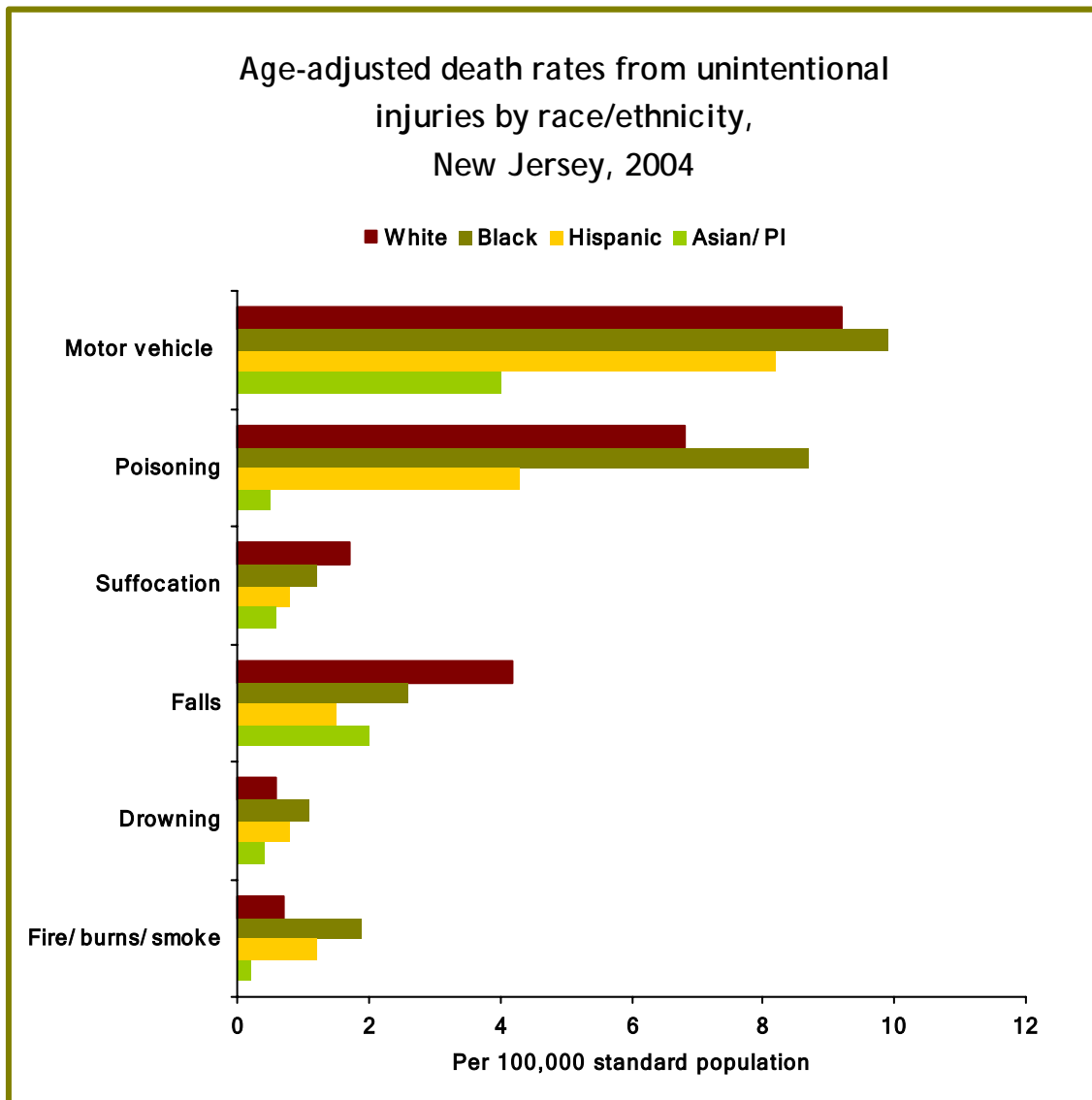
### Background Data

Unintentional injuries are the sixth leading cause of death for all New Jerseyans. Eighty percent of fatal injuries are the result of motor vehicle crashes, poisoning, falls, suffocation (choking and asphyxiation) or fires. Injuries are also the cause of 6 percent of all hospitalizations and emergency department visits in the state each year.

Overall, blacks suffer the highest rate of fatal unintentional injury (35.3 per 100,000) as compared to all other groups combined (20.3). This pattern is consistent with national figures. In particular, blacks have higher death rates from motor vehicle, poisoning, drowning, and fire, burn, or smoke injuries. Whites are more likely to suffer fatal injuries due to suffocation and also as a result of falls than other racial/ethnic groups.



*Source: New Jersey Department of Health and Senior Services, Center for Health Statistics*



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

Mechanism	White	Black	Hispanic	Asian/PI
Motor vehicle-related	9.2	9.9	8.2	4.0
Poisoning	6.8	8.7	4.3	0.5*
Suffocation	1.7	1.2	0.8	0.6
Falls	4.2	2.6	1.5	2.0
Drowning	0.6	1.1	0.8	0.4
Fire/burns/smoke	0.7	1.9	1.2	0.2*

Source: NJDHSS, Center for Health Statistics \*Number of cases was too low to compute a statistically reliable rate.

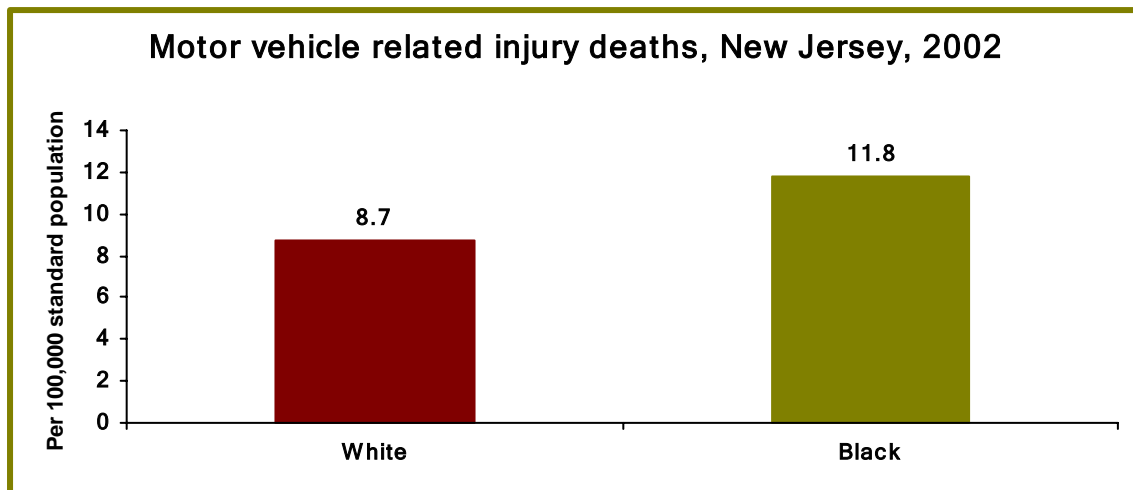
## Traumatic brain injury

One HNJ 2010 objective is to reduce the incidence rate of traumatic brain injuries (TBI) per 100,000 standard population. Overall reduction in incidence occurred from 1997 (baseline) to 2002 (the most recent data year), however, the TBI incidence rate is higher among blacks and Hispanics as compared to whites. Rates could not be calculated for Asians/Pacific Islanders because the number of injuries was too small to compute a statistically reliable figure. Major causes of TBI are motor vehicle injuries, falls, and assaults. In the case of blacks, excess TBI results primarily from elevated rates of motor vehicle injuries and assaults.

Traumatic brain injury incidence rates by race/ethnicity, New Jersey, 1997-2002			
Race/Ethnicity	1997 (Baseline)	Most Recent Data (2002)	2010 Target
White	102.0	84.5	96.3
Black	157.7	108.0	146.8
Hispanic	119.2	123.6	*

*\*A target was not set because data for sub-population were statistically unreliable, Source: NJDHSS, Center for Health Statistics*

## Motor vehicle related injury

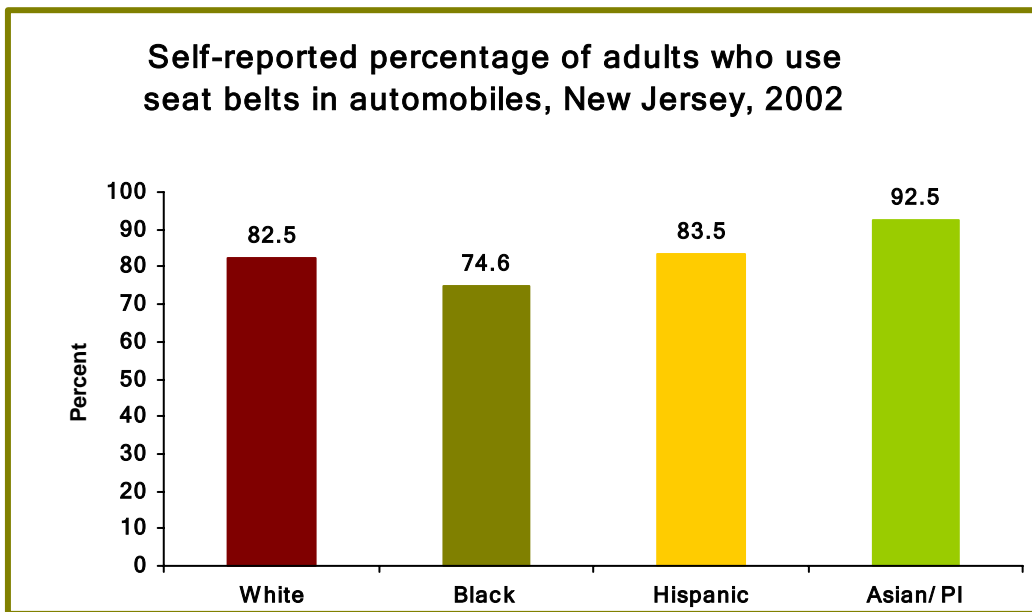


*Source: New Jersey Department of Health and Senior Services, Center for Health Statistics*

Motor vehicle injuries are a significant cause of excess injury mortality for blacks. The HNJ 2010 target for mortality from motor vehicle injuries for blacks is 6.9 per 100,000 standard population, far below current levels. Declines in fatalities from motor vehicle injuries have been relatively flat among all racial/ethnic groups in recent years, but blacks in particular have rates which are higher than those of other groups, and exceed the HNJ 2010 target by a considerable extent.

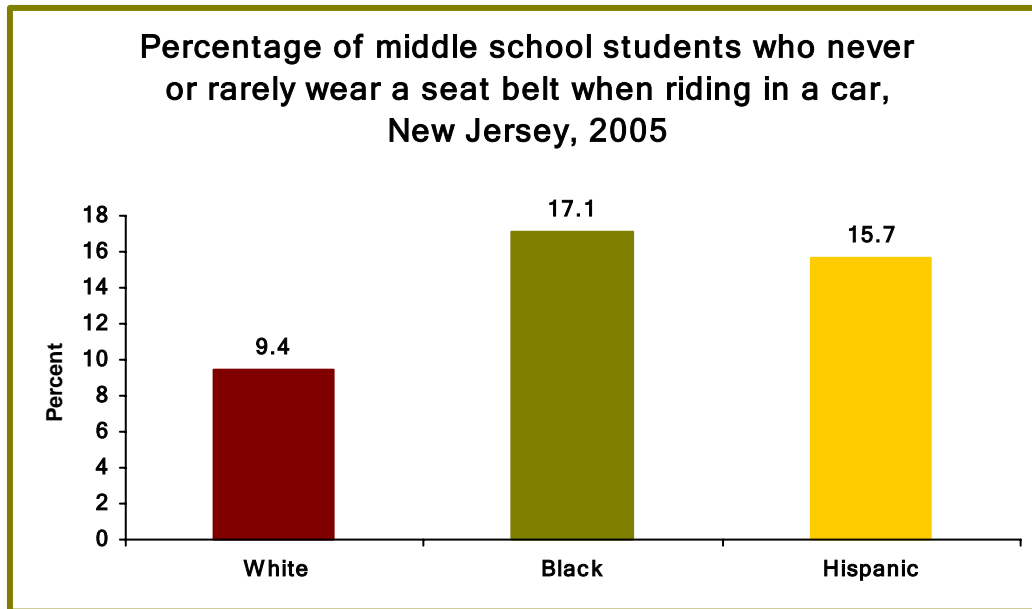
### Seat Belt Use

One important component of reducing fatalities from motor vehicle crashes is seat belt use. The rate of seat belt use among blacks is considerably below those of other groups. Recent data from the NJBRFS shows that approximately 75 percent of blacks report seat belt use, as compared with 82 percent of whites, 84 percent of Hispanics, and 92 percent of Asians/Pacific Islanders.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

According to the 2005 Youth Behavior Risk Survey, black and Hispanic children are far less likely than white children to wear a seat belt on a regular basis when riding in a car.



Source: 2005 Youth Behavioral Risk Survey, NJ Middle School Survey, New Jersey Department of Education

## Pedestrian Injury

A category of motor vehicle injury which is particularly relevant to racial disparities is pedestrian injury. Children and older adults are at especially high risk for pedestrian injuries, but among blacks, rates are elevated at all ages relative to other racial/ethnic groups. No specific HNJ 2010 objectives were established by race/ethnicity with regard to pedestrian injuries, but rates among blacks exceed general target levels set for the overall population.

Transportation-related pedestrian death rates <sup>†</sup> by race/ethnicity, New Jersey, 1999-2003		
Race/Ethnicity	Number	Rate (per 100,000)
White	549	1.8
Black	172	3.1
Hispanic	132	2.6
Asian/Pacific Islander	36	1.8

<sup>†</sup>Rates are age-adjusted using the US 2000 standard population, Source: NJDHSS, Center for Health Statistics

## *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, such as central nervous system (CNS) injury surveillance, violent death surveillance, the creation of a state trauma registry, and the creation of a statewide strategic plan for injury control and prevention. OISP, in conjunction with the New Jersey Commission on Spinal Cord Research and the New Jersey Commission on Brain Injury Research, and with original funding from the CDC, has developed a CNS Registry, which is evolving into a statewide trauma registry which will include all major traumas.
- The OISP maintains the CDC-funded New Jersey Violent Death Reporting System which is a detailed database on violent fatalities in the State.
- OISP is currently working with New Jersey Department of Transportation (NJDOT) on a number of projects designed to reduce motor vehicle injuries, including combining crash data with hospitalization and death data to learn more about location and circumstances of motor vehicle crashes causing severe injury and death. Additionally, OISP is in the process of finalizing a statewide injury control and prevention plan, which is the result of collaboration with injury prevention specialists in state government and elsewhere. The strategic plan will include specific recommendations for actions to reduce injury in all major injury areas.
- OISP is working to integrate surveillance data with injury prevention and control efforts statewide. Injury reduction activities also take place in NJDHSS's Divisions of Family Health Services and Senior Services, as well as in many other agencies of state and local government.

- The NJDHSS Division of Family Health Services Program's *Community Partnership for Healthy Adolescents* project addresses risk-taking behaviors among youth, including injury-related risk behaviors. The overall goals of the program are to establish community-based partnerships to improve the health of adolescents and to provide the foundation for the development and maintenance of positive health habits among adolescents. Grantees include local health departments and community organizations. Many are targeting issues related to suicide. As of 2003, eight agencies were funded, serving nearly 1,800 adolescents.
- The NJDHSS Division of Senior Services funds and directly provides a number of injury prevention programs. Many are targeted at preventing osteoporosis and falls. They have worked with OISP to obtain data on hip fractures, falls and other measures that are relevant to their program areas. A post-doctoral fellow in nursing with expertise in falls is working to develop fall prevention initiatives to be implemented in a variety of settings.

**Goal: Reduce excess morbidity and mortality due to unintentional injuries among minorities.**

### *Action Plan*

#### Steps and Timeline

*FY2007-2010*

- Support injury prevention activities in community-based organizations by providing appropriate data and materials for distribution. Specific areas to target are pedestrian safety for children and the elderly, driver safety, seat belt use, child car seat use, and smoke alarm installation and maintenance, water safety and swimming ability.
- Work with NJDOT to identify geographic areas of high pedestrian injury rates among minorities. Collaborate with NJDOT on evaluating the impact on

pedestrian injuries of environmental modifications to roadways by providing data on injuries and fatalities. Support pedestrian safety activities in communities by providing appropriate data on injuries.

### *Outcome Measures*

- Complete and release the Comprehensive Injury Prevention and Control Strategic Plan for New Jersey, scheduled for April, 2007.
- Reduce the age-adjusted mortality rate from motor-vehicle-related injuries for blacks to 6.9 per 100,000 standard population.
- Increase the percentage of minorities ages 18 and over who use seat belts in automobiles to 85 percent.
- Reduce the age-adjusted mortality rate from motor vehicle related injuries for blacks to 6.9 per 100,000 standard population.
- Reduce the age-adjusted pedestrian mortality rate from transportation-related injuries to 1.0 per 100,000 standard population for blacks and Hispanics.

## II. Strengthening the Infrastructure

## A. Strengthening the Infrastructure: Language Access

More than a quarter of New Jerseyans do not report English as their primary language, according to 2000 US Census data. Among these, approximately 11 percent speak Spanish, and another 12 percent speak other Indo-European or Asian and Pacific Island languages. About 10 percent of those who speak another language report that they speak English less than very well. Between 1990 and 2000, the number of New Jerseyans speaking a language other than English at home grew from 1.4 million to 2 million. The number of New Jersey Spanish-speakers grew 56 percent.

Studies demonstrate a wide range of adverse effects that limited English proficiency can have on health and use of health services, including:

- impaired health status;
- lower likelihood of having a regular physician;
- lower rates of mammograms, pap smears, and other preventive services;
- non-adherence with medications;
- greater likelihood of a diagnosis of more severe psychopathology;
- leaving the hospital against medical advice among psychiatric patients;
- lower likelihood of being given a follow-up appointment after an emergency department visit;
- increased risk of intubations among children with asthma;
- greater risk of hospital admissions among adults;
- increased risk of drug complications;
- longer medical visits;
- higher resource utilization for diagnostic testing;
- lower patient satisfaction; and
- impaired patient understanding of diagnoses, medications, and follow-up.

Also, recent research demonstrates that the use of untrained, non-professional interpreters, such as family members, is associated with a substantially higher risk of interpreter errors of potential or actual clinical consequence.<sup>iii</sup>

Like many other states, NJ State law mandates a patient's right to receive the services of a translator or interpreter to facilitate communication between them and the health care provider.

### *Building on Success*

New Jersey is a culturally diverse state with more than 100 languages spoken. OMMH commissioned a study to determine to what extent NJ hospitals are meeting the needs of the LEP population. The study 1) assessed the effectiveness of current interpreter services in New Jersey's hospital meeting the needs of LEP patients and, 2) made recommendations on how best to meet the needs of LEP patients in New Jersey.

- As a result of the Department-commissioned study, the New Jersey Hospital Association (NJHA) developed the NJHA Language Access Task Force that released an "Interpreter/Translation Services White Paper" in February 2007. This groundbreaking paper included a series of recommendations to increase access to medical interpreters and other language services in New Jersey hospitals.
- OMMH also conducted a focus group on language access throughout the Department. The group discussed various department programs, the communities they serve and their language access needs. The group also discussed the availability, or lack thereof, of interpretation and translation services. In addition, they suggested solutions about what is needed within the Department in order to meet the needs of those whose primary language is not English.
- OMMH now makes available through its website a limited number of hospital documents translated into four different languages (Spanish, Hindi, Haitian Creole, and Mandarin Chinese).

- The NJDHSS has made numerous health information documents available in Spanish as well as other languages frequently spoken in New Jersey. NJDHSS also has provided interpreters on some of its 800 health information lines.

**Goal: Increase access to language services for those who are more proficient in a language other than English.**

### *Action Plan*

#### *Steps and Timeline:*

##### *FY 2007-2010*

- Develop a website with translated health education materials.
- Pilot a demonstration project in partnership with the NJHA to train bilingual staff as medical interpreters.
- Pilot a demonstration project to train community based-organization bilingual staff as medical interpreters.
- Disseminate “I Speak Poster” to New Jersey hospitals in partnership with NJHA to assist in interpretation.
- Increase capacity of NJDHSS licensing staff members that monitor health care facilities to assess language access services.
- Revise the discharge planning section of the licensing regulations to explicitly address language and cultural barriers.

#### *Outcome Measures*

- Increase by 100 percent materials posted on the OMMH “translated materials” webpage.
- Two 8-hour training sessions conducted in Atlantic County for hospital bilingual staff.

- Staff of eight to ten minority community-based organizations (CBOs) trained in medical interpretation, cultural competency and community health.
- All NJHA member hospitals receive the “I Speak” poster an interpretation assistance tool.
- Increased number of NJDHSS licensing staff members who are trained in monitoring language access services at regulated facilities.
- Review and amend the hospital discharge planning rules to incorporate specific elements related to language access.

## B. Strengthening the Infrastructure: Data

Public health experts agree that improving data collection is essential to addressing health disparities. Data can tell the story of which population is more affected by a disease and which population is least likely to receive critical treatments. There are multiple data sources available; however, there is inconsistency in the collection process. There is limited data not only based on collection but on population size. For the Hispanic population, undercounting and problems in collecting and coding race/ethnicity data may lead to problems in fully understanding health disparity issues for that population. Similarly, with the Asian American and Pacific Islander populations, diversity and population size can limit analysis of health disparity data. In New Jersey, there has been no reporting on the impact of health disparities on Native Americans because of the small population size.

The basis for all racial and ethnic data reporting in governmental settings is derived from the guidelines of the Federal Statistical Policy Directive No. 15, first issued by the Office of Management and Budget (OMB) in 1978. The original guidelines required that all Federal agencies, at a minimum "...collect and present data on at least four racial groups- American Indian or Alaska Native, Asian or Pacific Islander, Black and White; and one ethnic group- Hispanic" (McKinney, 1994).

OMB Directive No. 15 was updated in 1997 and now requires that all Federal agencies collect and report the following racial and ethnic categories; American Indian or Alaska Native, Asian, black or African American, Native Hawaiian or Other Pacific Islander, white, and Hispanic or Latino or Not Hispanic or Latino (U.S. Census Bureau, <http://www.census.gov/population/www/socdemo/race/racefactcb.html>). In addition, to account for individuals who identified with more than one race, OMB allowed self-identification to include more than one race.

These data collection standards were expanded upon by the Census Bureau for the 2000 census. OMB granted permission for the census questionnaires to add a sixth racial

category, “Some Other Race” to account for individuals who did not identify with the available racial categories (U.S. Census Bureau, <http://www.census.gov/population/www/socdemo/race/racefactcb.html>).

For the Census 2000, there were a total of 15 check box response categories and 3 write-in areas which could be collapsed into the OMB minimum race categories.

### *Building on Success*

- Rutgers Center for State Health Policy (CSHP) assisted OMMH in revising and administering a Survey designed to identify which NJDHSS programs collect racial and ethnic demographic data. The Survey was completed by 29 programs within the Department. The Survey was used to identify baseline data for current Department programs that collect information on racial and ethnic data. This survey inquired about cultural competency, language access, community partnerships and evaluation within NJDHSS programs. The survey gauged the extent to which these components are included in current NJDHSS programs.
- This was accomplished by first conducting a comprehensive search for NJDHSS publications that reported on racial and ethnic data. CSHP’s information specialist searched the NJDHSS website, several on-line databases and contacted NJDHSS units and programs to be provided with the latest published State reports. Thirteen State publications utilizing a variety of categories reporting race and ethnicity data were identified.
- Department projects which focus on measuring health care quality, including NJDHSS report cards, collect patient race and ethnicity data. This allows the Department to monitor whether race and ethnicity are factors in health care delivery. The licensing program also uses race and ethnicity information from the cardiac services data collection projects to review new Certificate of Need applications in order to ensure equal access.

- Additionally, the NJDHSS collects discharge data from acute care hospitals in New Jersey. In January 2007, the Department implemented a revised code list for patient race and ethnicity. The revised list was developed to provide consistent reporting of race and ethnicity across various data sets collected by the Department. The Department is developing a version in which there will be an additional variable for collecting patient primary language.

**Goal: To standardize the collection and reporting of race/ethnicity data across the Department.**

### *Action Plan*

#### *Steps and Timeline:*

*FY 2007- 2010*

- Center for Health Statistics will identify all divisions/programs within NJDHSS that collect race and ethnicity data.
- Center for Health Statistics will provide uniform categories based on OMB 15 standards for the reporting of race and ethnicity.
- Center for Health Statistics will develop a specific template for reporting race and ethnicity data to be used by NJDHSS grantees.
- OMMH will develop an orientation program for NJDHSS grantees on requirements for collecting race and ethnicity and primary language spoken data.
- Center for Health Statistics will develop criteria for standard footnotes in NJDHSS reports whenever the standard categories for reporting are omitted.

#### *Outcome Measures*

- One hundred percent of NJDHSS grantees will use the standardized NJDHSS template when reporting race, ethnicity, and primary language spoken.
- One hundred percent of NJDHSS reports will use the NJDHSS standard race and ethnicity categories.

## C. Strengthening the Infrastructure: Minorities in the Health Professions

Increasing the racial and ethnic diversity of the health care workforce is essential for the adequate provision of culturally competent care for minority communities. The same is true for those who provide health promotion and disease prevention education to consumers of health care. Health educational messages and programs intended to target minority communities can be more effective when members of the targeted community participate in developing programs and establishing policy. A diverse health care and public health workforce provides an environment in which the experts who understand what's required to address health care concerns also engender the trust of the population they are serving because of shared culture and mutual understanding and respect.

Currently, at the NJDHSS, minorities represent 22% of the total number of management employees and 16% of the total number of supervisory employees. Overall minority representation in management and supervisory positions could be improved.

### *Building on Success*

The NJDHSS Office of Human Resources has developed an *Interview Technique Booklet*. This booklet provides guidance for interviewers in developing written questions that will ensure that they ask each candidate the same questions and remain consistent throughout the interview process. The Office of Human Resources also regularly sends notification of entry-level and professional positions to minority colleges and organizations.

**Goal: Increase minority representation in management/policy-making positions at the NJDHSS.**

## *Action Plan*

### *Steps and Timeline*

*FY 2007- 2010*

- Develop a list of minority employees who display supervisory/management potential and enroll them into Human Resources Development Institute (HRDI) supervisory/management training courses. Enroll at least five (5) minority employees per year into HRDI supervisory/management training courses.
- Develop a mentoring program whereby qualified, selected employees are linked with senior managers.
- Train managers and supervisors on the proper methods of interviewing.
- Actively recruit, hire and promote more minorities to fill management and supervisory positions. Increase minority representation by 2% in fiscal year 2008.

### *Outcome Measures*

- Recruitment of at least 15 managers and supervisors trained to be mentors.
- Enrollment of 5 minority employees in HRDI supervisory and management training.

## D. Strengthening the Infrastructure: Community Outreach

Empowering communities with information to more effectively participate in decision making about their health care is an important component of addressing health disparities. Minority community-based organizations, including faith-based groups, can be effective in conducting campaigns or outreach efforts that are culturally competent. These organizations are also well positioned to build communication networks that aim to reach minority communities. Public health messages must be consistent and credible and must take into account the specific characteristics of the targeted audience.

Outreach workers and patient navigators are also key in disseminating information, linking patients to care and systems of support, and navigating complicated health care systems. Individuals who may have directly or indirectly experienced biased treatment from health care providers based on their race, ethnicity, gender, language spoken, values or beliefs may be hesitant to return to these systems of care even when their health is threatened. Outreach workers who come from minority communities and who have established relationships within these communities can engender the trust needed to effectively reach those disenfranchised patients. Another area where outreach services can be of benefit is in reaching the homeless population. The lack of permanent shelter, transportation and telephone services are significant barriers to accessing health care.<sup>iv</sup> The New Jersey Community Health Worker Institute, a project of New Jersey Area Health Education Centers (AHEC), an affiliate program of the University of Medicine & Dentistry of New Jersey-School of Osteopathic Medicine is developing a plan for training community health workers and reimbursing their work.

In addition, the NJDHSS must reach out to community leaders and other public health stakeholders to enhance the health disparities agenda. The Federal Office of Minority Health is launching a National Action Agenda to End Health Disparities for Racial and Ethnic Minority Populations. Their mission is to work with individuals and organizations to create a nation free of health disparities, with quality health outcomes for all.

## *Building on Success*

- The Office of Minority and Multicultural Health funds minority community-based organizations that include community health workers who provide outreach information to minority communities that make linkages to needed services for diabetes and asthma.
- Annually in September, the OMMH promotes Minority and Multicultural Health Month, helping to raise awareness of minority health issues and highlight the efforts of community and faith-based organizations, hospitals and other institutions.
- The OMMH supports the South Asian Health Project (SAHP), which increases awareness of the health concerns within the South Asian community in New Jersey. SAHO fosters meaningful relationships with South Asian ethnic media, using ethnic media for outreach and to promote health and wellness.
- The Immigration and American Citizenship Organization (IACO) provides health and prevention information and promotes Department services among difficult to reach Latino immigrants.

**Goal: Support new and maintain established partnerships with community-based organizations, including faith-based groups, advocacy groups, and agencies that have minority health agendas to maximize outreach and increase awareness of health disparities.**

## *Action Plan:*

### *Steps and Timeline:*

*FY 2007-2010*

- Initiate the OMMH Empowering Communities with Health Information Project, EMCHIP, which will fund at least 5 community-based organizations to conduct community education workshops to equip those at greatest risks for health disparities to make more informed decisions about their health.
- Provide a two-day training for NJDHSS staff to increase skills in developing health literacy materials that more effectively target minority communities.
- Federal Region II will join the nation in launching a series of health disparities roundtable discussions in 2007 in order to develop a national blueprint for addressing health disparities. The roundtable discussions will provide an important opportunity for communities at the local level to develop agendas that build on current NJDHSS initiatives.

### *Outcome Measures*

- Based on availability of funding, OMMH will fund the Empowering Communities with Health Information Project.
- A minimum of 25 NJDHSS staff will be trained to develop easy to read documents that take into account the characteristics of the targeted audience.
- OMMH will conduct one community roundtable discussion and issue a report that outlines specific strategies for partnership with NJDHSS in addressing health disparities.

### III. Summary of Actions

The New Jersey Department of Health and Senior Services recognizes disparities in health outcomes and health care to be a priority. The Department is committed to implementing this Plan to eliminate health disparities using all its available resources and intends to utilize the Plan as a foundation for current and future work in this area. The Department expects that this plan will be a reference for and inspire more action in this area. The action steps and timeline for each of the medical areas this Plan has focused on are listed below.

**Goal: Reduce the number of minorities with asthma who use hospital emergency departments as a main source of care, prevent asthma mortality and make it possible for children and adults to live healthier lives.**

#### *Action Plan*

##### *Steps and Timeline:*

###### *FY 2007-2010*

- Collect Centers for Primary Health Care asthma collaborative data on quality of care.
- Increase the number of Centers for Primary Health Care participating in asthma collaboratives.
- Provide training to promote uniform, high quality asthma care among providers serving minorities at risk.
- Provide training to increase use among providers of the *Asthma Action Plan* which personalizes an asthma management program for school-age children.

**Goal: Increase awareness of cancer initiatives and screenings for the New Jersey minority population.**

### *Action Plan*

#### *Steps and Timeline:*

*FY 2007-2010*

- Continue the work of NJCEED Lead Agencies together with cancer county coalitions' outreach initiatives and expand screening capacity for cervical and prostate cancer at the agencies to prevent instituting waiting lists.
- Continue to partner with numerous minority community-based organizations and existing social networks to raise awareness of the NJCEED Program and to provide education to the community at large regarding the importance of screening and early detection.
- Identify and address barriers to screening and follow-up care.
- Evaluate the data on the impact of screening programs on minority populations.

**Goal: Reduce the number of deaths due to cardiovascular disease through organized outreach and education efforts.**

### ***Action Plan***

#### ***Steps and Timeline:***

*FY 2007- 2010*

- Seek funding to create a centralized cardiovascular control program that addresses health disparities.
- Adopt administrative rules to implement licensing requirements for designation of stroke centers.

**Goal: Increase the number of minorities living with diabetes who receive high quality care and linkages to social supports.**

### ***Action Plan***

#### ***Steps and Timeline:***

*FY 2007-2010*

- NJDHSS diabetes grantees will collect diabetes outcome data.
- Additional Centers for Primary Health Care will participate in the Diabetes Collaboratives.
- Increase the number of minority clients who have access to needed pharmaceuticals through section 340B programs.
- Encourage diabetes grantees to explore funding opportunities from the Centers for Disease Control and Prevention and the American Diabetes Association.
- Encourage minority community-based organizations to participate in American Diabetes Association initiatives.

**Goal: Decrease disparities in obesity and increase healthy eating and physical activity across the lifespan among high risk groups (including black and Hispanic populations and those with low socioeconomic status) in New Jersey.**

### *Action Plan*

#### *Steps and Timeline:*

*FY 2007- 2010*

- Create a State Office of Obesity Prevention under the domain of the Department of Health and Senior Services that will utilize existing resources to address obesity prevention and reduction, especially among children.
- Appoint an Obesity Prevention Task Force to address the goals and objectives of the NJ Obesity Prevention Action Plan.
- Release the NJ Obesity Prevention Action Plan.
- Apply for external funding.

**Goal: Reduce the incidence of HIV/AIDS among minority populations through increased education and facilitation of greater access to care.**

### *Action Plan*

#### *Steps and Timeline:*

*FY 2007-2010*

- Increase percentage of HIV positive individuals receiving care.
- Increase percentage of individuals tested for HIV, and the number who receive their test results.
- Implement and evaluate syringe exchange programs over a three-year period.

- Encourage providers to discuss more routinely with their patients safe sex options, particularly condom usage.

**Goal: Decrease disparities in birth outcomes between white and black infants.**

### *Action Plan*

#### *Steps and Timeline:*

*FY 2007- 2010*

- Provide cultural competency training for paraprofessional and professional health care staff.
- Increase outreach and basic education to the community on black infant mortality.
- Increase funding to support enhanced prenatal and pediatric services.
- Utilize newborn screening and genetic services follow-up programs to ensure that all infants born in New Jersey who have abnormal newborn screening test results receive appropriate and timely case management services.
- Inform appropriate parties including primary care physicians, medical specialists and parents of abnormal screening results.

**Goal: Reduce excess morbidity and mortality due to unintentional injuries among minorities**

### *Action Plan*

#### **Steps and Timeline:**

*FY2007-2010*

- Support injury prevention activities in community-based organizations by providing appropriate data and materials for distribution. Specific areas to target are pedestrian safety for children and the elderly, driver safety, seat belt use, child car seat use, and smoke alarm installation and maintenance, water safety and swimming ability.
- Work with NJDOT to identify geographic areas of high pedestrian injury rates among minorities. Collaborate with NJDOT on evaluating the impact on pedestrian injuries of environmental modifications to roadways by providing data on injuries and fatalities. Support pedestrian safety activities in community by providing appropriate data on injuries.

**Goal: Increase access to language services for those who are more proficient in a language other than English.**

### *Action Plan*

#### *Steps and Timeline:*

##### *FY 2007-2010*

- Develop a website with translated health educational materials.
- Pilot a demonstration project in partnership with the NJHA to train bilingual staff as medical interpreters.
- Pilot a demonstration project to train community based-organization bilingual staff as medical interpreters.
- Disseminate “I Speak Poster” to New Jersey hospitals in partnership with NJHA to assist in interpretation.
- Increase capacity of NJDHSS licensing staff members that monitor health care facilities to assess language access services.
- Revise the discharge planning section of the licensing regulations to explicitly address language and cultural barriers.

**Goal: To standardize the collection and reporting of race/ethnicity data across the department.**

### *Action Plan*

#### *Steps and Timeline*

*FY 2007- 2010*

- Center for Health Statistics will identify all divisions/programs within NJDHSS that collect race and ethnicity data.
- Center for Health Statistics will provide uniform categories based on OMB 15 standards for the reporting of race and ethnicity.
- Center for Health Statistics will develop a specific template for reporting race and ethnicity data to be used by NJDHSS grantees.
- OMMH will develop an orientation program for NJDHSS grantees on requirements for collecting race and ethnicity and primary language spoken data.
- Center for Health Statistics will develop criteria for standard footnotes in NJDHSS reports whenever the standard categories for reporting are omitted.

**Goal: Increase minority representation in management/policy-making positions at the NJDHSS.**

### *Action Plan*

#### *Steps and Timeline:*

*FY 2007- 2010*

- Develop a list of minority employees who display supervisory/management potential and enroll them into Human Resources Development Institute (HRDI) supervisory/management training courses. Enroll at least five (5) minority employees per year into HRDI supervisory/management training courses.

- Develop a mentoring program whereby qualified, selected employees are linked with senior managers.
- Train managers and supervisors on the proper methods of interviewing.
- Actively recruit, hire and promote more minorities to fill management and supervisory positions. Increase minority representation by 2% in fiscal year 2008.

**Goal: Support new and maintain established partnerships with community-based organizations, including faith-based groups, advocacy groups, and agencies that have minority health agendas to maximize outreach and increase awareness of health disparities.**

***Action Plan:***

***Steps and Timeline:***

*FY 2007-2010*

- Initiate the OMMH Empowering Communities with Health Information Project, EMCHIP, which will fund at least 5 community-based organizations in conducting community education workshops to equip those at greatest risks for health disparities to make more informed decisions about their health.
- Provide a two-day training for NJDHSS staff to increase skills in developing health literacy materials that more effectively target minority communities.
- Federal Region II will join the nation in launching a series of health disparities roundtables in 2007 in order to develop a national blue print for addressing health disparities. The roundtables will provide an important opportunity for communities at the local level to develop agendas that build on current NJDHSS initiatives.

## IV. TECHNICAL NOTES

### *Race/Ethnicity Groups*

Throughout this report the following mutually exclusive race and ethnicity groups are used: white, black, Hispanic, and Asian/Pacific Islander. Data for white, black, and Asian/Pacific Islander 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 and Pacific Islanders are sometimes misreported. Efforts are underway to improve the reporting of Hispanic ethnicity and Asian and Pacific Islander races on the health data collected by the New Jersey Department of Health and Senior Services. For now, data presented for Hispanics and Asian/Pacific Islanders should be used with caution as they may understate the true rates.

### *Definitions*

**Birth Weight** -- the first weight of the newborn obtained after delivery.

**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

**Healthy Migrant Effect** -- Selective in- and out-migration, also known as the “healthy migrant effect” and the “salmon-bias effect,” may contribute to the Hispanic and Asian/Pacific Islander mortality advantages, since a relatively high proportion of those living in New Jersey are foreign-born ([Singh, 2001](#), [Palloni, 2004](#)).

**Infant Death** -- a death within the first year of life.

**Live Birth** -- the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

**Low Birth Weight** -- birth weight of less than 2,500 grams or approximately 5 pounds, 8 ounces.

**Motor Vehicle-Related Injuries** -- Motor vehicle-related injury is a broad term encompassing a number of different types of motorized vehicles and a variety of circumstances covering an encounter of an individual with a motorized vehicle. A motor vehicle is defined in *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, Volume 1* as

“any mechanically or electrically powered device, not operated on rails, upon which any person or property may be transported or drawn upon a highway. Any object such as a trailer, coaster, sled, or wagon being towed by a motor vehicle is considered a part of the motor vehicle.” The Manual includes automobile; bus; construction, industrial, or farm machinery; fire engine; motorcycle; moped; motorized scooter; trolley bus not operating on rails; truck; and van in its definition of motor vehicle. Persons killed or injured by a motor vehicle can be drivers, passengers, bicyclists, or pedestrians. Injuries and fatalities related to the use of motor vehicles are not currently labeled “accidents” by public health professionals, as these events are considered preventable.

**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.

**Very Low Birth Weight** -- birth weight of less than 1,500 grams or approximately 3 pounds, 5 ounces.

## *Rates*

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.

**Emergency Department (ED) Visit Rate** -- the number of resident ED visits per 100,000 population.

**Hospitalization Rate** -- the number of resident hospital admissions per 100,000 population.

**Infant Mortality Rate** -- the ratio of the number of deaths to children less than one year of age in a given year per 1,000 births in the same year.

**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>
Asthma	J45-J46
Female Breast Cancer	C50 (females only)
Cervical Cancer	C53
Prostate Cancer	C61
Colorectal Cancer	C18-C21
Coronary Heart Disease	I11, I20-I25
Stroke	I60-I69
Diabetes	E10-E14
HIV Infection	B20-B24
Sudden Infant Death Syndrome (SIDS)	R95
Unintentional Injuries	V01-X59, Y85-Y86
Motor Vehicle-Related Injuries	V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0-V87.8, V88.0-V88.8, V89.0, V89.2
Poisoning	X40-X49
Suffocation	W75-W84
Falls	W00-W19
Drowning	W65-W74
Fire/burns/smoke	X00-X09

## 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 2003 estimates were used with 2001 - 2003 data, and Vintage 2004 estimates were used with 2004 data. For more information about the bridged-race population estimates: [www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm](http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm)

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, 2000-2005								
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

Bridged-Race Population Estimates by County, New Jersey, 2005									
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 behavioral risk factors	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
Emergency department visit rates	NJDHSS, Center for Health Statistics NJ Emergency Department File
Cancer incidence rates and stage of diagnosis	NJDHSS, Cancer Epidemiology Services NJ Cancer Registry
Childhood obesity prevalence and seatbelt usage	NJ Department of Education Youth Risk Behavior Survey
End-stage renal disease prevalence	NJDHSS, Division of Family Health Services Diabetes Prevention and Control Program
AIDS/HIV incidence and prevalence rates	NJDHSS, Division of HIV/AIDS Services HIV/AIDS Epidemiological Services Unit
Infant mortality rates	NJDHSS, Center for Health Statistics NJ Resident Matched Death and Birth Certificates
Birth weight, prenatal care, and maternal age	NJDHSS, Center for Health Statistics NJ Resident Birth Certificates
Traumatic brain injury rates	NJDHSS, Center for Health Statistics Traumatic Brain Injury Surveillance System

## V. APPENDICES

- A. The Legislation Mandating the *Eliminating Health Disparities Initiative* in New Jersey
- B. Map of the Percentage of Racial and Ethnic Populations by County
- C. Map of the Centers for Primary Health Care by Legislative District
- D. Map of Acute Care District Hospitals by Legislative District

A.

**THE LEGISLATION MANDATING THE *ELIMINATING HEALTH  
DISPARITIES INITIATIVE* IN NEW JERSEY**

CHAPTER 137

**AN ACT** concerning the New Jersey Office on Minority and Multicultural Health and supplementing Title 26 of the Revised Statutes.

**BE IT ENACTED** *by the Senate and General Assembly of the State of New Jersey:*

C.26:2-167.1 "Eliminating Health Disparities Initiative" in Office on Minority and Multicultural Health.

1. The Commissioner of Health and Senior Services shall establish the "Eliminating Health Disparities Initiative" in the Office on Minority and Multicultural Health. The commissioner shall require the office to develop and implement a comprehensive, coordinated plan to reduce health disparities between White and racial and ethnic minority populations in the State in the following priority areas: asthma; infant mortality; breast, cervical, prostate and colorectal cancer screening; kidney disease; HIV/AIDS; hepatitis C; sexually transmitted diseases; adult and child immunizations; cardiovascular disease; diabetes; and accidental injuries and violence. As used in this act, "office" means the New Jersey Office on Minority and Multicultural Health.

C.26:2-167.2 Duties of office.

2. The office shall:

a. Establish measurable outcomes to achieve the goal of reducing health disparities in the areas provided in section 1 of this act.

b. Enhance current data tools to ensure a Statewide assessment of the risk behaviors associated with the health disparity priority areas provided in section 1 of this act. To the extent feasible, the office shall conduct the assessment so that the results may be compared to national data.

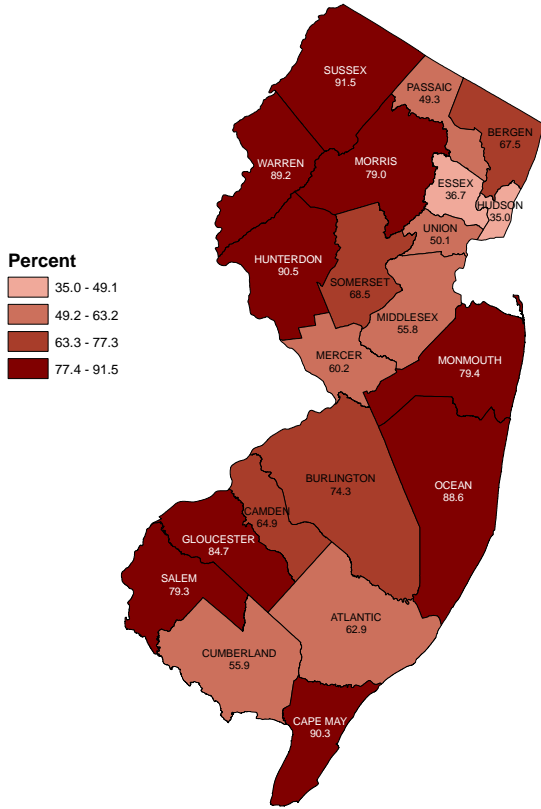
C.36:2-167.3 Rules, regulations.

3. The Commissioner of Health and Senior Services shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act.

4. This act shall take effect immediately.

Approved September 1, 2004.

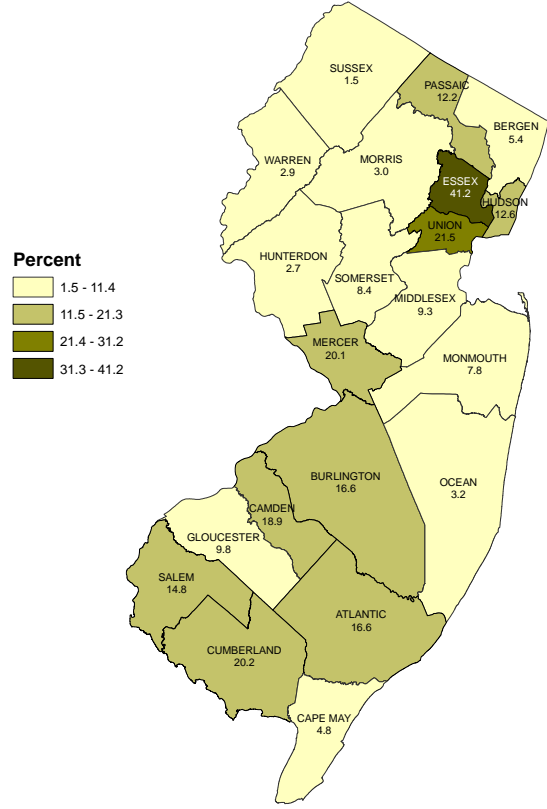
**Percentage of the Population That is White by County  
New Jersey, 2005**



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

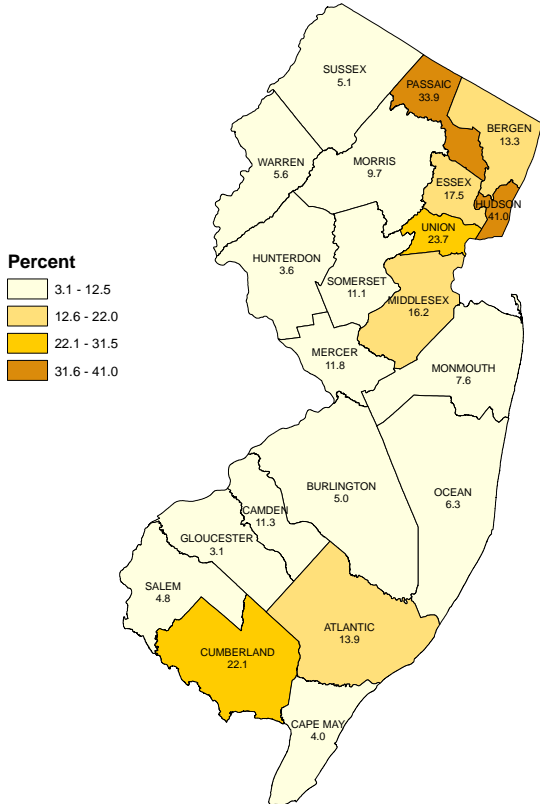
B.

**Percentage of the Population That is Black by County  
New Jersey, 2005**



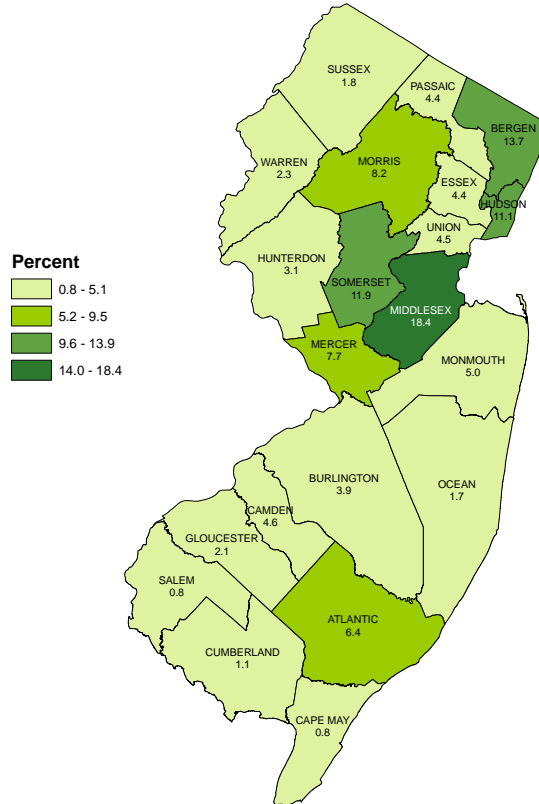
Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

**Percentage of the Population That is Hispanic by County  
New Jersey, 2005**



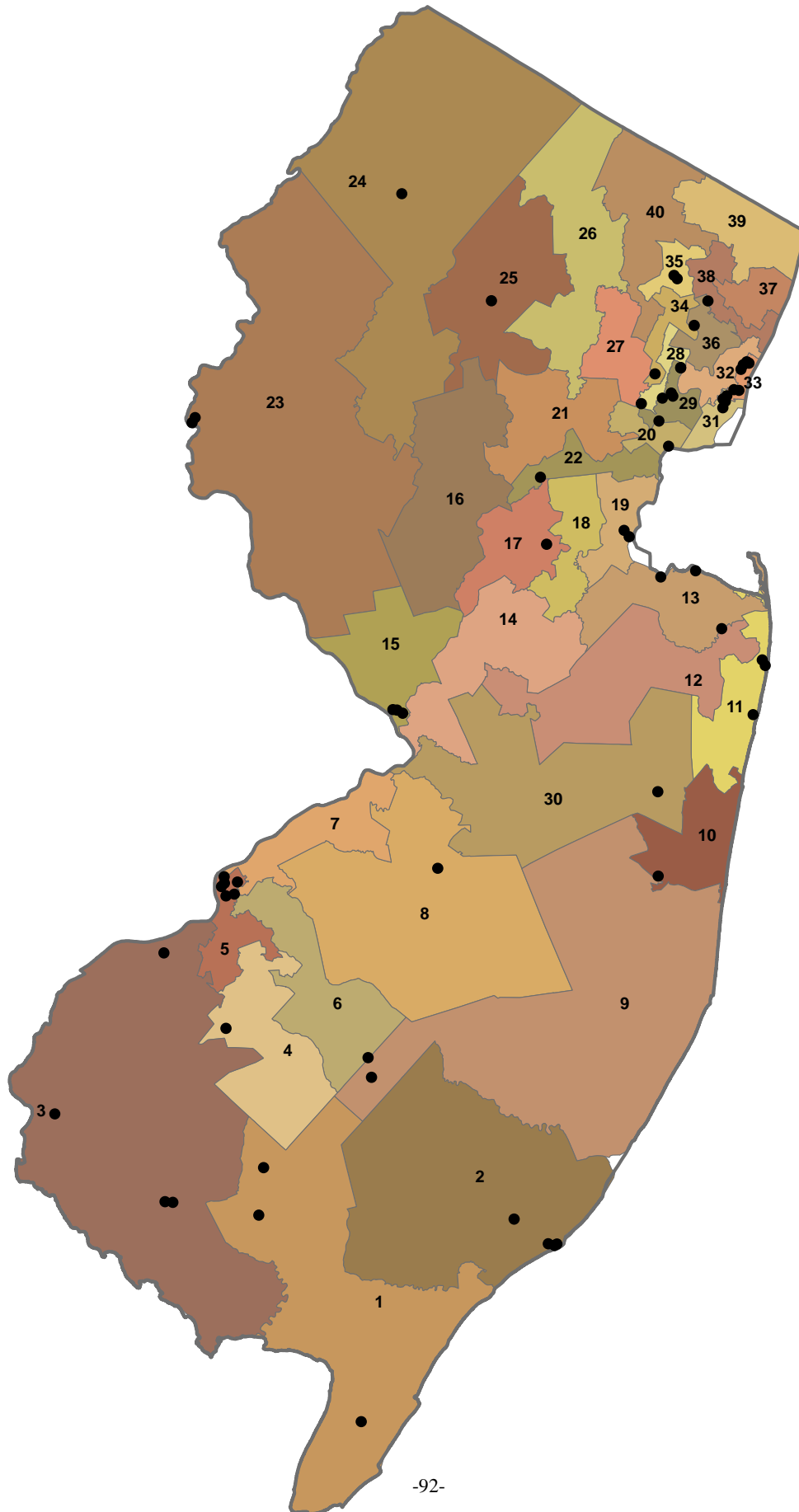
Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

**Percentage of the Population That is Asian by County  
New Jersey, 2005**



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

C. Centers for Primary Health Care, 2007  
By Legislative District, New Jersey

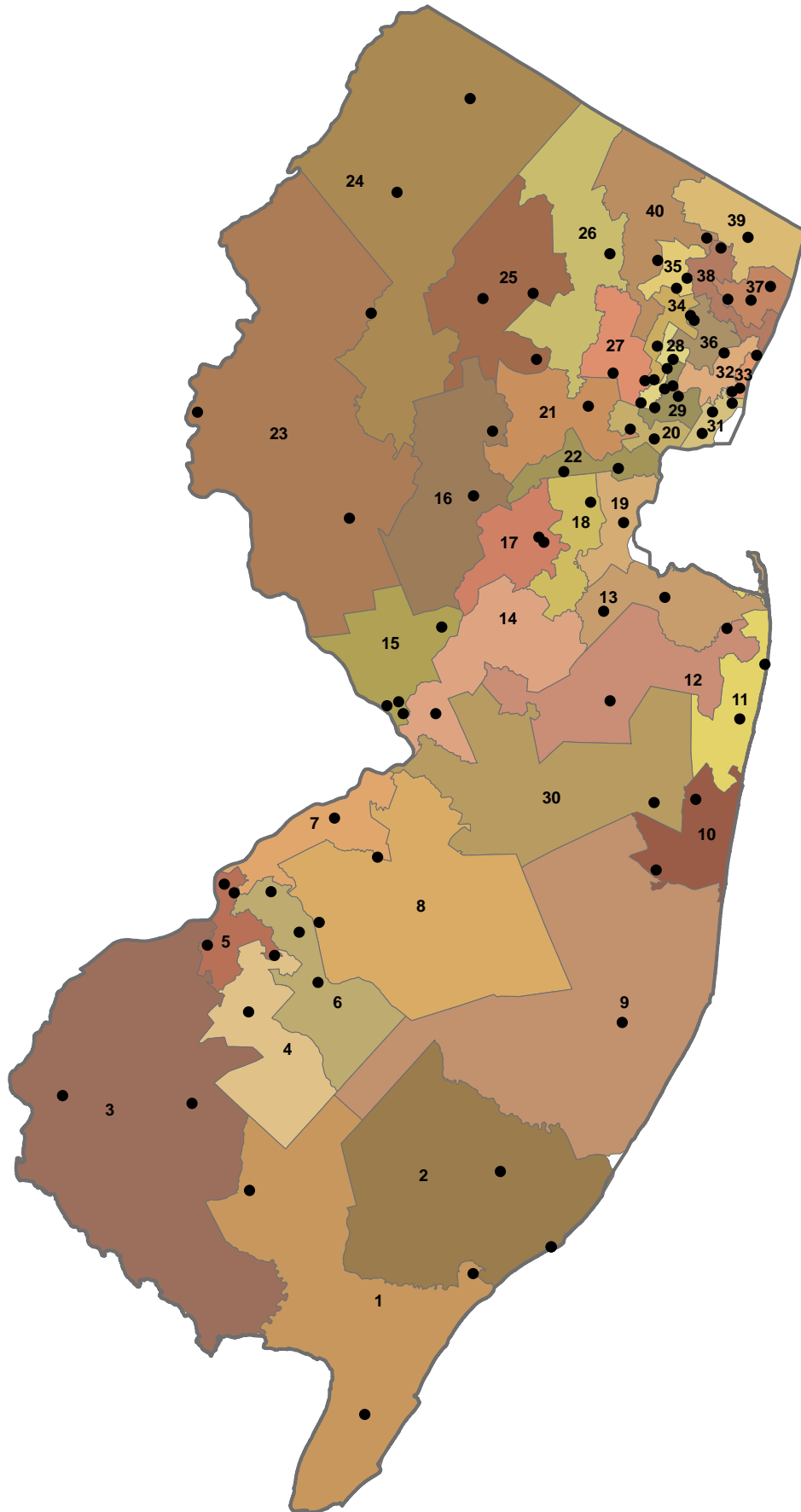


CENTERS FOR PRIMARY HEALTH CARE, AGENCY AND FACILITY NAMES, 2007		
LEGISLATIVE DISTRICT	COMMUNITY HEALTH CENTER AGENCY	FACILITY NAME
1	Community Health Care, Inc	Cape Community Health Center
1	Community Health Care, Inc	Millville Community Health Center
1	Community Health Care, Inc	Vineland Medical & Dental Center
2	AtlanticCare Health Services	AtlanticCare Health Services at Covenant House
2	AtlanticCare Health Services	AtlanticCare Health Services for the Homeless
2	Southern Jersey Family Medical Centers	Atlantic City
2	Southern Jersey Family Medical Centers	Pleasantville
3	CAMcare Health Corporation	Paulsboro
3	Community Health Care, Inc	Bridgeton
3	Community Health Care, Inc	Cohansey Medical Center
3	Southern Jersey Family Medical Centers	Salem
4	Community Health Care, Inc	Glassboro Community Health Center
5	CAMcare Health Corporation	East
5	CAMcare Health Corporation	Gateway Health Center
5	CAMcare Health Corporation	North
5	CAMcare Health Corporation	South
5	Project Hope/Project Hope at Our Lady of Lourdes Medical Center	Bergen Lanning Health Center
5	Project Hope/Project Hope at Our Lady of Lourdes Medical Center	Our Lady of Lourdes Health Foundation Homeless Project
6	Southern Jersey Family Medical Centers	Hammonton
8	Southern Jersey Family Medical Centers	Buttonwood
9	Southern Jersey Family Medical Centers	Hammonton Dental Center
10	Ocean Health Initiatives, Inc	Toms River
11	Monmouth Family Health Center	Long Branch, Broadway
11	Monmouth Family Health Center	Long Branch, Second Ave.
11	Visiting Nurse Association of Central Jersey	Asbury Park
12	Visiting Nurse Association of Central Jersey	Red Bank Community Health Center
13	Visiting Nurse Association of Central Jersey	Keansburg Community Health Center
13	Visiting Nurse Association of Central Jersey	Keyport Primary Care Center
15	Henry J Austin Health Center	Chambers Manor Family Practice
15	Henry J Austin Health Center	Ewing Health Center
15	Henry J Austin Health Center	Henry J Austin Health Center
17	Eric B Chandler Health Center	New Brunswick
19	Jewish Renaissance Medical Center	Perth Amboy
19	Jewish Renaissance Medical Center	Perth Amboy Center for the Elderly (P.A.C.E)
20	Plainfield Health Center	E-Port Community Health Center
22	Plainfield Health Center	Plainfield
23	Plainfield Health Center	Phillipsburg, Marshall Street
23	Plainfield Health Center	Phillipsburg, South Main Street
24	Plainfield Health Center	Newton Community Health Center
25	Zufall Health Center	Dover Community Clinic
28	Newark Community Health Centers, Inc.	Irvington Community Health Center at Irvington General Hospital
29	Newark Community Health Centers, Inc.	Broadway Health Center
29	Newark Community Health Centers, Inc.	Dayton Street Health Center

CENTERS FOR PRIMARY HEALTH CARE, AGENCY AND FACILITY NAMES, 2007		
LEGISLATIVE DISTRICT	COMMUNITY HEALTH CENTER AGENCY	FACILITY NAME
29	Newark Community Health Centers, Inc.	James White Manor
29	Newark Community Health Centers, Inc.	Newark Community Health Center at Newark Emergency Services for Families
29	Newark Community Health Centers, Inc.	Newark Community Health Centers, Inc.
29	Newark Homeless Health Care	Newark Homeless Health Care
30	Ocean Health Initiatives, Inc	Lakewood
31	Horizon Health Center	Journal Square
31	Metropolitan Family Health Network	Homeless Program
31	Metropolitan Family Health Network	Jersey City
32	Horizon Health Center	Jersey City
32	North Hudson Community Action Corporation Health Center	Jersey City
32	North Hudson Community Action Corporation Health Center	North Bergen
33	Metropolitan Family Health Network	West New York
33	North Hudson Community Action Corporation Health Center	Hoboken
33	North Hudson Community Action Corporation Health Center	Union City
33	North Hudson Community Action Corporation Health Center	West New York
34	Newark Community Health Centers, Inc.	East Orange Primary Care
35	Paterson Community Health Center	Broadway
35	Paterson Community Health Center	Clinton Street
36	North Hudson Community Action Corporation Health Center	Garfield
36	North Hudson Community Action Corporation Health Center	Passaic

D.

# Acute Care Hospitals, 2007 By Legislative District, New Jersey



ACUTE CARE HOSPITALS BY LEGISLATIVE DISTRICT	
LEGISLATIVE DISTRICT	HOSPITAL NAME
1	Burdette Tomlin Memorial Hospital
1	Shore Memorial Hospital
1	South Jersey Healthcare-Regional Medical Center
2	Atlanticare Regional Medical Center City Division
2	Atlanticare Regional Medical Center Mainland Division
2	William B. Kessler Memorial Hospital
3	Memorial Hospital of Salem County
3	South Jersey Healthcare-Elmer Hospital
4	Kennedy Memorial Hospitals UMC Washington Township
5	Cooper Health System
5	Kennedy Memorial Hospitals UMC Stratford
5	Our Lady of Lourdes Medical Center
5	Underwood-Memorial Hospital
6	Kennedy Memorial Hospitals UMC Cherry Hill
6	Virtua West Jersey Hospital – Berlin
6	Virtua West Jersey Hospital – Voorhees
7	Lourdes Medical Center of Burlington County
7	Virtua Memorial Hospital of Burlington County
8	Virtua West Jersey Hospital – Marlton
9	Southern Ocean County Hospital
10	Community Medical Center
10	Ocean Medical Center
11	Jersey Shore University Medical Center
11	Monmouth Medical Center
12	Centrastate Healthcare System
12	Riverview Medical Center
13	Bayshore Community Hospital
13	Raritan Bay Medical Center - Old Bridge
14	Robert Wood Johnson University Hospital at Hamilton
15	Capital Health System - Fuld Campus
15	Capital Health System - Mercer Campus
15	St. Francis Medical Center
15	University Medical Center at Princeton
16	Somerset Medical Center
16	VA New Jersey Health Care System (LYONS)
17	Robert Wood Johnson University Hospital
17	St. Peter's University Hospital
18	JFK Medical Center
19	Raritan Bay Medical Center - Perth Amboy
20	Trinitas Hospital
20	Union Hospital
21	Overlook Hospital
22	Muhlenberg Regional Medical Center
22	Robert Wood Johnson University Hospital at Rahway
23	Hackettstown Community Hospital
23	Hunterdon Medical Center
23	Warren Hospital

ACUTE CARE HOSPITALS BY LEGISLATIVE DISTRICT	
LEGISLATIVE DISTRICT	HOSPITAL NAME
24	Newton Memorial Hospital
24	St. Clare's Hospital/Sussex
25	Morristown Memorial Hospital
25	St. Clare's Hospital/Denville
25	St. Clare's Hospital/Dover
26	Chilton Memorial Hospital
27	St. Barnabas Medical Center
28	Clara Mass Medical Center
28	Columbus Hospital
28	Irvington General Hospital
29	Newark Beth Israel Medical Center
29	St. James Hospital
29	St. Michael's Medical Center
29	University Of Medicine And Dentistry Of New Jersey-University Hospital
30	Kimball Medical Center
31	Bayonne Medical Center
31	Liberty Health - Greenville Hospital Campus
31	Liberty Health-Jersey City Medical Center Wilzig Hospital
32	Christ Hospital
32	Liberty Health-Meadowlands Hospital Campus
32	Palisades Medical Center-New York Presbyterian Healthcare System
33	St. Mary Hospital
34	East Orange General Hospital
34	Mountainside Hospital
34	VA New Jersey Health Care System (East Orange)
35	Barnert Hospital
35	St. Joseph's Regional Medical Center
36	PBI Regional Medical Center
36	St. Mary's Hospital Passaic
37	Englewood Hospital And Medical Center
37	Hackensack University Medical Center
37	Holy Name Hospital
38	Bergen Regional Medical Center L.P.
39	Pascack Valley Hospital
40	St. Joseph's Wayne Hospital
40	Valley Hospital

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<sup>i</sup> New Jersey Office of Minority and Multicultural Health web page;  
<http://www.state.nj.us/health/omh/background.shtml>.

<sup>ii</sup> *Reducing Health Disparities*, Policy Research Institute For the Region, Woodrow Wilson School of Public & International Affairs, Princeton University, 2006, pg. 7.

<sup>iii</sup> *Flores G, Abreu M, et al. Errors of medical interpretation and their clinical consequences: A comparison of hospital interpreters, ad hoc interpreters, and having no interpreter. Pediatric Res. 2003; 578A (3278).*

<sup>iv</sup> NJPCA & NJSORH Quarterly Newsletter, Winter 2007, *Serving the Needs of New Jersey's Homeless Population.*

This document can be viewed and downloaded at  
**<http://www.state.nj.us/health/omh/documents/healthdisparityplan07.pdf>**

To request copies of this document, please email your request to

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or mail in your request to the following address:

**New Jersey Department of Health and Senior Services  
Office of Minority and Multicultural Health  
Health & Agriculture Bldg., Rm. 501  
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