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Preliminary Report

HEALTH PROFILE: BLACK AND MINORITY POPULATIONS IN NEW JERSEY

June, 1989

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NEW JERSEY DEPARTMENT OF HEALTH
A BETTER STATE OF HEALTH

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

Preliminary Report

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June, 1989

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Commissioner of Health

NEW JERSEY DEPARTMENT OF HEALTH
A BETTER STATE OF HEALTH

State of New Jersey

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

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

June 1, 1989

Distinguished Colleagues:

This conference on the State of Black and Minority Health represents the most recent aspect of our continuing drive to insure that all New Jerseyans receive the best public health and medical care possible.

The New Jersey Department of Health has a wide range of programs that serve minorities. Nevertheless, both nationally and in New Jersey public health leaders recognize that a more explicit focus on minority health itself is needed.

On the federal level this realization led to the establishment of the Office of Minority Health in 1984 and the preparation of the Secretary of Health and Human Services' Report on Black and Minority Health. Last fall, I convened a Minority Health Task Force within the Department of Health to develop a New Jersey data base similar to that which has been accumulated nationally.

This report, "Health Profile: Black and Minority Populations in New Jersey," represents the first stage of the task force's work. The task force has compiled significant and disturbing data which indicate that New Jersey, like the rest of the country, must do a great deal more to improve the health of its minority populations.

This spring I also convened a Commissioner's Advisory Committee on Minority Health to advise me on minority health issues. We have already met to review this report. The Committee will review recommendations from the Department of Health and your input from this conference at our next meeting.

A special effort has been made to produce this health profile so that it would be available for this conference. We look forward to receiving your comments.

Sincerely,

Molly Joel Coye

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

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Table of Contents

	Page
Executive Summary	3
How to Review This Document	4
Table of Illustrations	5
Introduction (Section 1)	12
AIDS (Section 2)	22
Maternal and Child Health (Section 3)	60
Chronic and Communicable Diseases (Section 4)	75
Occupational and Environmental Health Hazards (Section 5)	113
Injury (Section 6)	121
Substance Abuse (Narcotics) (Section 7)	133
Alcohol Abuse and Dependence (Section 8)	144
Access to Care (Section 9)	153
Glossary (Section 10)	169
Appendices (Section 11)	176

- Commissioner's Advisory Committee on Minority Health
- Department of Health Minority Health Task Force

EXECUTIVE SUMMARY

Despite major advances in modern medicine and technology, the reality remains in that a significant disparity exists between the health status of the minority and White populations of this Nation. In New Jersey, the preliminary findings as they are presented in this document are unfortunately similar.

Based on the 1980 Census, minority populations represent almost 14 percent of New Jersey's population. By 1990, the minority population will be almost 19 percent of the total population, due primarily to the significant increase in the Hispanic population.

In 1984 the Report on Black and Minority Health was issued by the Secretary of Health and Human Services. The report's findings laid the groundwork for many states to begin a more critical review of the health status of minority populations within their geographic areas. In New Jersey several individual organizations, institutions and agencies have initiated activities. Among these groups are the State of Black Health in New Jersey, the Puerto Rican Congress of New Jersey, the University of Medicine and Dentistry of New Jersey Minority Health Institute and the Hispanic Women's Task Force.

The most recent effort initiated at the State level was the establishment of a Minority Health Task Force by Commissioner Molly Joel Coye, MD, MPH within the Department of Health. Dr. Coye charged this group with the development of a statistical profile of the state of Black and minority-health in New Jersey, and with the identification of Department of Health programs that serve minority populations. In addition, the Task Force was requested to address deficiencies in health data systems and to recommend strategies for resolving these problems. The work of the Task Force is summarized in this workbook.

The health priority areas selected for review included those considered in the Secretary's Task Force Report, and two others that have been specifically targeted by the Department of Health. The eight areas include:

AIDS
Maternal and Child Health
Chronic and Communicable Disease
Occupational and Environmental Health
Injury
Substance Abuse
Alcohol Abuse and Dependence
Access to Care

In developing this workbook, the Department hoped to provide the statistical information that would be needed to initiate more extensive dialogue and action between state, federal and local agencies. The ultimate goal is to reduce the disparities identified, and to improve the quality of life and health for minority populations in New Jersey.

How to Review This Document

This workbook is presented in several sections as follows:

Introduction

AIDS

Maternal and Child Health

Chronic and Communicable Disease

Occupational and Environmental Health Hazards

Injury

Substance Abuse (Narcotics)

Alcohol Abuse and Dependence

Access to Care

Glossary

Appendices

Exclusive of the Introduction, Glossary and Appendices, each section is subdivided into three areas: 1) background; 2) program description; and 3) graphic illustrations. The Background provides an overview of key statistical facts and findings from various Department of Health data bases. The Program Description provides a highlight of relevant Department of Health programs that directly or indirectly impact on minority populations. Finally, the Graphic Illustrations include charts, graphs and tables from the Department of Health files that assist in displaying the disparities between minority and non-minority populations for various health status indicators.

Because of inconsistencies in the definition of race, for various data sets, a separate Glossary is provided for each health priority area.

TABLE OF ILLUSTRATIONS

TITLE	PAGE
INTRODUCTION	
Minority Population in New Jersey Based on 1980 Census	16
Minority/Non-Minority Populations in New Jersey 1980 and 1990 (Projected)	16
Average Annual Rates of Years of Potential Life Lost Before Age 65 by Cause, Gender, and Race, NJ 1985-1987	18
NJ Population, by Race and Age for 1980, including Median Age	19
Average Lifetime in Years, by Race and Sex: US and NJ	20
Selected Socio-Economic Indicators, Poverty, Income 1983 and Unemployment 1984 and 1988	21
AIDS	
AIDS Cases, State of New Jersey, As of Nov. 30, 1988	25
AIDS Cases, State of New Jersey, As of April 30, 1989	26
Human Immunodeficiency Virus (HIV) - Transmission Risks	27
NJSDOH - Racial/Ethnic Distribution of AIDS Cases United States and New Jersey as of Nov. 30, 1988	28
Cumulative Incidence (6/1/81 - 11/30/88)* of AIDS by Racial/Ethnic Group, US and NJ	29
Cumulative Incidence* of AIDS for Men by Racial/Ethnic Group, US and NJ	30
Cumulative Incidence of AIDS for Women by Racial/Ethnic Group, US and NJ	31
Cumulative Incidence of AIDS for Children by Racial/Ethnic Group, US and NJ	33
Relative Risk of AIDS, Associated with Intravenous Drug Abuse, US and NJ	34
Cumulative Incidence of AIDS, Associated with Intravenous Drug Abuse, by Racial/Ethnic Group, NJ	35

TABLE OF ILLUSTRATIONS

TITLE	PAGE
AIDS	
Relative Risk of AIDS, Associated with Homosexual Activity, US and NJ	37
Cumulative Incidence of AIDS, Associated with Homosexual Activity, by Racial/Ethnic Group, NJ	38
Cumulative Incidence of AIDS, Associated with Undetermined Means of Acquiring HIV Infection (UMAHI) by Racial/Ethnic Group, NJ	40
AIDS Prevention and Education Program Funds to Minority Community Based Organizations, NJ, 1987-1989	41-42
AIDS - Educational Material with Minority Focus	43
Staffing of AIDS Counseling and Testing Sites	46
Women Tested and Post-Test Counseled at Counseling and Testing Sites (CTS) by Racial/Ethnic Group	47
Men Tested and Post-Test Counseled at CTS by Race/Ethnic Group	48
Women Tested and Post-Test Counseled at Satellite Sites, by Racial/Ethnic Group	49
Men Tested and Post-Test Counseled at Satellite Sites, by Racial/Ethnic Group	50
CTS Clients by Racial/Ethnic Group and Sex, All Sites	51
AIDS Hospital and Post-Hospital Support Program - Selected Clients Demographics	52
AIDS Hospital and Post-Hospital Support Program - Client Demographics	53
AIDS Hospital and Post-Hospital Support Program - Clients by Employment Status	54
AIDS Hospital and Post-Hospital Support Program - Clients by Health Insurance Status	55
AIDS Hospital and Post-Hospital Support Program - Clients Referral Source	56

TABLE OF ILLUSTRATIONS

TITLE	PAGE
AIDS	
AIDS Community Support Program - Drug Treatment Coupon Program - 1987-1988	57
AIDS Community Support Program - Mobile Health Van - Client Referrals	58
AIDS Community Support Program - Mobile Health Van -Client Demographics	59
MATERNAL AND CHILD HEALTH	
Family Planning Client Distribution, 1985	64
Age Specific Fertility Rates by Race and Age, 1986	65
Resident Births by Age Group (15-19 yrs.), Race and Marital Status	65
Infant Mortality Rates, by Race, US and NJ	66
Non-White and White Infant Mortality Rates (per 1,000 live births), NJ (1976 - 1987)	67
Very Low Birth Weight (less than 1500 grams), NJ (1972 - 1986)	68
Relative Risk for Select Causes of Infant Mortality New Jersey Residents, 1986	69
Relative Risk for Select Causes of Infant Mortality New Jersey Residents, 1987	70
NJ State WIC Program - 1987 Pediatric Nutrition Surveillance - Low Birth Weight by Ethnic Group	71
NJ State WIC Program - 1987 Pregnancy Nutrition Surveillance - Prevalence of Low Birth Weight (less than 2500 grams) by Smoking Status and Ethnicity	72
NJ State WIC Program - 1987 Pregnancy Nutrition Surveillance Ethnic Distribution	73
1980 Rate of Pediatric Admissions into Hospitals in NJ by Age Group and Race	74

TABLE OF ILLUSTRATIONS

TITLE	PAGE
CHRONIC AND COMMUNICABLE DISEASES	
Unadjusted Cancer Incidence, NJ 1979 - 1985	80-87
Black Females	
Black Males	
Hispanic Females	
Hispanic Males	
Other Non-White Females	
Other Non-White Males	
White Females	
White Males	
Unadjusted Cancer Mortality, NJ 1979 - 1985	88-95
Black Females	
Black Males	
Hispanic Females	
Hispanic Males	
Other Non-White Females	
Other Non-White Males	
White Females	
White Males	
Newly Diagnosed Hypertensives	96
Proportion Minority Hypertensives, Screened and Diagnosed	97
NJ Diabetes Related Lower Extremity Amputations -Crude Rates Per 100,000 Population 1979 - 1985	98-99
NJ Hospitalization Discharges with a Principal Discharge Diagnosis of Diabetes-Crude Rates Per 100,000 Population 1985	100-101
Chronic Dialysis Patients - Total, by Race, 1987	102
Chronic Dialysis Patients - Females, by Race, 1987	103
Chronic Dialysis Patients - Males, by Race, 1987	104
Dialysis Patient Distribution by Race, 1982 - 1986	105
Transplants Performed in NJ, By Recipient Race 1982 - 1986	106

TABLE OF ILLUSTRATIONS

TITLE	PAGE
CHRONIC AND COMMUNICABLE DISEASES	
Refugee Arrivals by Country of Origin, NJ (FY 1984 -1988)	107
Hepatitis B Carriers (Infected/tested), Indochinese and Non-Indochinese Refugees, NJ 1984 - 1988	108
Infection Mortality by Age, Race and Sex (Average 1985 - 1987)	109
Reported Primary and Secondary Syphilis Cases and Case Rates by Race, NJ 1983 - 1987	110
Reported Gonorrhea Case Rates by Race (Where Stated), NJ 1983 - 1987	111
Reported Tuberculosis Case Rates by Race, NJ, 1986 - 1987	112
OCCUPATIONAL AND ENVIRONMENTAL HAZARDS	
Fatal Unintentional Injuries by Race (1983 - 1986)	116
Frequency of Hospitalizations of Persons with Chemical and Dust-Related Lung Diseases 1983 - 1986	117
Frequency of Hospitalization of Persons with Other Lung Conditions	118
Frequency of Hospitalizations of Persons with Chemical Poisonings	119
Frequency of Hospitalizations of Persons for Finger (including thumb) Amputations	120
INJURY	
All Injuries Mortality by Age, Race and Sex. Note: All injury charts are based on a three year average (1985 - 1987)	123
X* (Trans)-Port Injury Mortality by Age, Race and Sex	124
Suicide Mortality by Age, Race and Sex	125
Fall Mortality by Age, Race and Sex	126

TABLE OF ILLUSTRATIONS

TITLE	PAGE
INJURY	
Fire Mortality by Age, Race and Sex	127
Guns Mortality by Age, Race and Sex	128
New Jersey Gun Death Rate 1979-87 by Race	129
Homicide Mortality by Age, Race and Sex	130
?*(Unknown) Intention Injury Mortality by Age, Race and Sex	131
Drown Mortality by Age, Race and Sex	132
SUBSTANCE ABUSE (NARCOTICS)	
All Treatment Admissions by Race and Sex 1978 - 1987	136
Admissions - 1987, by Race and Sex	137
Race - Ethnicity by Age at Admission, 1987	138
Admissions, 1987, Health Insurance Status	139
Primary Drug of Choice, 1987 Admissions - Major Drug Types	140
Secondary Drug of Choice, 1987 Admissions - Major Drug Types	141
Modality at Admission - 1987 Admissions	142
Time in Treatment - 1987 Admissions	143
ALCOHOL ABUSE/DEPENDENCE	
Health Coverage of Hispanic Clients, 1987	146
Health Coverage of Black Clients, 1987	147
Health Coverage of White Clients, 1987	148
Race Breakdown by Employment	149
Legal Status of Race	150
Clients by Age/Race Ethnicity, 1987	151
Client Race/Ethnicity, 1987	152

TABLE OF ILLUSTRATIONS

TITLE	PAGE
ACCESS TO CARE	
Long Term Care Bed Utilization by Race, 1985	158
Long Term Care Bed Medicaid Recipients by Race, 1987	159
Long Term Care - Medicaid Expenditures by Race, 1987	160
Emergency Department Cover Letter/Utilization Survey	161-162
Minority Graduates (1983-1988) - UMDNJ Medical Schools, School of Osteopathic Medicine, Dental School, and Graduate School in Biomedical Sciences	163-168

Introduction

Black infants in New Jersey are dying at a rate **more than 2 1/2** times that of White infants. This very startling statistic, however, is only one of many health facts that plagues New Jersey's Black community --

AIDS deaths among Black infants are **14 times greater** than White infants.

Fertility rates among young Black adolescents are **almost 7 times greater** than young White adolescents.

Syphilis rates among Black adults are **25 - 30 times greater** than White adults.

Homicide death rates among Black adults are **almost 4 times greater** than White adults.

Esophageal Cancer death rates among Black males are **3 times greater** than White males.

Chemical poisonings (measured by frequency of hospitalization) among the employed Black population are **almost 3 times greater** than the employed White population.

These are just a few examples of the differences in death, disease and injury rates between white and minority populations. It is important to note here that as a result of data frequently being classified as White and Non-white, that the true severity may also be skewed by the use of these types of racial/ethnic identifiers. Although data deficiencies limit our ability to analyze and accurately display the health status of New Jersey's Black population in comparison to the White population, information on the health of Hispanics is even more inadequate. Inconsistencies in defining race and ethnicity and underreporting have contributed significantly to these problems. Increased attention to the needs of New Jersey's Hispanic population is critical, however, because this population is experiencing the most rapid population growth in the State. According to the Census Bureau, the overall Hispanic population has increased by more than one-third in this decade, and is growing nearly five times faster than the rest of the population. Information on other minority populations, i.e., Asian/Pacific Islander, American Indian, etc., are even less available.

Despite this, we know that there are major gaps between the health status of White Americans and minority Americans. In New Jersey, these gaps contribute a greater number of the years of potential life lost among minorities for all causes of death than that for non-minorities. (Table 1). These gaps are not just differences in numbers --they are real babies, children, teenagers, working adults, parents, and grandparents. They live in New Jersey, and helping them to protect and improve their health is our job in the Department of Health.

Purpose of the Workbook

This workbook is intended to begin an active discussion within the Department of Health and between our Department and all the active community and professional groups concerned about minority health in our state. It presents the information we have on minority health and the gaps or disparities between the health of minority and White populations. It describes programs in the Department of Health that target these disparities. It lists initial key recommendations of our staff to make us more effective in reducing the disparities we know of, and to improve our collection of information in order to discover problems we may not recognize now. The balance of

the document consists of tables, graphs and charts that display morbidity and mortality rates for a wide range of disease categories. For the reader's clarification, interpretive statements are also provided with the illustrations, and a glossary of terms is provided in Section 10.

By sharing the information we have at this early stage, we hope to encourage a state-wide debate about how best to improve minority health in New Jersey. We want to give minority organizations access to this important information and encourage them to work even more directly with us in program design and implementation. Coalition building with local community based organizations as well as national organizations will be an effective tool in assuring change.

National Developments

In 1985, the Secretary of Health and Human Services established the Secretary's Task Force on Black and Minority Health. In an open letter to the nation, the Secretary discussed the findings of the report:

> "That report -- like its predecessors -- documented significant progress. Americans were living longer, infant mortality had continued to decline: the overall health picture showed almost uniform improvement. But, and that "but" signaled a sad and significant fact; there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation's population as a whole. That disparity has existed ever since accurate federal recordkeeping began -- more than a generation ago. And although our health charts do itemize steady gains in the health status of minority Americans, the stubborn disparity remained -- an affront both to our ideals and to the ongoing genius of American medicine."

The Secretary's Task Force found that six causes of death collectively accounted for more than 80% of the excess mortality in the Black and minority populations from 1979 to 1981. The six health priority areas are:

- cancer
- cardiovascular disease and stroke
- chemical dependency
- diabetes
- homicide suicides and unintentional injuries
- infant mortality

Analysis of these six priority areas formed the basis of the report. In addition to analyzing excess death statistics, the Task Force also reviewed selected morbidity indicators such as chronic and infectious diseases, hospital admissions and physicians visits; and also non-disease specific issues pertaining to access, finance and health care personnel.

The final recommendations of the Task Force focused on six specific areas: health information and education; delivering and financing health services; health professions' development; cooperative efforts with the non-federal sector; data development, and research agenda.

Since the release of the Secretary's Task Force recommendation, there has been increased activity both at the federal level and among several states in the nation to develop strategies to dissolve the disparity and create equity in the quality of life experienced by minority populations.

Activities initiated at the federal level include the establishment of the Department of Health and Human Services, Office of Minority Health (OMH). The Office of Minority Health was established in December, 1985, and mandated to develop objectives, programs, and policies to ensure implementation of the recommendations outlined in the 1985 Secretary's Task Force Report. In its efforts to meet this challenge, the OMH conducts conferences, provides funding for innovative health care models targeted to minority populations, and operates the OMH Resource Center, established in 1987.

Ohio Commission on Minority Health

The Ohio Commission on Minority Health was established under legislative mandate in June 1987. This autonomous, free standing agency reports to the Governor and is charged with monitoring and facilitating the recommendations set forth in the Governor's Task Force on Black and Minority Health. These recommendations are consistent with the Secretary's Task Force recommendations.

The Commission received a two-year appropriation of $3.4 million dollars from the General Revenue. Three million dollars is being expended as grants to community based organizations and $400,000 for staff and operations.

Michigan Office of Minority Health

The Michigan Office of Minority Health was established by Governor James Blanchard in October 1988. This office reports to the Director of the Michigan Department of Public Health and is charged with implementing the recommendations of the Director's Task Force on Minority Health. These recommendations are also consistent with the federal recommendations.

An appropriation of $700,000 was received from the General Fund of which $600,000 will be expended as grants.

In New Jersey

In the Fall of 1988, an ad hoc organization of Black health professionals sponsored a one-day symposium on "The State of Black Health in New Jersey", as part of the Black Issues Convention. The ad hoc organization entitled The State of Black Health in New Jersey Steering Committee, also worked with Oliver Bartlett of the New Jersey Hospital Association and The Honorable Assemblyman John Watson to have a $70,000 budget resolution introduced to fund a statewide conference on Black health. On June 30, 1988, Governor Thomas H. Kean signed into law P.L. 1988, Chapter 47, and conference planning commenced. In an effort to expand the focus of the conference which is to be held mid-year 1989, the Department has appropriated an additional $15,000 to the State of Black Health in New Jersey Steering Committee so that Hispanic and other minority health issues can be presented and discussed.

In addition to this Steering Committee, the University of Medicine and Dentistry of New Jersey has established a statewide Minority Health Institute and several Hispanic organizations have held statewide conferences on Hispanic health issues.

These organizations include: the Puerto Rican Congress of New Jersey, the Hispanic Women's Task Force and the Boricula Health Organization.

A critical component of successful implementation of these initiatives will be contingent, however, upon the availability of an up-to-date epidemiological profile. In October, 1988, Commissioner of Health, Molly Joel Coye, M.D., M.P.H., established a Minority Health Task Force within the Department of Health to produce and analyze this information. The task force members consisted of a cross-section of staff from the various divisions in the Department. The charge to this core group was to highlight information on Department of Health programs that directly or indirectly maintain a minority focus and to present a statistical, graphic profile on the state of Black and Minority health in New Jersey. In addition, the members were requested to address such issues as data deficiencies and strategies for resolving the problems.

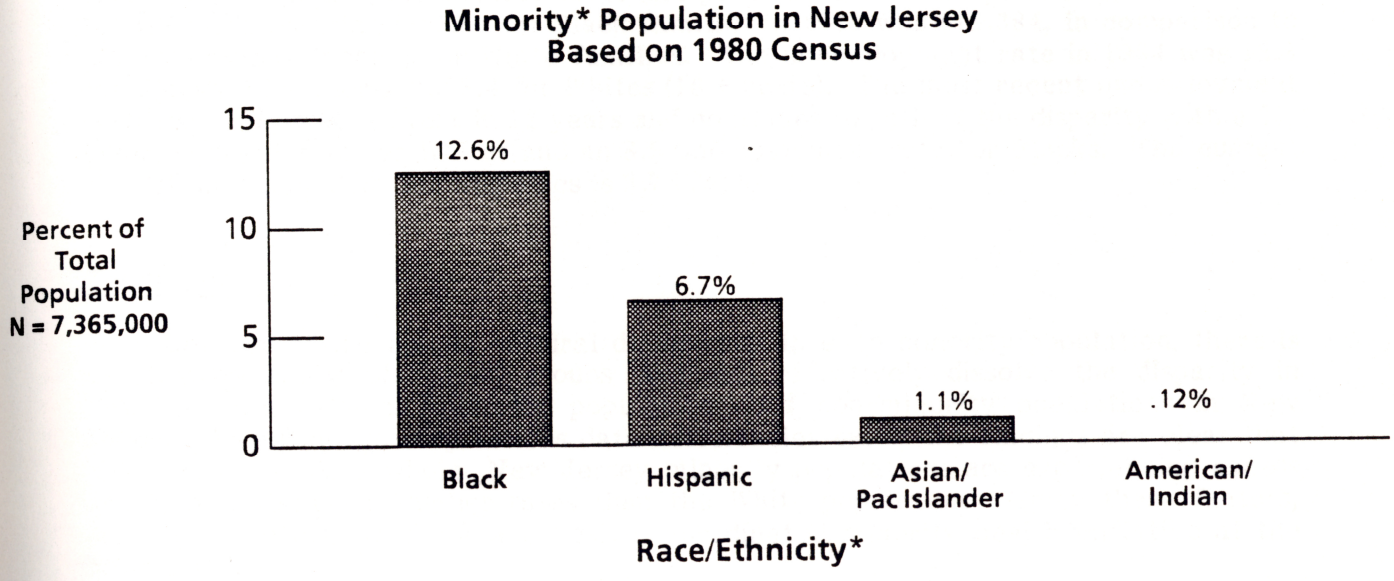
In order to compile as much information as possible within a relatively short time frame, eight sub-groups were established. These sub-groups are: Chronic and Communicable Diseases, Injury, Maternal and Child Health Services, Access to Care, Narcotics (Substance Abuse), and Alcohol (Substance Abuse). In addition to the six priority areas, an AIDS sub-group and an Occupational and Environmental Sub-group were also established. The work of the Task Force is summarized in this workbook. The members and staff that served/participated are listed in the Appendix, along with their program title and affiliation. In March, 1989, Dr. Coye appointed a statewide Advisory Committee on Minority Health. The primary functions of this committee will be to perform a technical review of the findings summarized in this report, to advise the Department, and to make recommendations on "closing the gap" that exists in the health status of Minority and White populations in New Jersey.

The Department of Health acknowledges that this is the first effort at developing a comprehesive base-line profile on minority populations in New Jersey. It is therefore important that future revisions address such areas as mental health and illness, dental health, violence as a public health problem and other forms of substance abuse.

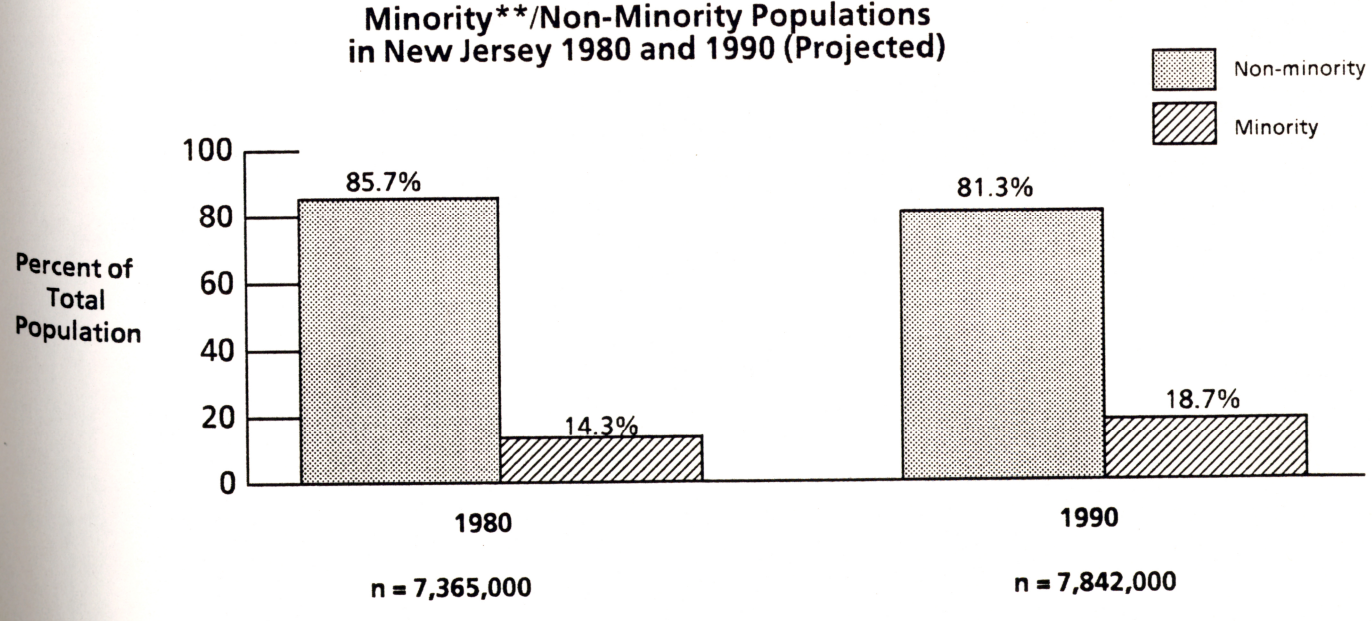
The Department is fully cognizant of the multidisciplinary problem solving approach that must be utilized in the effort to improve the health status of minority populations. Within the next few months, a series of recomendations will be developed along with the Advisory Committee on Minority Health that will not only consider the major areas influencing disease and death rates among minority populations, but also the physiological, cultural, psychiological and societal (including socio-economic, educational, underempowerment, and access to health care) factors that also influence health status.

Demographic Profile

According to the U.S. Bureau of Census, New Jersey had a population of 7,365,000 in 1980, of which 12.6% (925,000) were Black; 6.7% (492,000) were Hispanic; .12% (8,400) were American Indians, and 1.1% (104,000) were Asian/Pacific Islanders. Although more current population estimates have been calculated, they are not available for each ethnic population. Therefore, for the purpose of this report, the 1980 census is generally the denominator used for calculating incidence and mortality rates, except where otherwise indicated.



Projections for 1990 for all races is 7,842,000, of which 81.3% (6,372,600) are White and 18.7% (1,469,000) are non-White. It can be observed that the percentage of minorities in the New Jersey population is higher in the earlier age groups and that a sharp decrease occurs among minorities between the ages of 45 and 55 (Table 2).



**Minority is being defined as racial groups and not by ethnicity. Hispanics are generally included in both minority and non-minority racial groups.

Both nationally and in New Jersey, a disparity exists between the average life expectancy for the White and the Non-White population. In New Jersey, the average lifetime (in years) for White and Non-white males is 71.25 years and 64.25 years respectively (Table 3).

There are several socio-economic factors that impact on life expectancy. Two of these factors are income and unemployment. For example, in 1983, 24.4% Black families were below the poverty level and poverty rate in comparison to 6.3% White families. The median income for Black families in 1983 was $16,384, in comparison to $31,851 median income for White families. The unemployment rate in 1984 was 12.8 for Blacks (16 + years) and 5.4 for Whites (16 + years). The most recent unemployment data for 1988 is the lowest in 12 years and continues to reflect the disparity with a 3.1 unemployment rate for Whites and an 8.5 unemployment rate for Blacks. The current rate of unemployment for Hispanics is 5.7 (Table 4).

Conclusion

Because of the unique cultural differences in each minority population, there is no strategy applicable to all groups that will effectively dissolve the disparity in health status between minority populations and non-minority populations in New Jersey. And although very serious data deficiencies exist, the findings are clear that like the nation as a whole, New Jersey minority populations are experiencing excess deaths and disease at higher rates than the White population. Given these factors, there is a critical need for a cohesive, coordinated minority health initiative at the State level.

It is also important to note that since minorities represent a significant portion of the lower socio-economic population, that services and resources targeted to affect their overall health status will also contribute to improving the quality of life for all the poor regardless of race or ethnicity.

Table 1

Average Annual Rates of Years of Potential Life Lost before Age 65, by Cause, Gender, and Race
New Jersey, 1985-1987

	Male		Female	
Cause of Death	White	Non-White	White	Non-White
All Causes	57.10	121.43	29.68	62.27
All Injuries	10.55	14.96	3.21	5.31
Cardiovascular Diseases	11.54	16.56	5.18	9.40
Falls	0.56	0.71	0.11	0.20
Homicides	1.47	9.83	0.57	2.91
Infections	2.27	11.44	0.82	4.55
Neoplasms	8.90	10.62	8.24	8.85
Suicides	3.67	2.72	0.79	0.56
Transportation	6.70	6.68	2.19	2.16
Unknown Intention Injuries	0.55	1.42	0.12	0.39

Rates are expressed per 1,000 population.

Hispanics are included in the white and non-white population.

Table 2
NJ Population, by Race and Age for 1980, including Median Age

AGE	BLACK as % of total pop. of NJ	HISPANIC	WHITE
15	16.00%	7.83%	79.49%
25	13.15%	7.51%	81.86%
35	12.80%	7.36%	81.47%
45	12.47%	7.05%	83.40%
55	8.90%	4.01%	89.25%
65	7.50%	2.73%	91.08%
75	6.70%	2.50%	92.29%

(N.B. Total of columns exceeds 100% as Hispanic category includes all races).

As expected, the percentage of minorities in the New Jersey population is higher at the earlier ages, from which a higher birth rate is inferred. Significantly for our study, there is a sharp decrease between the ages of 45 and 55. The percentage of Blacks decreases by more than 3.5% and the percentage of Hispanic decreases by more than 3%. This decline in minority populations may indicate a significant increase in mortality rates for minorities between the ages of 45 and 55, leading to a significantly decreased percentage by age 75 in Black and Hispanic populations. This is further supported by statistics comparing the median ages of the three groups.

MEDIAN AGE	BLACK	HISPANIC	WHITE
	25.3	24.4	33.6

Table 3
Average Lifetime in Years
By Race and Sex: US and NJ

	NJ		US
White Males	71.25	yrs.	70.82
Non-White Males	64.25		64.10
White Females	77.99		78.22
Non-White Females	73.02		72.88

Source: U.S. Decennial Life Tables for 1979-81, Volume II, State Life Tables, Number 31.

Table 4
Selected Socio-Economic Indicators, Poverty, Income 1983 and Unemployment 1984 and 1988

1983 Number of Families Below Poverty Level and Poverty Rate

	Number	Rate
White Families	106,000	6.3%
Black Families	54,000	24.4%

1983 Median Family Income

	Number	Dollars
White Families	1,673,000	$31,851
Black Families	219,000	$16,384

1984 Unemployment Rate

	Number	Rate
White 16 + Years	178,000	5.4%
Black 16 + Years	53,000	12.8%

1988 Unemployment Rate

White	3.1%
Black	8.5%
Hispanic	5.7%

AIDS

Background - The Epidemiology of AIDS in New Jersey Minority Populations

- By the end of 1986, 2,570 cases of AIDS had been diagnosed by physicians in New Jersey.

- During 1987, 1,674 cases were diagnosed — an increase of 65% in a single year.

- From 1986-1988 the number of diagnosed AIDS cases among Whites increased 22.9%, Blacks increased 40.4% and Hispanics increased 22.3%.

- In 1988 2,431 cases were reported to the DOH - an increase of 160% over the year before (1,510 reported cases in 1987).

- Of the cumulative total of AIDS cases reported (5,502) in 1988, 34% were White; 52% Black and 13% Hispanic.

- New Jersey has the highest percentage of AIDS cases in women (20%) of any state in the U.S. Black and Hispanic women represent 77% of all female AIDS cases in New Jersey.

- New Jersey ranks second nationally in the number of pediatric AIDS cases. Both the Black and Hispanic communities in New Jersey have contributed a disproportionate share of AIDS cases in infants, 60% and 20% respectively.

- The relative risk of AIDS for New Jersey residents is higher than the risk for the United States population in every HIV risk category (homosexual, IVDU, transfusion, and undetermined risk). The risk is especially great among IV drug-using Black and Hispanic men, women, and their children.

- The relative risk of AIDS in New Jersey's Black and Hispanic communities was 10 times and 4.5 times greater respectively, than the risk of AIDS among New Jersey's White community. Other racial/ethnic groups in New Jersey have a relative risk of AIDS equal to or less than the White community.

- The risk of AIDS in New Jersey's Black and Hispanic children are 54 and 34 times as great as that in U.S. White children.

- The proportion of bisexual men among homosexual and bisexual men with AIDS is greater in Black and Hispanic males than in White males, 31%, 27% and 21% respectively.

- Of the more than 3,568 AIDS cases associated with IVDU risk categories in New Jersey, 23% occurred in Whites; 63% in Blacks; 13% in Hispanics, and less than 1% in other racial/ethnic groups.

- Among New Jersey's heterosexual IV drug users, Black men and women have, respectively, a 21 and 25 times greater risk of getting AIDS than their White counter parts.

Program Description

Medical Research Unit

- This program supports the overall AIDS prevention and control effort by tracking the seroprevalence of HIV infection in New Jersey and conducting research on the health, social needs, and costs of care for AIDS patients. The main focus of AIDS Research in the division is to determine the extent to which various population groups have been infected and to monitor how the virus is being spread. This would include seroprevalence surveys, research into HIV related mortality due to pneumonia and other diseases of interest, follow up on blood donors and recipients, and comparison of alternate methods of blood collection for HIV antibody testing.

Counseling and Testing, Notification Assistance, Surveillance and Data Analysis Unit

- The primary objectives of the counseling and testing sites are to provide testing and to educate individuals about HIV and the risk behaviors associated with its transmission (sex and/or needle sharing behaviors).

- There are contracts for counseling and testing services in 12 sites across the state and also in a variety of satellite facilities, including Tuberculosis (TB), Sexually Transmitted Disease (STD), Family Planning/Prenatal, and Drug Treatment Facilities.

- The primary focus of the notification program is to provide follow-up including risk reduction counseling and referral for testing to persons who have been exposed to HIV.

- Seven of the twelve counseling and testing sites employ 10 Bilingual, 8 Hispanics, 15 Blacks, and 1 Vietnamese counselor. Notification Assistance staff include 2 White, 1 Black and 2 Hispanic Counselors.

- The Department of Health's AIDS Registry and Surveillance and Data Analysis activities are located in this unit.

Prevention, Education and Training

- The primary objective is to develop, coordinate and implement all AIDS public education plans such as the AIDS Information & Referral Service and printed and audio visual materials.

- To administer 17 cooperative agreement grants to minority community based organizations in order to reduce the spread of AIDS. The Program contracts with 2 Native American, 1 Haitian, 8 Hispanic and 7 Black organizations.

- Under a separate funding initiative, i.e., Health Education Risk Reduction (HERR), other grants are awarded to organizations that primarily serve minority populations. Ten agencies are presently receiving HERR funds, six of these agencies are minority targeted. In Fiscal Year 1989, over 60% of AIDS prevention and education funding, available from the Minority Initiative and HERR were awarded to agencies with minority focused programs.

Hospital and Post-Hospital Support Program

- The primary objective is to develop an integrated network of AIDS health services that will provide for acute care and post-effective, post-hospitalization, community based care for AIDS/ARC patients, families and significant others.

- The data are collected from the two AIDS Health Services Programs that are located in Newark and Jersey City.

- The vast majority of clients are Black, (54%) and Hispanic, (13%).

- The Black client population has a higher percentage of unemployment and public insurance coverage. The Hispanic client population has a higher percentage of no insurance coverage.

- In studying the population receiving AZT through various entitlement programs, there is a low representation from the Black population.

Community Support Program

- The primary objective is to develop an integrated network of community based services including; but not limited to:

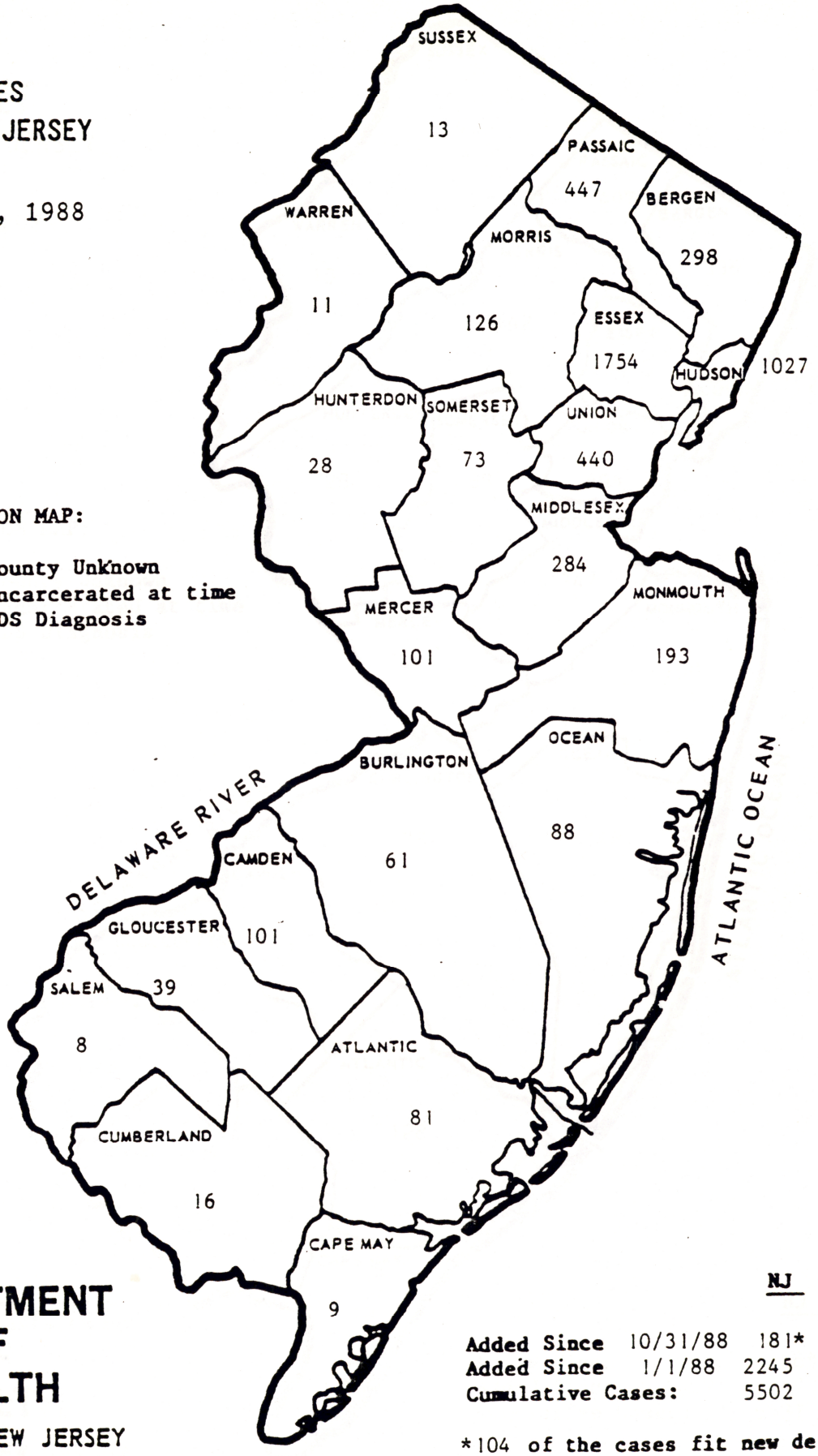
  - A mobile van unit to provide education, prevention, early intervention and referral services and information, to the following target populations (in order of priority): IVDUs, sex partners of IVDUs, and other residents.

  - Coupon programs for IVDUs to obtain (rentry) drug rehabilitation and treatment.

  - AIDS Coordinator Program

  - Community Health Education

AIDS CASES
STATE OF NEW JERSEY
AS OF
NOVEMBER 30, 1988



NOT INCLUDED ON MAP:

8 **Cases County Unknown**
296 **Cases Incarcerated at time of AIDS Diagnosis**

DEPARTMENT OF HEALTH

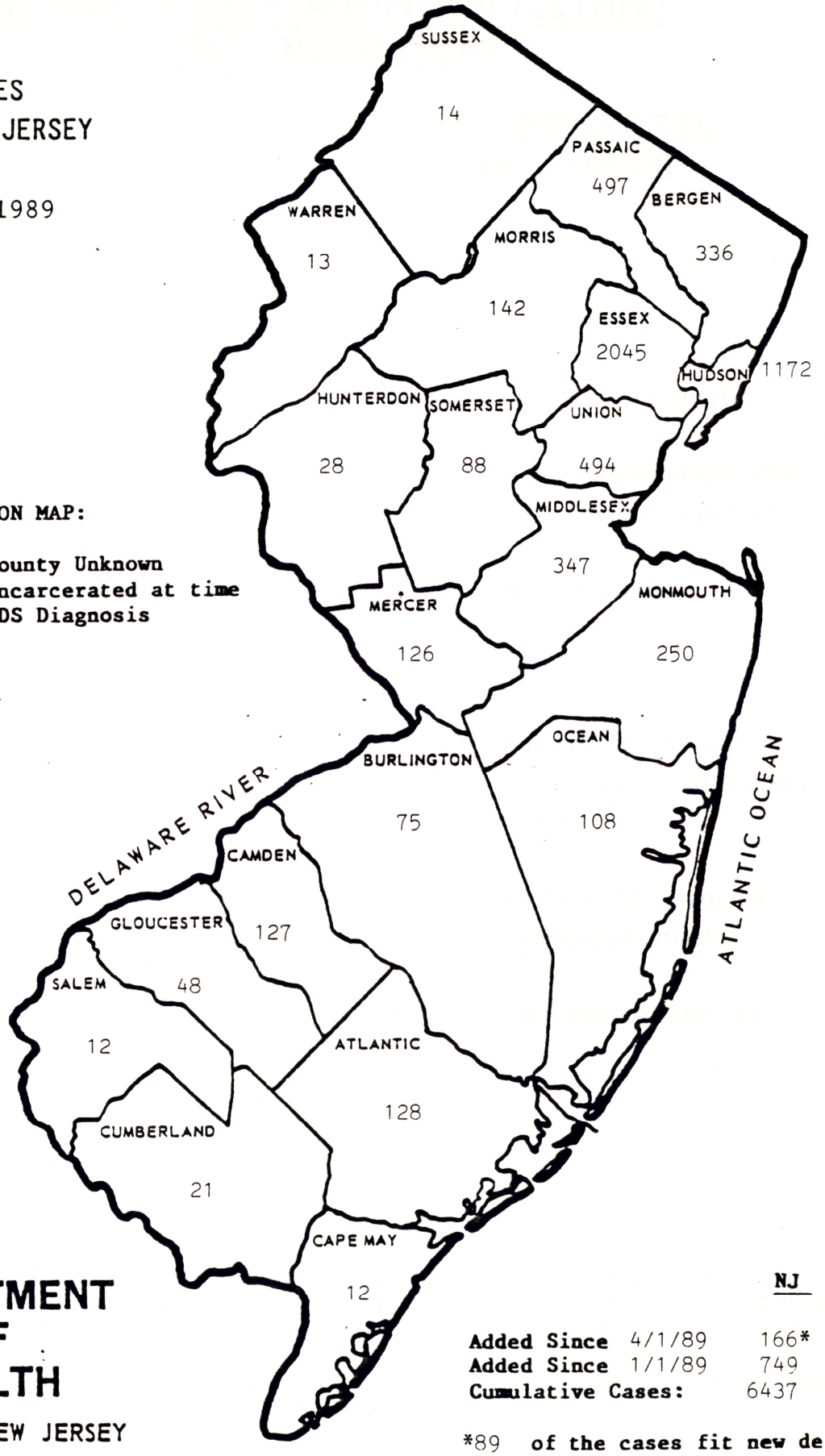
STATE OF NEW JERSEY

		NJ	US
Added Since	10/31/88	181*	2315
Added Since	1/1/88	2245	29643
Cumulative Cases:		5502	78985

*104 **of the cases fit new definition**

The largest cumulative numbers of AIDS cases reported through 1988 were reported in the counties near New York City. The numbers in each county do not include the people with AIDS who where incarcerated at the time of the case report, many of whom where from the counties with large numbers of AIDS cases.

AIDS CASES
STATE OF NEW JERSEY
AS OF
APRIL 30, 1989



NOT INCLUDED ON MAP:

8 Cases County Unknown
346 Cases Incarcerated at time of AIDS Diagnosis

	NJ	US
Added Since 4/1/89	166*	2894
Added Since 1/1/89	749	8584
Cumulative Cases:	6437	90,990

*89 **of the cases fit new definition**

DEPARTMENT OF HEALTH
STATE OF NEW JERSEY

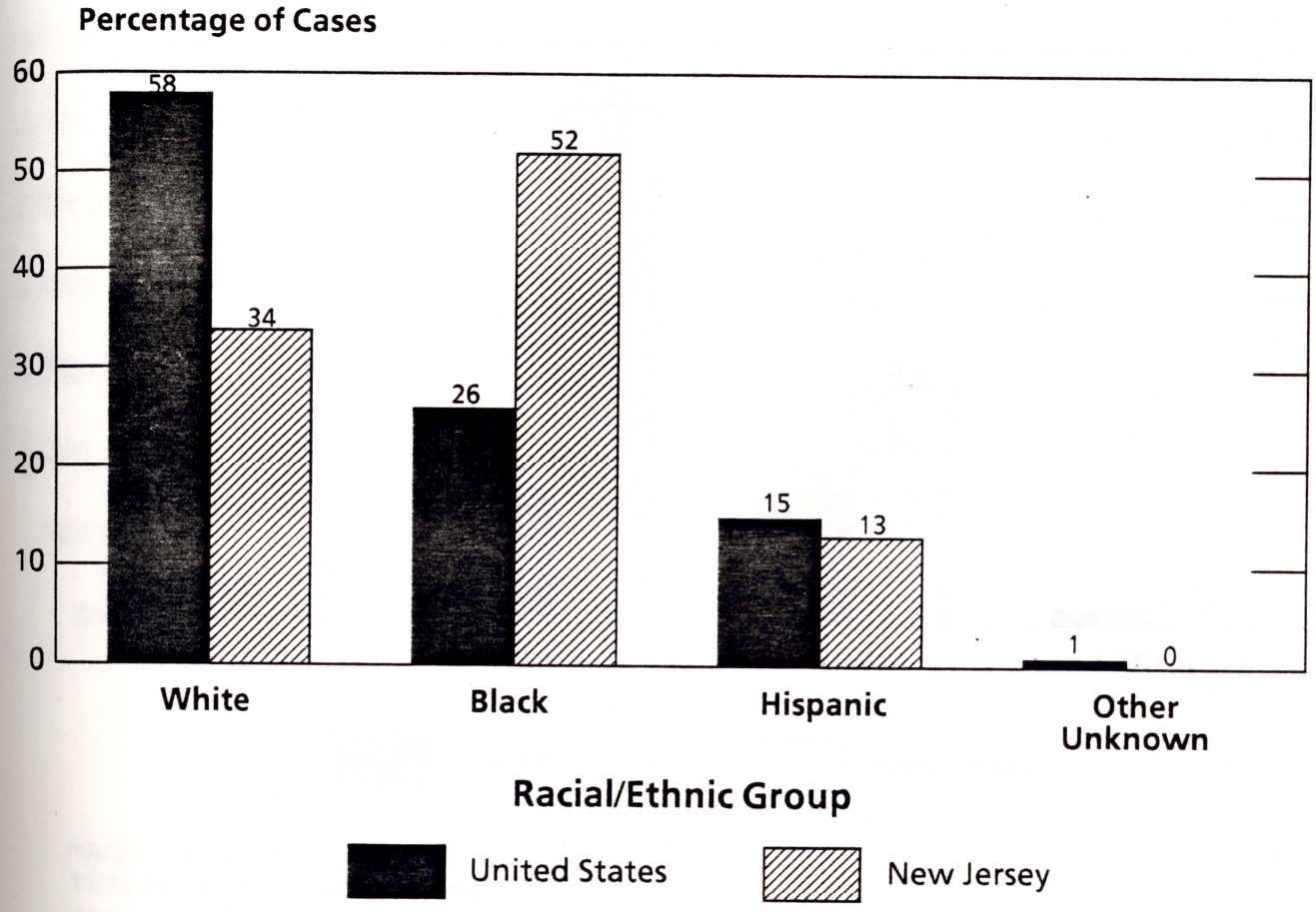
Human Immunodeficiency Virus (HIV) Transmission Risks

MODE OF TRANSMISSION	TRANSMISSION RISK (per exposure)	
Casual Contact	0	
Health Workers	1:800	
Transfusions	1:100,000 (varies by locality)	
IV Drug Abusers	1:300	(varies w/prevalence, freq. of sharing and injections)
Sexual Contacts (with a known HIV + person)	1:500	(unprotected)
	1:5000	(w/condom)
	1:10	(partner had HIV + transfusion, avg. risk of couples studies)
	1:2	(partner IVDU, avg. risk of couples studies)
Mother-to-Infant (perinatal)	1:2-3	(risk factors unknown)

Over the years there has been much public anxiety and scientific inquiry into the ways in which the Human Immunodeficiency Virus (HIV-I), the AIDS virus is spread from person to person. There is ample evidence that AIDS cannot be transmitted by casual contact.

This table presents a review of what is known about the risks of HIV transmission from studies and epidemiological evidence gathered to date.

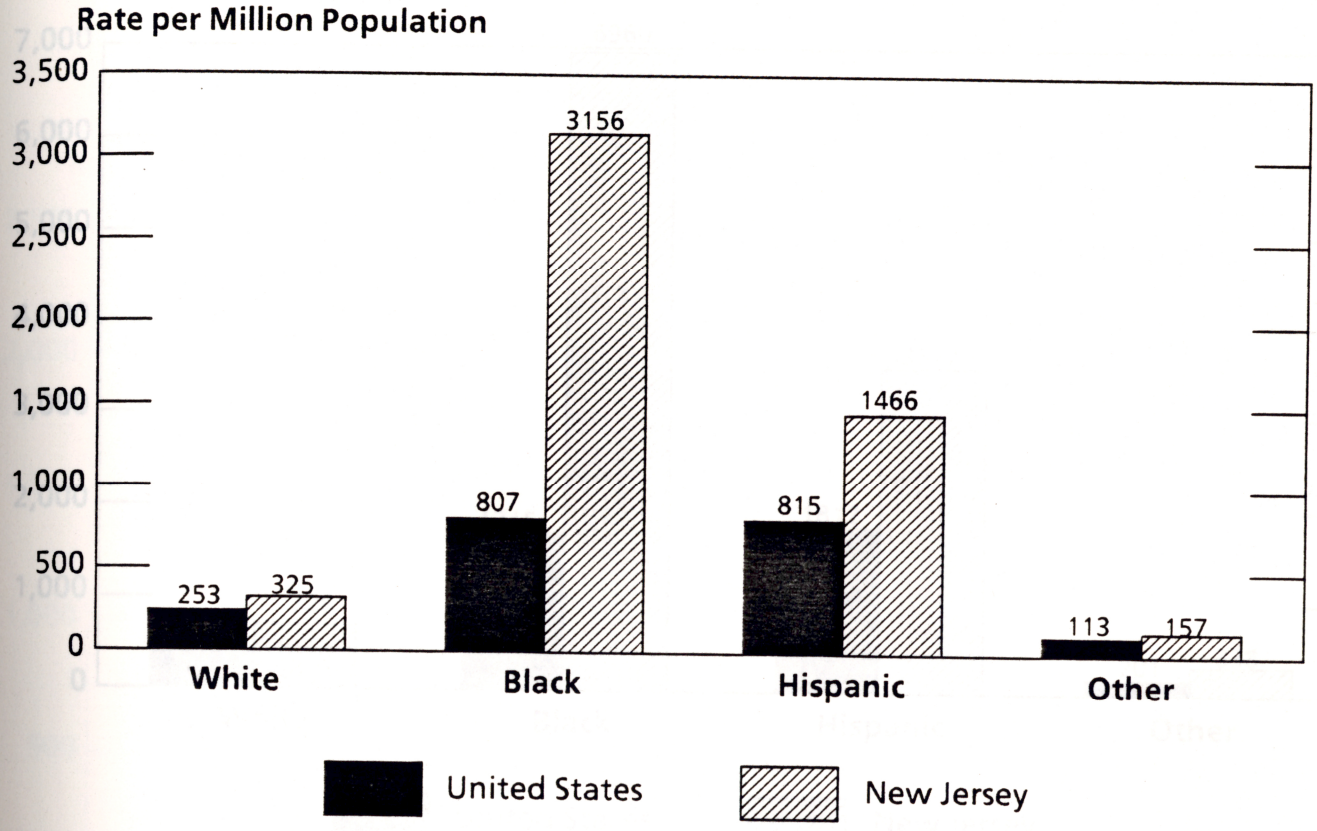
NEW JERSEY STATE HEALTH DEPARTMENT
Racial/Ethnic Distribution of AIDS Cases
United States and New Jersey



Based on 78,985 US and 5,502 NJ Cases
As of November 30, 1988

The racial distribution of New Jersey's AIDS cases is different from that of nation as a whole. The Black and Hispanic communities account for 65% of New Jersey's AIDS cases and 19% of its population, while nationally minorities represent only 40% of all AIDS cases and 18% of the population.

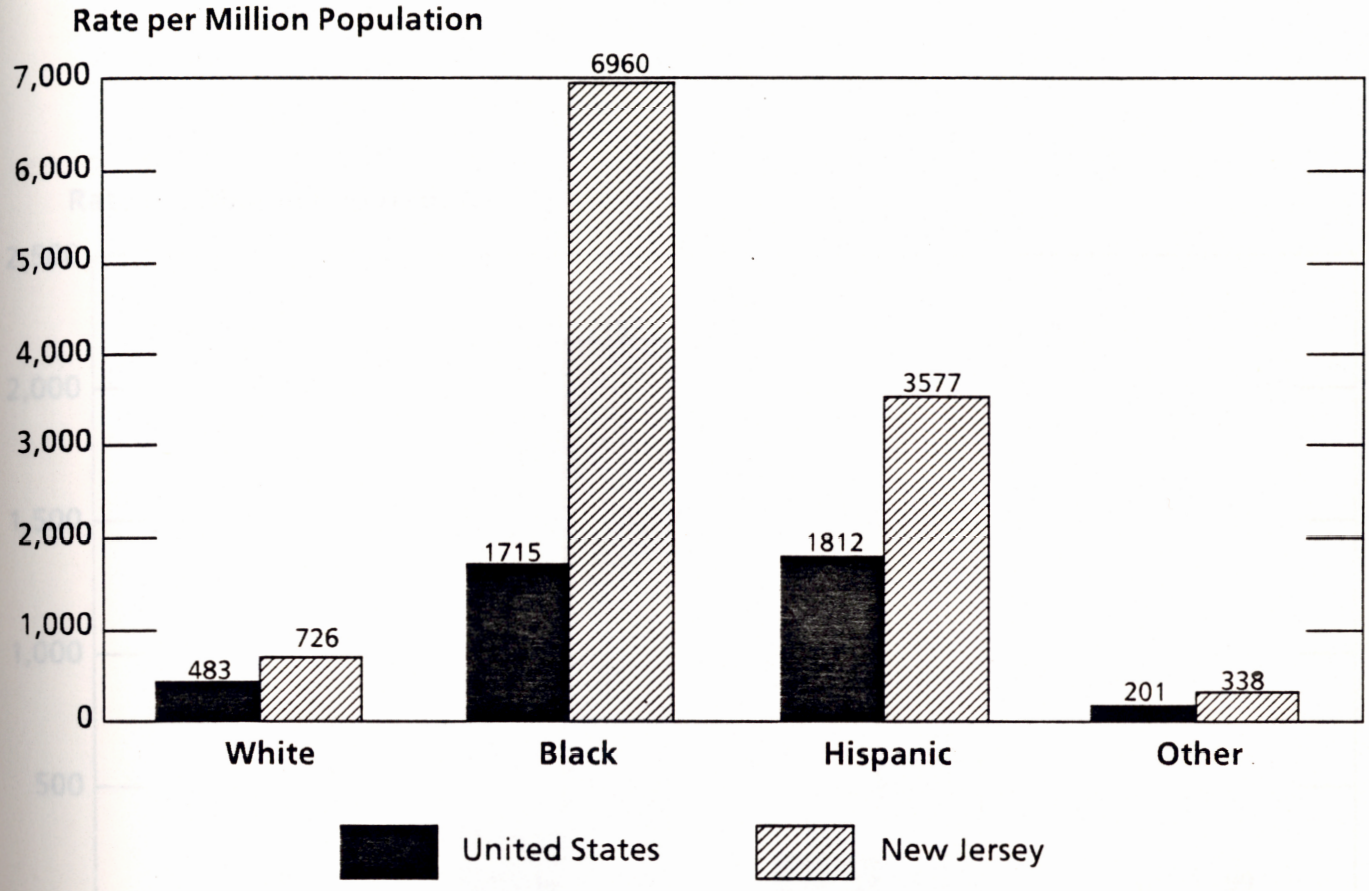
Cumulative Incidence* of AIDS by Racial/Ethnic Group United States and New Jersey



*AIDS cases reported from 6/1/81 to 11/30/88, per million population of same race/ethnicity.

Nationally the cumulative incidence rate of AIDS for non-whites is 3 times the rate for whites overall. The cumulative incidence rate of AIDS in New Jersey for Blacks and Hispanics was 3,156 and 1,466 cases per million population, respectively, which is 9.7 times and 4.5 times as great as that in New Jersey whites (325 cases per million population). The racial/ethnic difference in risk are greatest in association with intravenous drug abuse by heterosexuals.

Cumulative Incidence* of AIDS for Men by Racial/Ethnic Group United States and New Jersey



*AIDS cases reported from 6/1/81 to 11/30/88, per million population of same race/ethnicity.

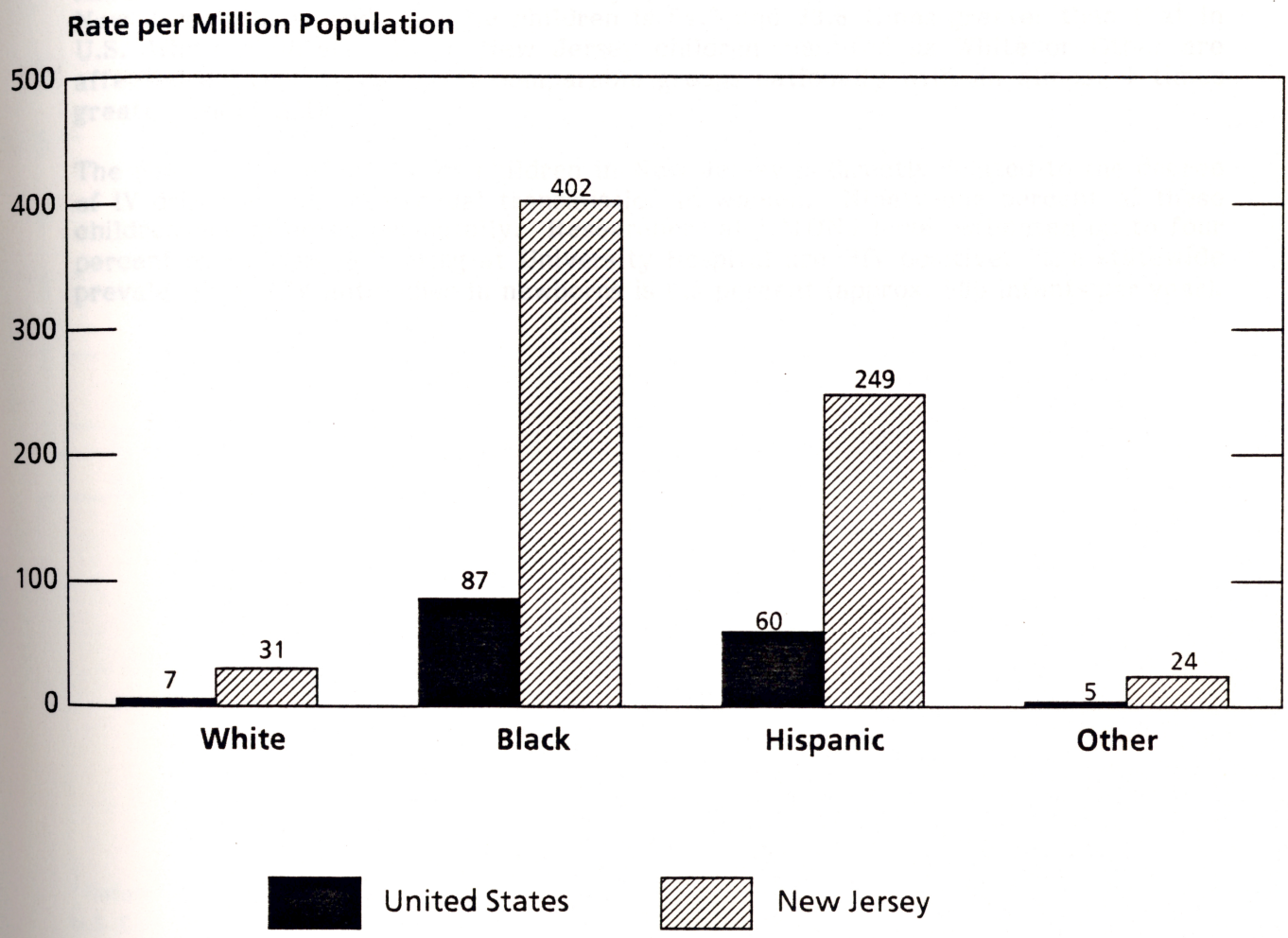
Black and Hispanic men in New Jersey have the highest cumulative incidence rates of AIDS of any population in New Jersey. Their rates of 6960 and 3577 cases, respectively, per million population are among the highest of any statewide population yet studied in the United States. This represents a relative risk of AIDS in New Jersey Black and Hispanic men 14.4 and 7.4, respectively, times that in U.S. White men. This risk is primarily related to the high prevalence of IV drug use among men from those communities.

CUMULATIVE INCIDENCE RATES OF AIDS, WOMEN

Black and Hispanic women in New Jersey have cumulative incidence rates of AIDS that are probably higher than any other population of women in the United States outside of New York City (3,577 and 605 cases, respectively, per million population). Their relative risk of AIDS is 87.5 and 24.2 times greater, respectively, than the risk of White women, nationally. Even, New Jersey women classified as White or Other are affected disproportionately to comparable groups nationally with a 4 times greater risk of AIDS.

New Jersey has the highest percentage of AIDS cases in women (20%) of any other state. Black and Hispanic women represented 77% of all AIDS cases in women in New Jersey. AIDS related maternal deaths have accounted for 8-11 percent of maternal deaths for the past three years in New Jersey. Sixty-six percent of female AIDS cases are IV drug users, while 30% claimed heterosexual contact with a high risk male.

Cumulative Incidence* of AIDS for Children by Racial/Ethnic Group United States and New Jersey



*AIDS cases reported from 6/1/81 to 11/30/88, per million population of same race/ethnicity.

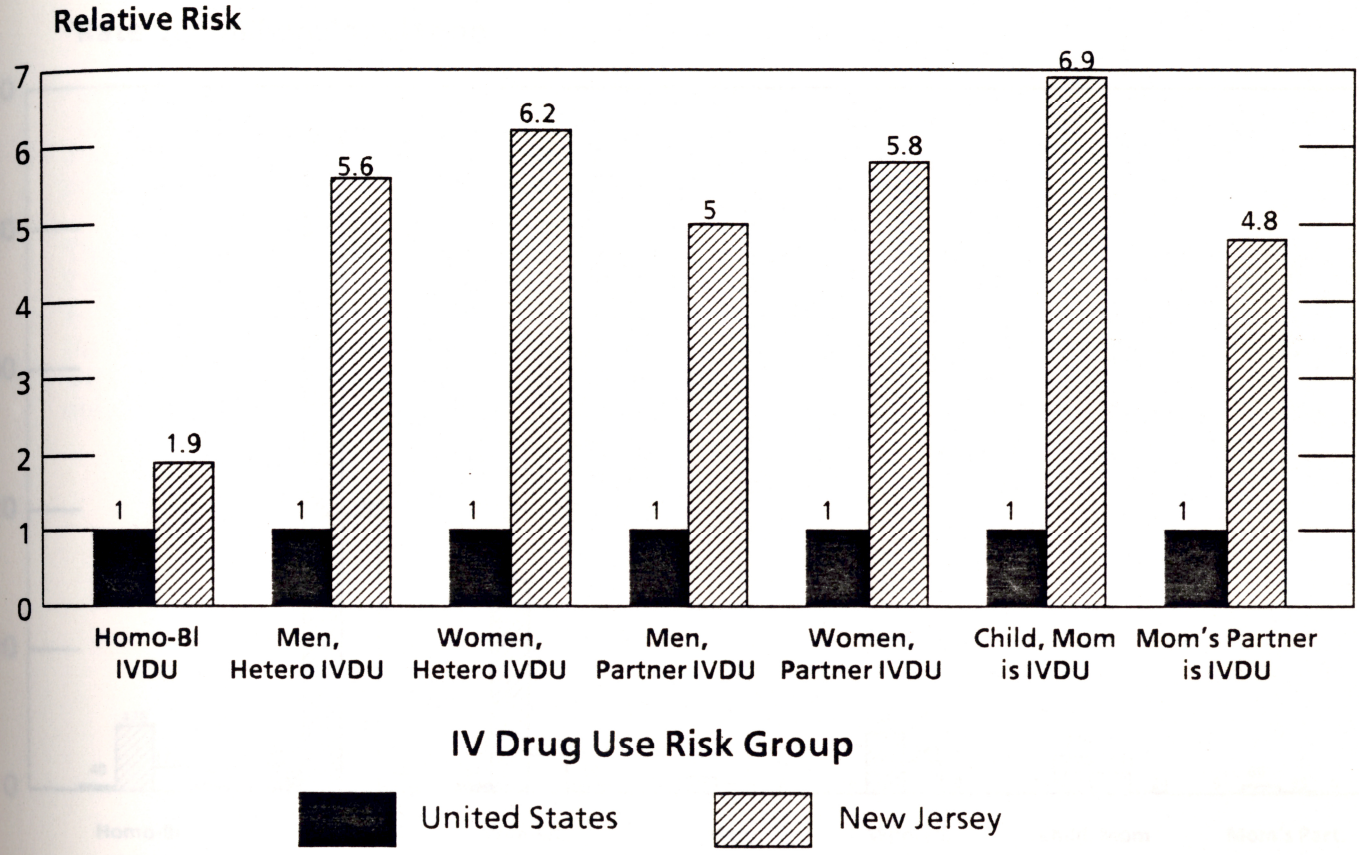
See Next Page.

CUMULATIVE INCIDENCE RATE OF AIDS, CHILDREN

New Jersey has the 2nd greatest number of pediatric AIDS cases in the nation. Black children account for 59% and Hispanic children make up 21% of New Jersey's pediatric cases. Black and Hispanic children in New Jersey have cumulative incidence rates of AIDS of 402 and 249 cases, respectively, per million population. The AIDS risk for New Jersey Black and Hispanic children is 54.3 and 33.6 times greater than that in U.S. White children. Even, New Jersey children classifed as White or Other are affected disproportionately to comparable groups nationally with an almost 4 times greater risk of AIDS.

The risk of HIV infection for children in New Jersey is directly related to the degree of IV drug use and hetersexual transmission in women. Ninety-one percent of these children are infected perinatally. Researchers at UMDNJ have estimated up to four percent of mothers delivering at University Hospital are HIV positive. The statewide prevalence of HIV antibodies in newborns is 0.5 percent (approx. 600 infants per year).

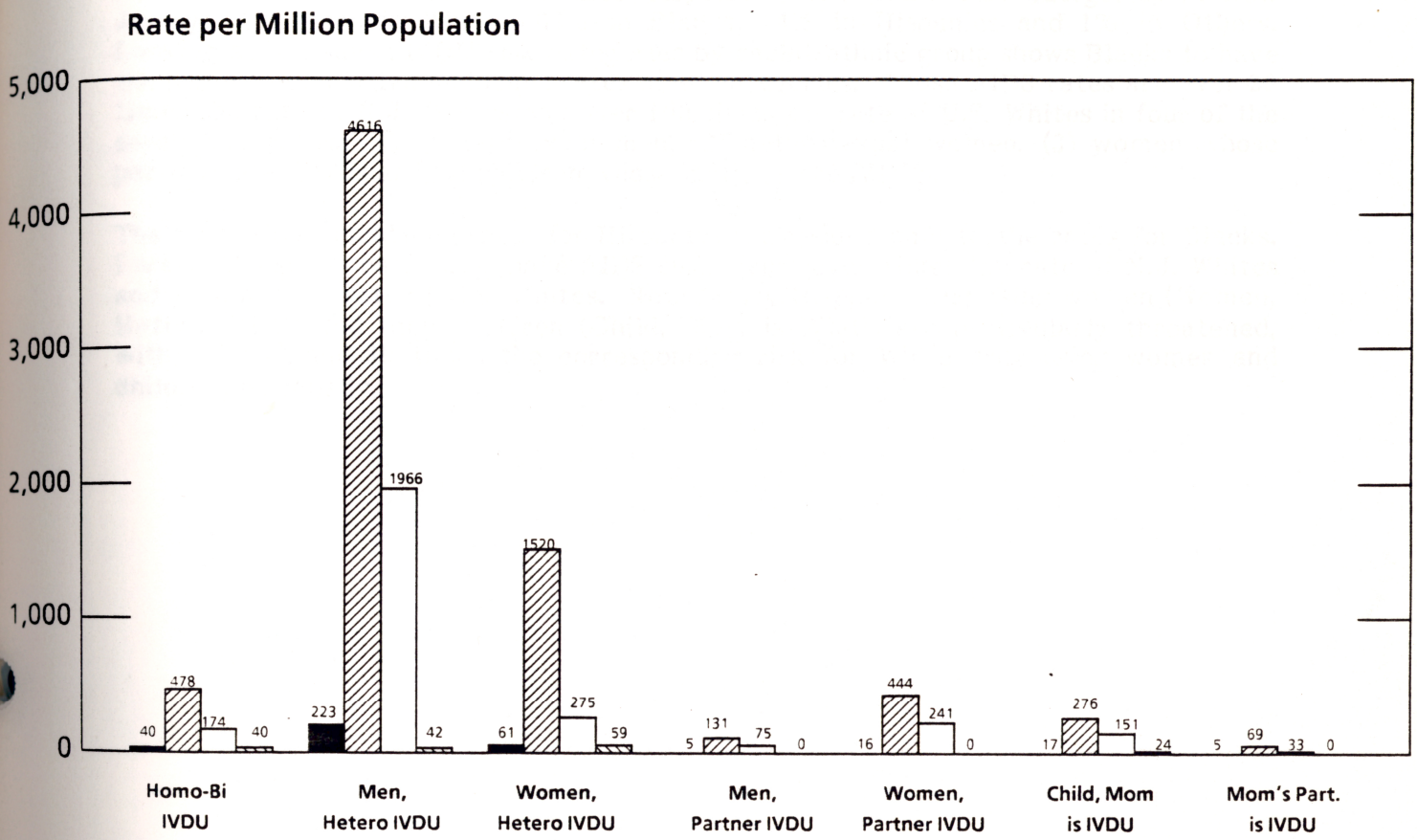
Relative Risk* of AIDS Associated with Intravenous Drug Use, United States and New Jersey



*Reference group for relative risk:
U.S. Cumulative Incidence for the same risk and gender group, November 30, 1988.

Except for homosexual/bisexual men who use IV drugs, the relative risks for AIDS in all other IVDU associated categories are 5 to 7 times higher in New Jersey than in the United States as a whole. IVDU risk represents 2/3 of the AIDS risk in New Jersey and is the opposite of the national pattern where homosexual activity is the predominant risk.

Cumulative Incidence* of AIDS Associated with Intravenous Drug Use, by Racial/Ethnic Group, New Jersey



*AIDS cases reported from 6/1/88 to 11/30/88 per million population of same race/ethnicity.

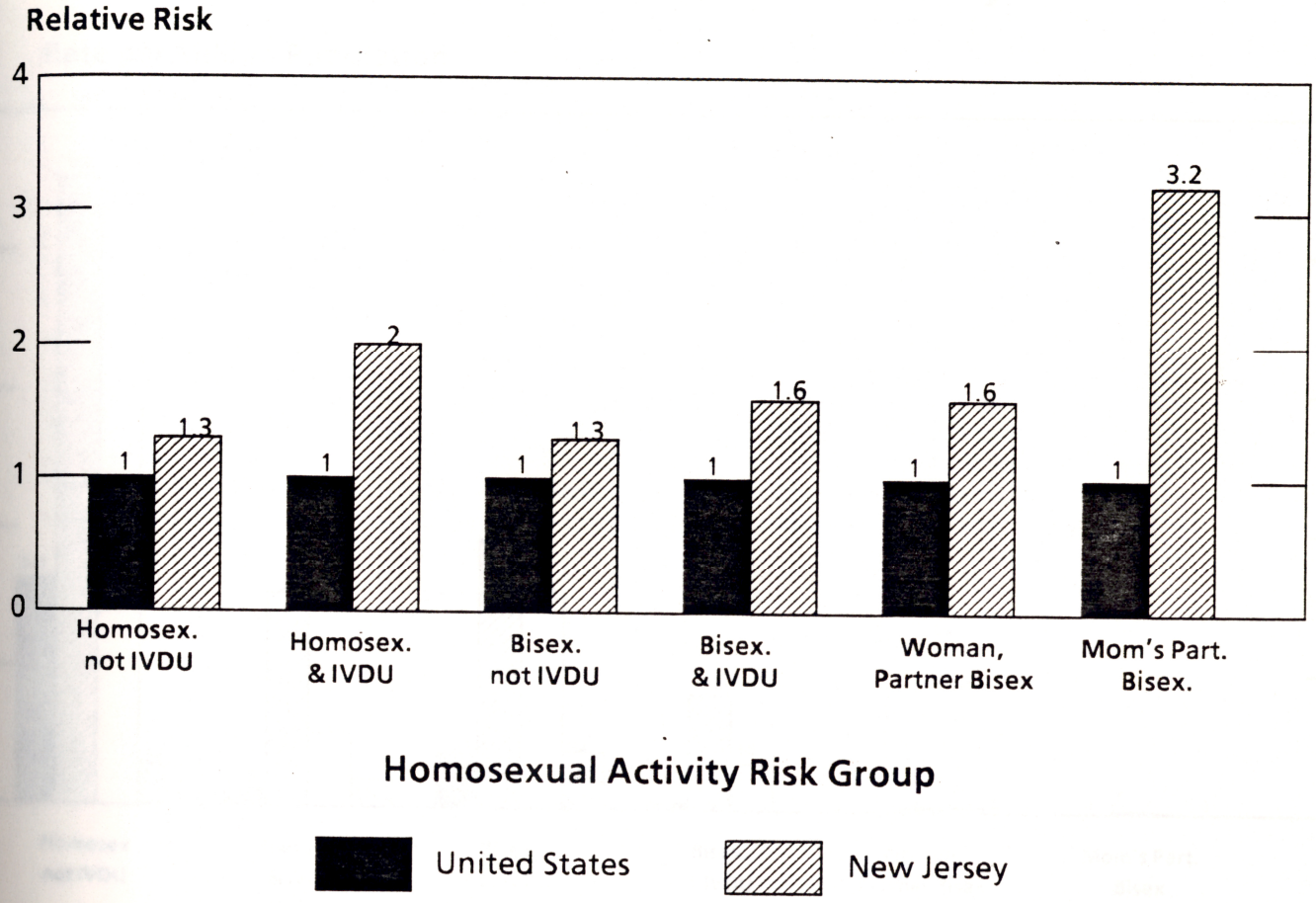
See Next Page

CUMULATIVE INCIDENCE OF AIDS ASSOCIATED WITH INTRAVENOUS DRUG USE BY RACIAL/ETHNIC GROUP

Of the more than 3,000 AIDS cases associated with IVDU risk categories in New Jersey, 23% were in Whites; 62% in Blacks; 14% in Hispanics and 1% in Others. Looking at the seven IVDU risk categories by racial/ethnic group shows Blacks to have the highest cumulative incidence rates in all categories. Those AIDS rates are over 20 times the rate of N.J. Whites and over 100 times the rate of U.S. Whites in four of the seven categories: (1) heterosexual men, (2) heterosexual women, (3) women whose partners are IVDUs and (4) children whose mothers are IVDUs.

The cumulative incidence rates for Hispanics are second only to the rates for Blacks. Five of the seven categories have AIDS risks over seven times the rate of N.J. Whites and 40 times the rate of U.S. Whites. New Jersey Hispanic drug using women (Women, Hetero IVDU) and their children (Child, Mom is IVDU) are particularly threatened, with risks 78 and 89 times the corresponding risk for White drug using women and children, nationally.

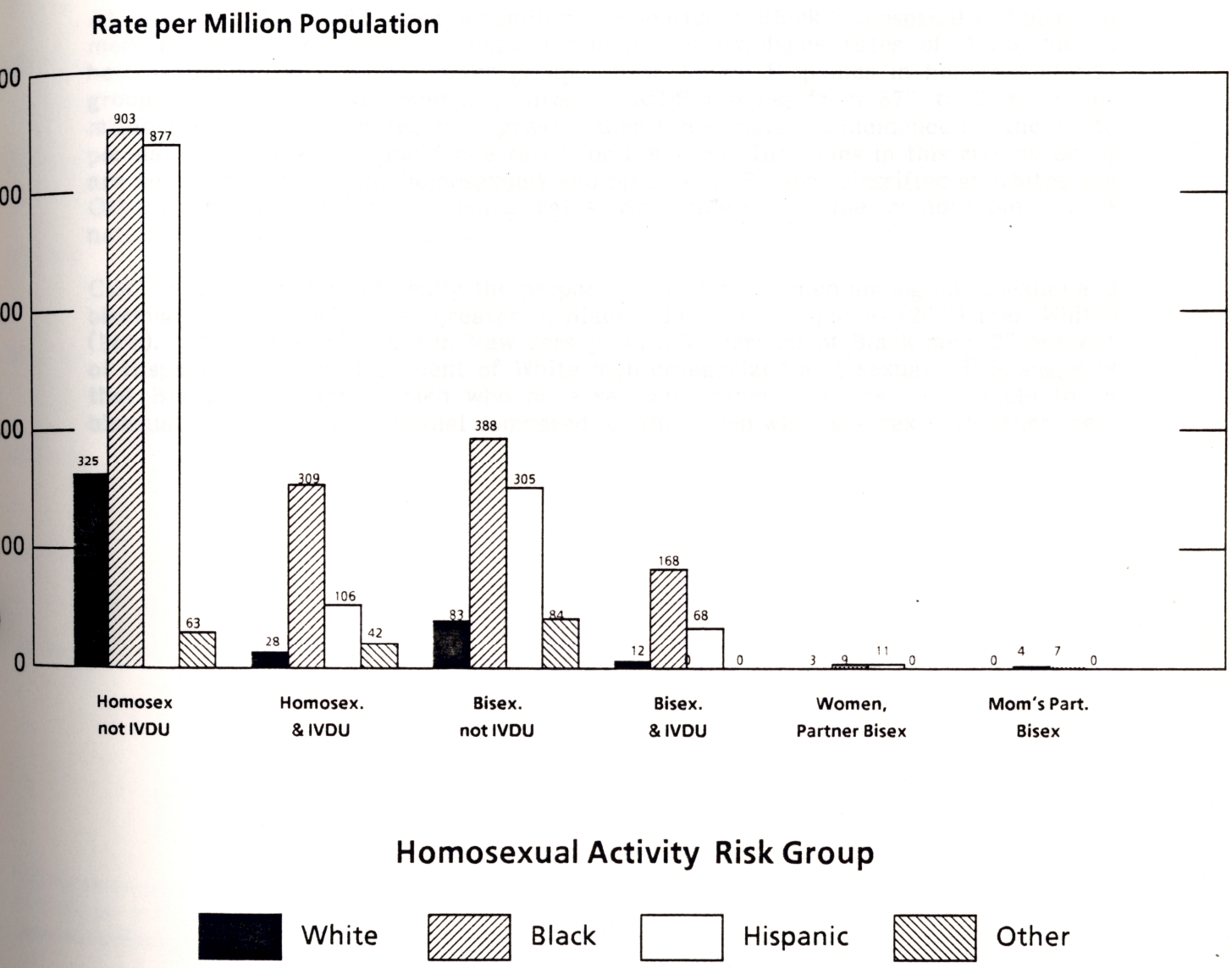
Relative Risk* of AIDS Associated with Homosexual Activity United States and New Jersey



*Reference group for relative risk:
U.S. Cumulative Incidence for the same risk and gender group, November 30, 1988.

When compared to the United States the relative risk of AIDS in New Jersey due to homosexual activity is almost twice as high in three of the six risk categories: homosexual and bisexual IVDUs, and their sex partners. (Children whose mothers had a bisexual sex partner showed the highest relative risk compared to national risk groups.) Of the more than 1500 AIDS cases associated with homosexual activity in New Jersey, 58% occurred in Whites, 29% in Blacks, 10% in Hispanics and 31% in Other racial/ethnic groups. This represents about one third of all AIDS cases in New Jersey and constitutes a different pattern of distribtuion both geographically and demographically from cases associated with IVDU.

Cumulative Incidence* of AIDS Associated with Homosexual Activity, by Racial/Ethnic Group, New Jersey



IDS cases reported from 6/1/88 to
/30/88 per million population of
me race/ethnicity.

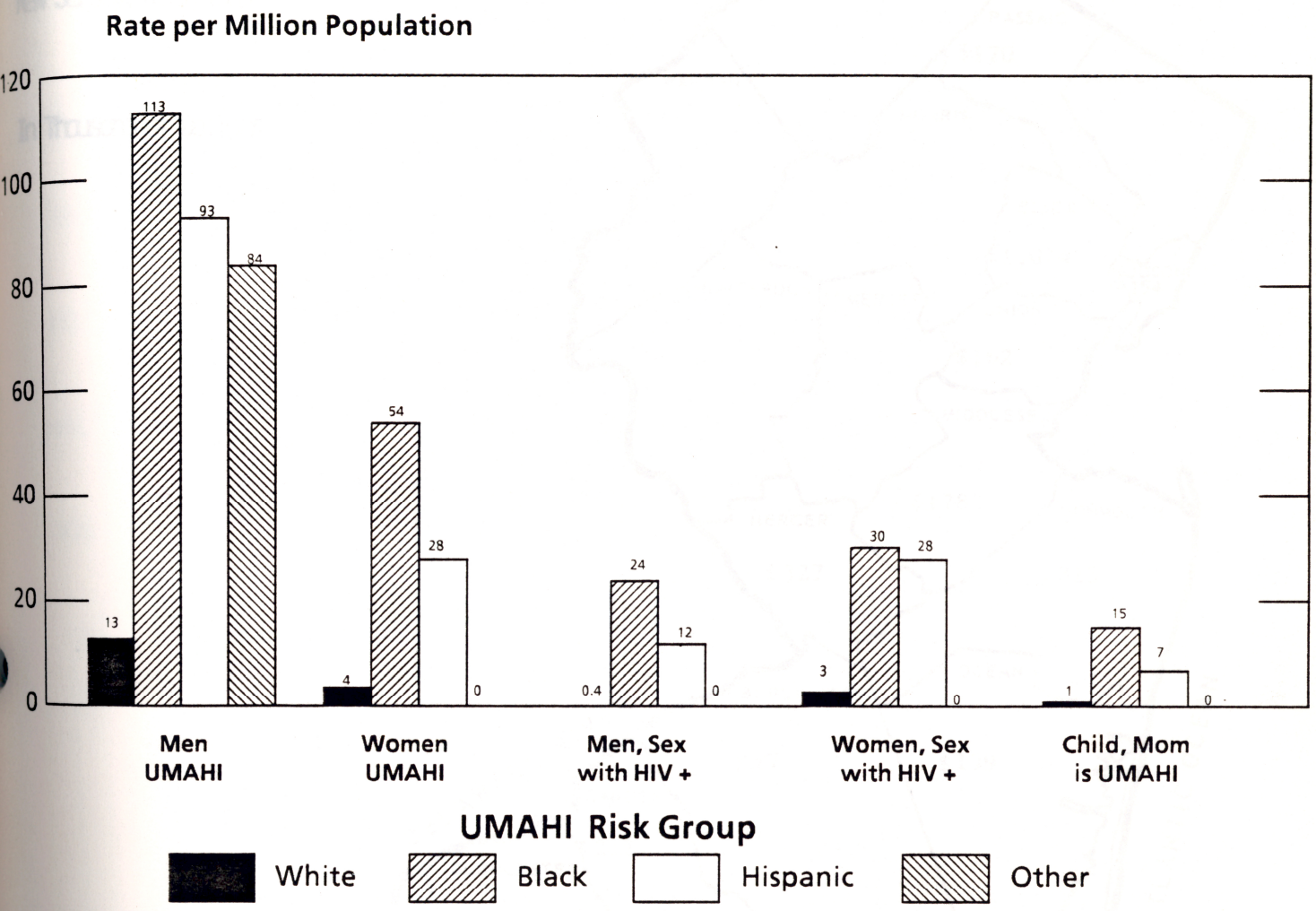
See Next Page.

CUMULATIVE INCIDENCE OF AIDS ASSOCIATED WITH HOMOSEXUAL ACTIVITY, BY RACIAL/ETHNIC GROUP

At rates of 903 and 388 cases per million, respectively, Black homosexual and bisexual men in New Jersey have the highest cumulative incidence rates of AIDS due to homosexual activity of any other group. New Jersey Hispanics in homosexual risk groups have cumulative incidence rates of AIDS ranging from 877 to 7 cases per million, which in each category is greater than the cumulative incidence for the White population. The highest incidence rates for Black and Hispanics in this risk category are among non-drug using homosexuals and bisexuals. Persons classified as Whites and Others have cumulative incidence rates very similar to the comparable groups nationally.

CDC data noted that nationally the proportion of bisexual men among homosexual and bisexual men with AIDS was greater in Blacks (30%) and Hispanics (20%) than Whites (14%). This is also the case in New Jersey, with 31 percent of Black men, 27 percent of Hispanic men and 21 percent of White men categorized as bisexual. This suggests that Black and Hispanic men who have sex with other men are more likely to be bisexual rather than homosexual compared to White men who have sex with other men.

Cumulative Incidence* of AIDS Associated with Undetermined Means of Acquiring HIV Infection** by Racial/Ethnic Group, New Jersey



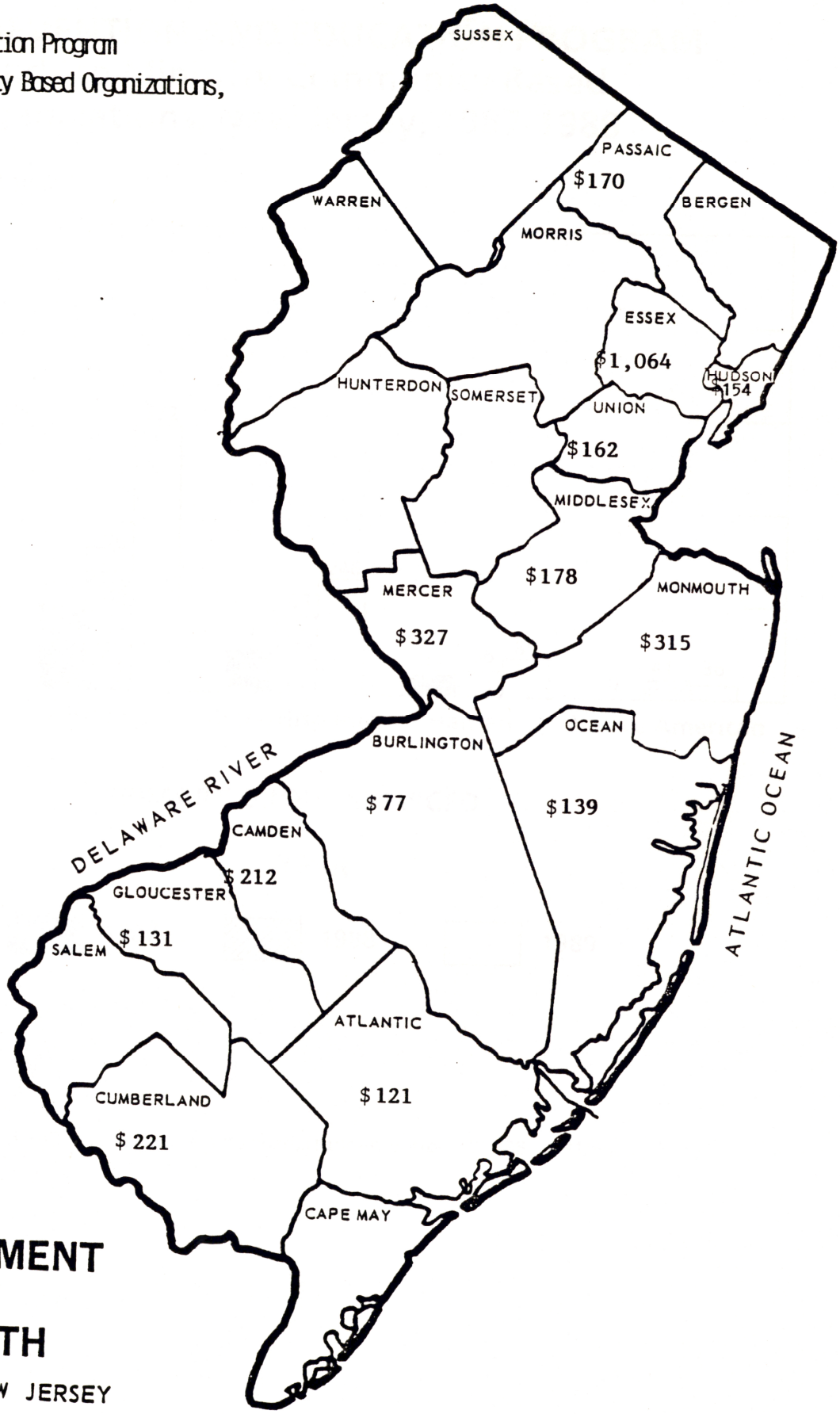
*AIDS cases reported from 6/1/88 to 11/30/88 per million population of same race/ethnicity.

** UMAHI

When broken down by gender and racial/ethnic group, the cumulative incidence rates of AIDS for the Black community are again higher than any other community. The highest incidence rates are for Men, UMAHI at 113 cases per million; Black Women, UMAHI had a rate of 54 cases per million. the Hispanic community's cumulative incidence rates for UMAHI range from 93 to 7 cases per million resulting in relative risks forAIDS 8 to 35 times greater than their White counterparts. In this risk category, New Jersey men who are classified as belonging to Other/Unknown racial/ethnic groups have incidence rates of AIDS higher than the White population.

AIDS Prevention and Education Program
Funds to Minority Community Based Organizations,
New Jersey, 1987-1989

In Thousand of Dollars

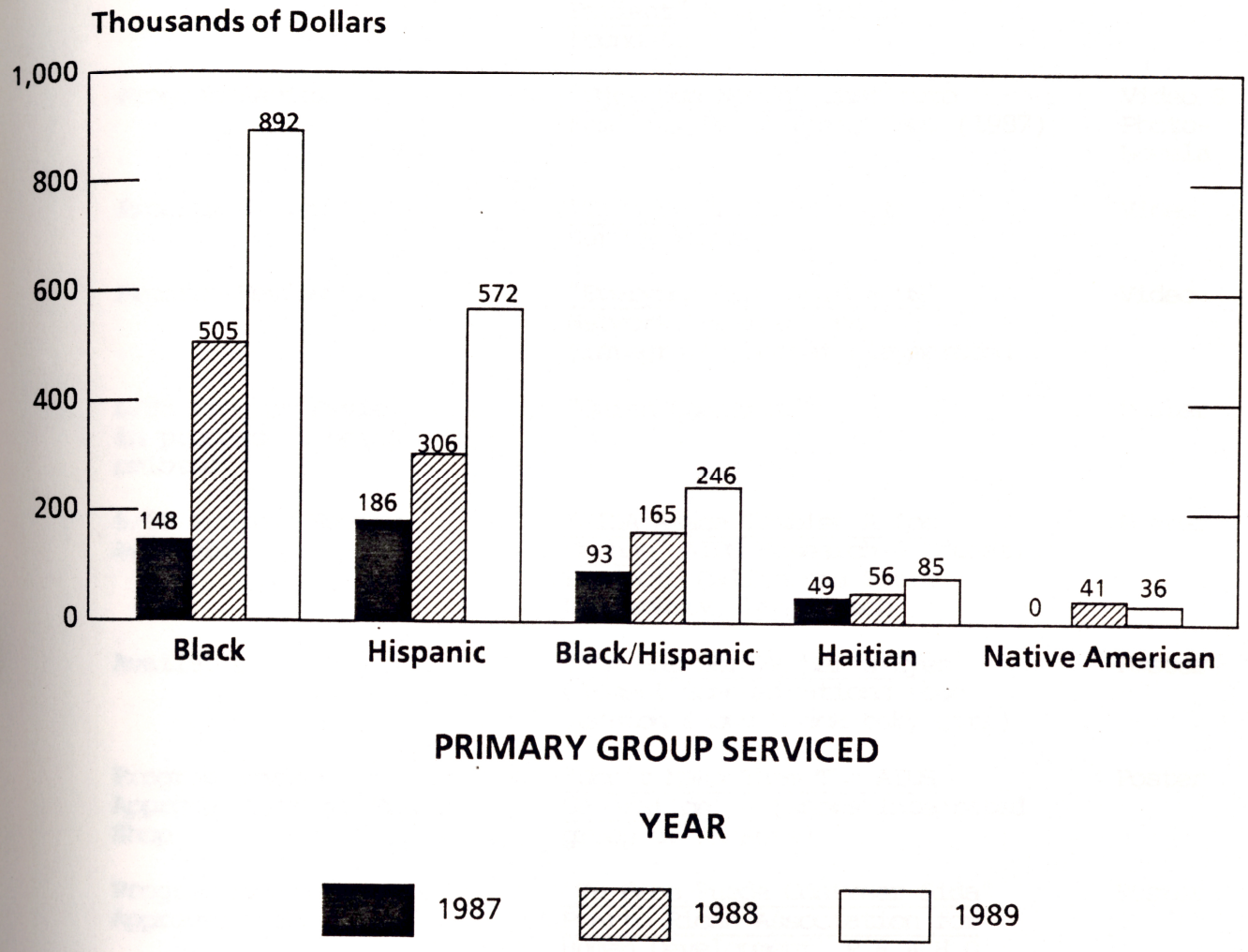


DEPARTMENT OF HEALTH

STATE OF NEW JERSEY

This map indicates the funds allocated to minority community based organizations, by county thru December 1988.

AIDS PREVENTION AND EDUCATION PROGRAM
Funds to Minority Community Based Organizations, New Jersey, 1987-1989



Black (10), Hispanic (8), Blk/Hisp (2),
Haitian (1), Native American (1)
(Number of Organizations Funded)
FUNDED PERIOD 5/1/88 - 12/31/88 except Native American, (funded period 10/1/88 - 3/31/88)

EDUCATIONAL MATERIAL WITH MINORITY FOCUS

DATE APPROVED OR STAGE OF DEVELOPMENT	TITLE & SOURCE	FORMAT
Program Review	"Caring for the Latino AIDS Patient" Novela Health Foundation 1988	Video
Program Review	"Ojos Que NoVen" Instituto Familiar De La Raza, Inc. (1987)	Video & Photo-Novela
Program Review	"Till Death Do Us Part" Durrin Films	Video
Program Review	"Everyone Can Avoid AIDS" Network Publications (Integrated Format-Claymation)	Video
6/88 Program Review In process of being printed	"Quien Comparte"	Poster
6/88 Program Review Available	"SIDA Ataca Tambien A Los Machos" AIDS Research & Education Project, California State University, Long Beach	Poster
Available	"She Has Her Father's Eyes" Clement Communications (one version shows black baby girl)	Poster
Program Review Approval 6/88 at Print Shop	"Don't Make Them The AIDS Generation" - (shows integrated group of infants)	Poster
Program Review Approval 9/88	"Tu Bebe Puede Contraer Sida" Puerto Rican Association for Human Development, P.R.A.H.D. Perth Amboy	Poster
Program Review Approval 9/88 - Waiting Delivery	"Sharing Needles Can Give You AIDS/Tu Puedes Contraer el Sida, Al Compartir Agujas" - San Francisco AIDS Foundation 1987	Card Size Foldover with Clean your Works Instructions
Program Review Approval 9/88 Selective one time distribution	"How to Usa a Condom (Rubber) HERO - Spanish Version	Small folded flyer
Program Review 9/88 Approval	"Lo Que La Gente Joven" Channing Beta - Scripto Graphic Not Ordered - Inquiry	Booklet
Internal Review 2/1/89 Not Approved	1/88 shows revision with major changes - not passed by Internal Review on 2/1/89	

DATE APPROVED OR STAGE OF DEVELOPMENT	TITLE & SOURCE	FORMAT
Program Review 5/87 in use	You Don't Have to be White or Gay to get AIDS	Pamphlet
	Further titles going back to 1986 - not in use	
Reviewed Internally Review Panel 1/89 returned for further development	AIDS: Life or Death and SIDA: Vida O Muerta from Hispanic Association of Ocean County Lakewood	Video Script
Internal Review 1/89 Returned for revisions	"Cuidate, y Cuda Los Tuyos Mujer y Madre Hispana"	Pamphlet
Approved Internal Review 1/89 - Program Review will see 3/6/89	"El Despertar de Ramon" Novela Health Foundation	Photo-Novela
1/9/89 Approved Program Review with limitation to use in training in Counseling and Testing unit only for purposes of discussion of Counseling process	"Drugs & AIDS - Counseling the HIV Antibody Positive Patient" (Spanish version) from Los Angeles County Medical Association	Video

ALSO: 7 items with minority focus submitted for Review 2/22/89 by:
Puerto Rican Association for Human Development P.R.A.H.D. - Perth Amboy.

1. "America Responds to AIDS" Campaign
   - 9 PSAs localized (6 in English - 3 in Spanish) for distribution to major stations, cable networks and 2 Spanish stations.
   - 15 copies of above have been made available to CBOs, individuals, organizations, etc.
   - Complete campaign incorporates messages targeting youth, adults, women, couples, family in the Black, Hispanic and general population, in both printed and electronic media.
   - 3,000 transit cards targeting the Black and Hispanic community are now in production for placement in 500 N.J. Transit Buses.
   - Print PSAs have been submitted to 6 newspapers - including Spanish tabloids.
   - Print ready copies in various formats are available upon request - dual sets - one targeted to the general population and the other to minorities (Blacks and Hispanics).

2. Division Produced PSA on "Women and AIDS"
   - Features a Spanish tag
   - Bilingual texts
   - Racially and ethnically balanced talent

3. Bands to Beat AIDS
   - Includes 8 posters featuring minority artists (Black - Hispanic)
   - 2 have been translated into Spanish (Kool & the Gang & Jelly Bean Bemitez)

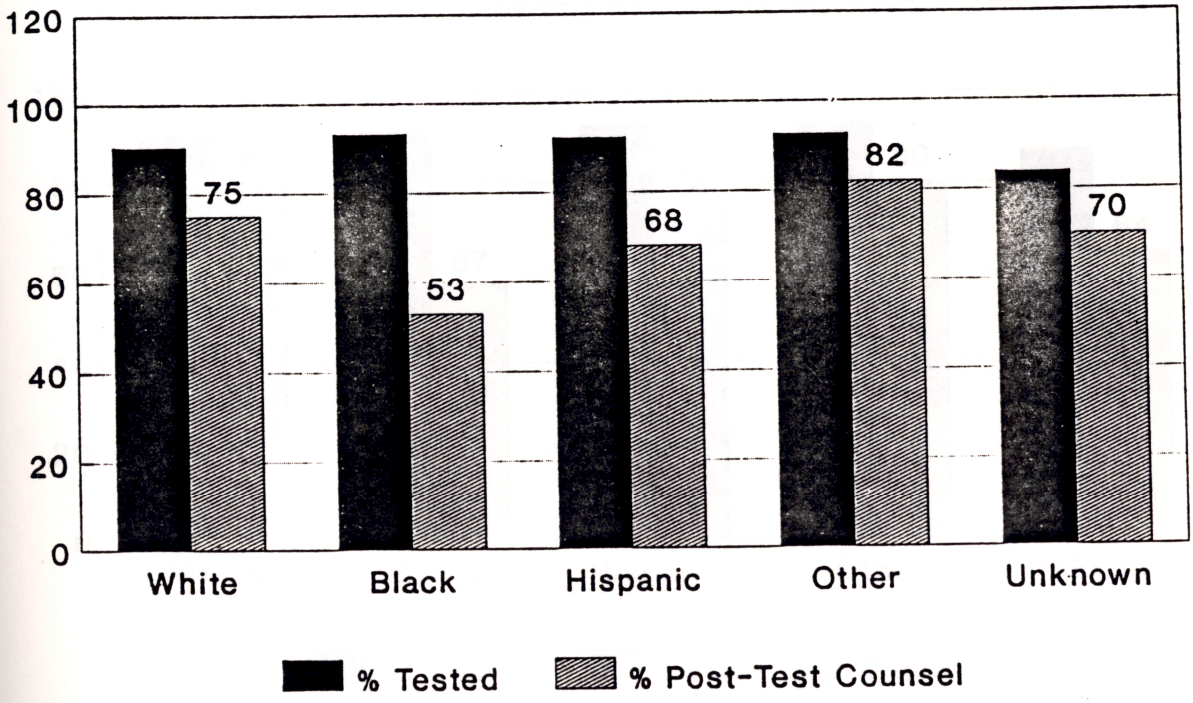
STAFFING OF COUNSELING AND TESTING SITES:

1. St. Michaels - 4 bilingual - hispanics, 6 black
2. Jersey City Medical Center - 1 bilingual - hispanic, 0 black
3. Robert Wood Johnson - 1 bilingual - hispanic, 0 black
4. Atlantic City Health Dept. - 1 bilingual - hispanic, 0 black
5. Paterson - 0 bilingual, 0 hispanic, 1 black
6. Camden - 2 bilingual (1 hispanic), 1 black, 1 vietnamese
7. Trenton - 0 bilingual, 0 hispanic, 2 black
8. E. Orange - 1 bilingual, 1 hispanic, 2 black
9. Morristown - 0 bilingual, 0 hispanic, 0 black
10. Jersey Shore - 0 bilingual, 0 hispanic, 0 black
11. Ocean City - No one hired
12. Bergen County - No one hired

Bilingual = Spanish/English Speaking

2 Black Coordinators

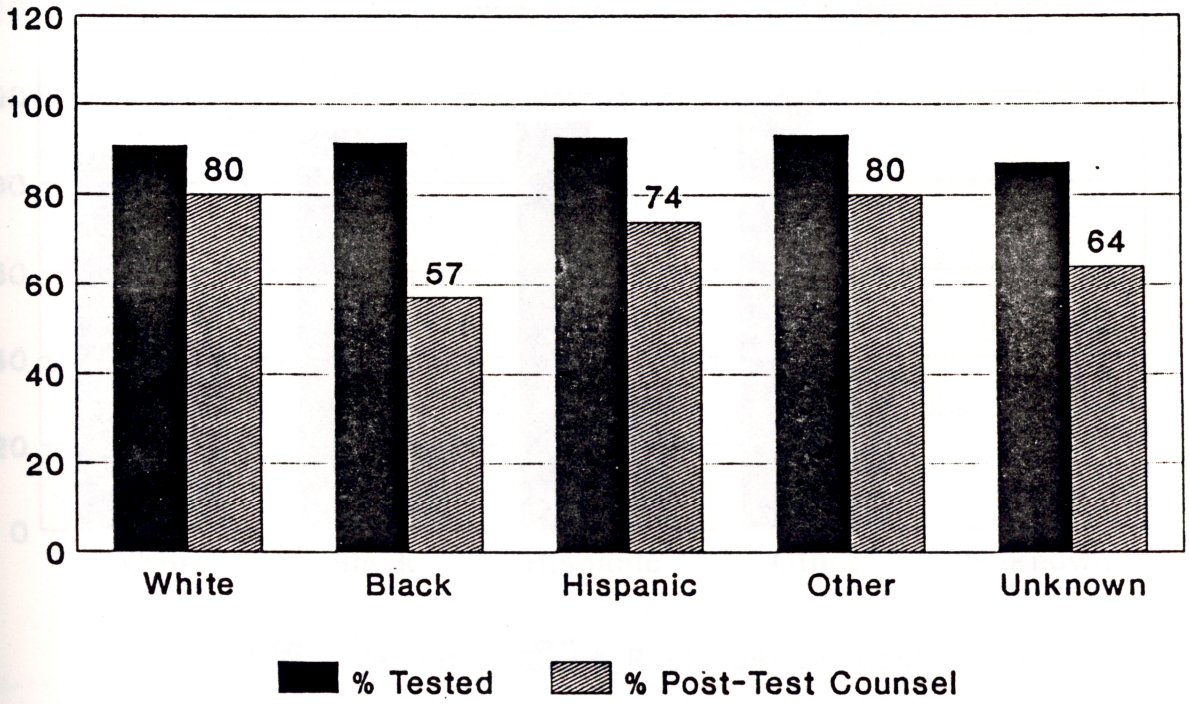
Women Tested and Post-Test Counseled at CTS'* by Racial/Ethnic Group



5/88 - 9/88, N = 3051
* Counseling and Test Sites

There are no major differences in the percentage of male and female clients who chose to be tested for HIV at the CTS. When comparing the three major race categories (White, Black and Hispanic), Whites were more likely to return for Post Test Counseling than their Black or Hispanic counterparts.

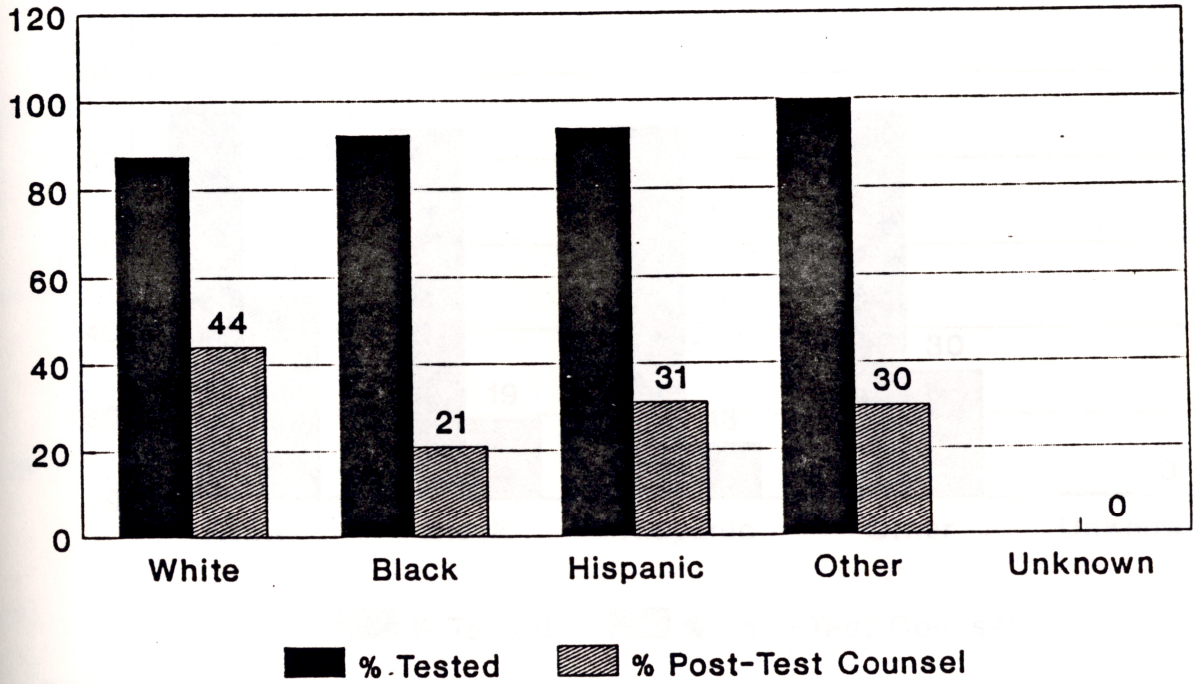
Men Tested and Post-Test Counseled at CTS'* by Racial/Ethnic Group



5/88 - 9/88, N = 3862
* Counseling and Test Sites

There are no major differences in the percentage of male and female clients who chose to be tested for HIV at the CTS. When comparing the three major race categories (White, Black and Hispanic), Whites were more likely to return for Post Test Counseling than their Black or Hispanic counterparts.

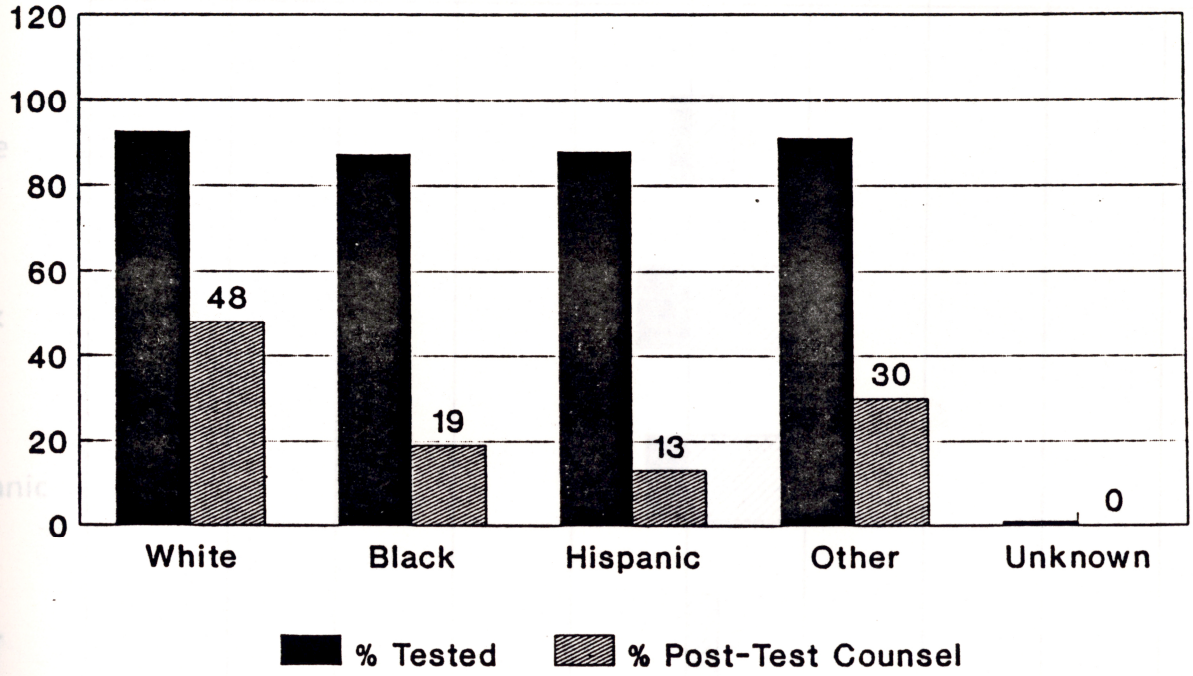
Women Tested and Post-Test Counseled at Satellite Sites*, by Racial/Ethnic Group



5/88 - 9/88, N = 883
* Fam. Planning, Prenatal, STD, Drug Treatment and Tuberculosis Clinics

There is no major difference in the numbers of men and women choosing to be tested for HIV in the satellite sites. The low number of individuals (male and female) returning to these sites are alarming when compared to the CTS (50% vs 50% respectively). compliance.

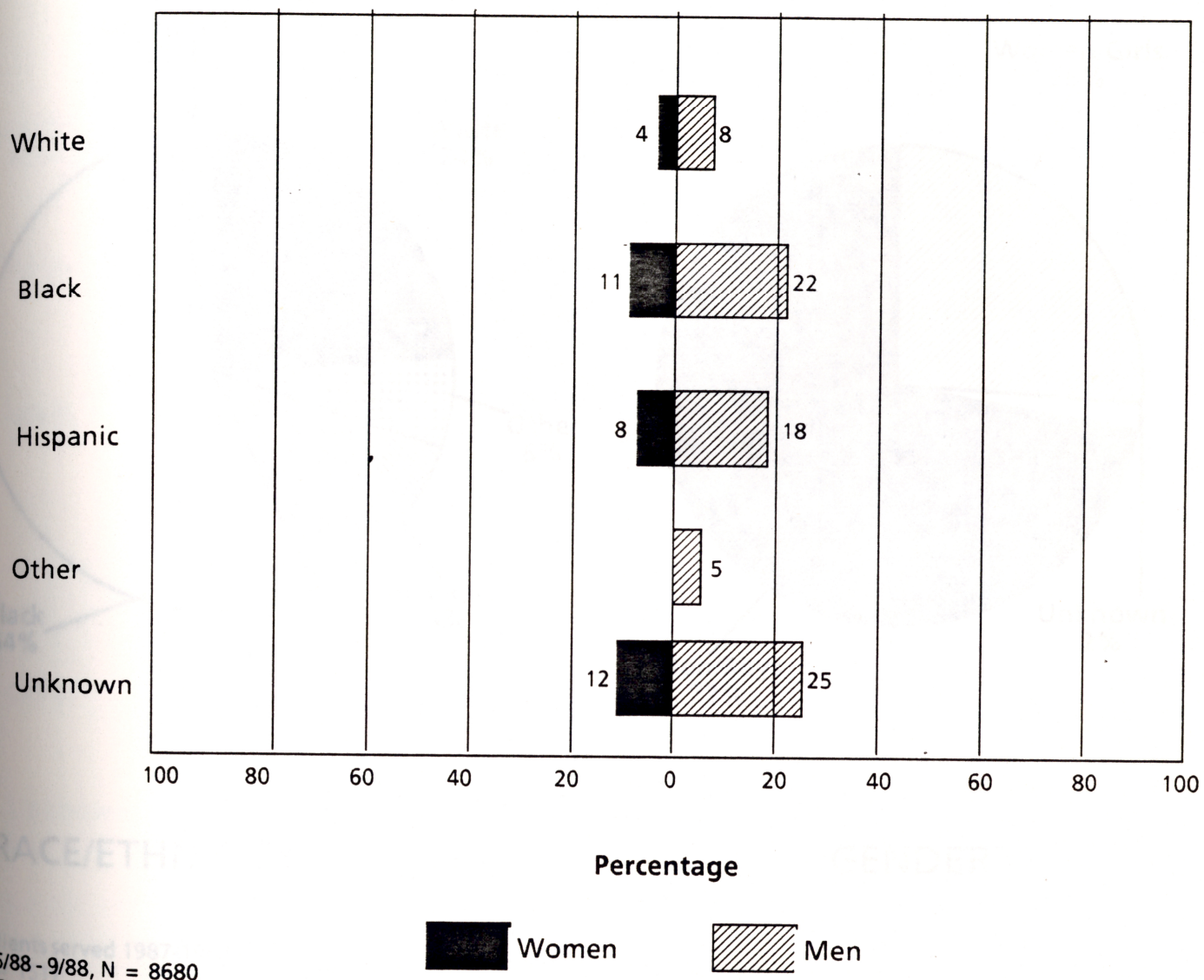
Men Tested and Post-Test Counseled at Satellite Sites*, by Racial/Ethnic Group



5/88 - 9/88, N = 875
* Fam. Planning, Prenatal, STD, Drug Treatment and Tuberculosis Clinics

There is no major difference in the numbers of men and women choosing to be tested for HIV in the satellite sites. The low number of individuals (male and female) returning to these sites are alarming when compared to the CTS (50% vs 50% respectively). compliance.

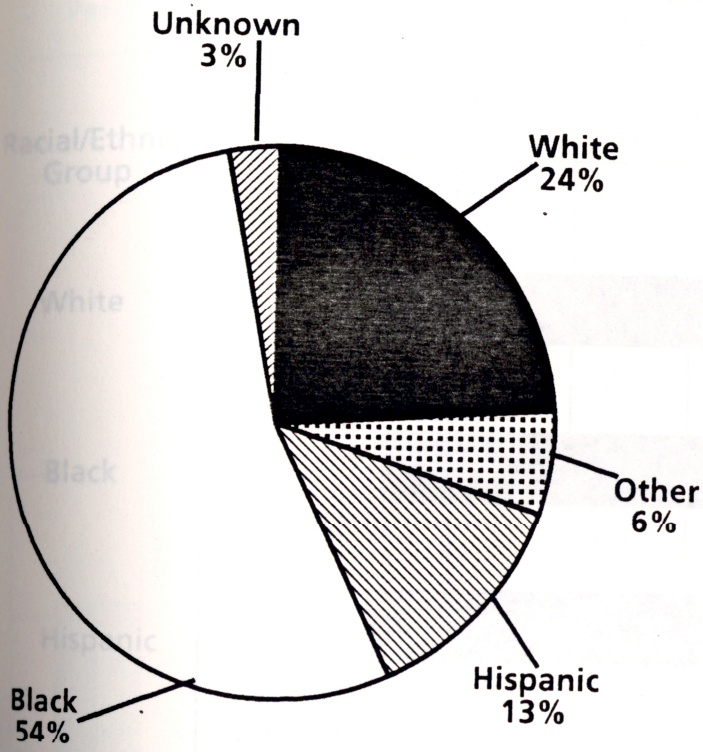
CTS Clients by Racial/Ethnic Group and Sex, All Sites*



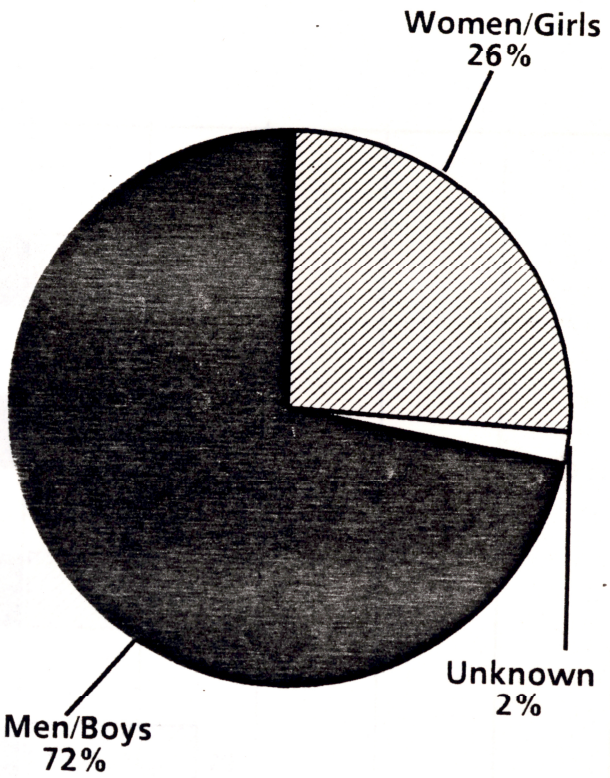
5/88 - 9/88, N = 8680
*Counseling and Test Sites and Satellite Sites (FP, PN, STD, DTC, TB)

Men of all races are twice as likely as women to utilize counseling and testing services. This is not surprising inasmuch as males represent approximately 80% of the total number of AIDS cases in the State.

AIDS Hospital and Post-Hospital Support Program Selected Client* Demographics



RACE/ETHNICITY

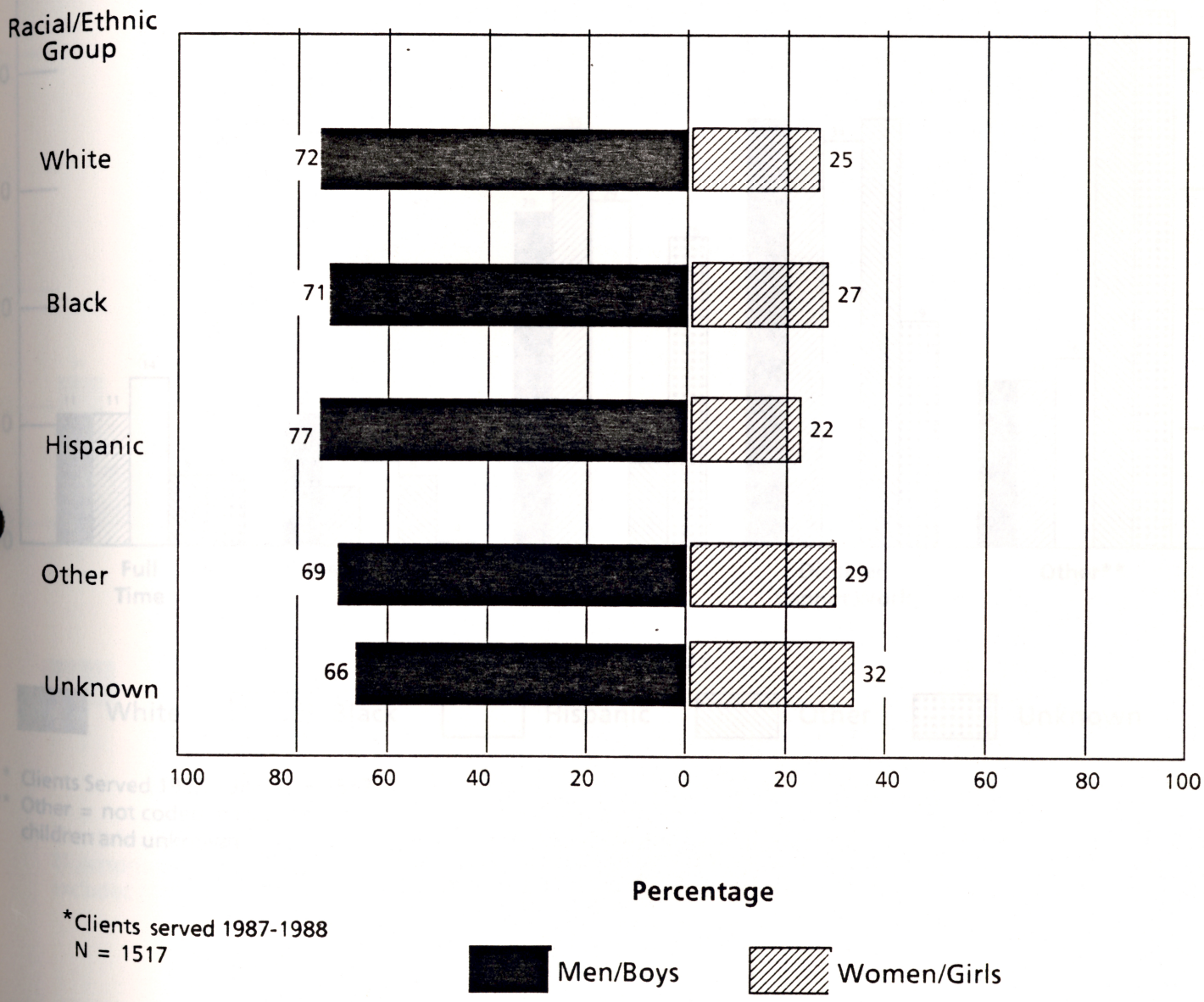


GENDER

*Clients served 1987-1988
N = 1517

The vast majority of clients served via this program are Black and Hispanic, 54% and 13% respectively. This compares almost identically to the State AIDS Registry. Whites are under represented in the program, with more persons falling into the unknown or other categories. The percentage of women served is 26%. This is significant compared to the State average of 20% and national average of 8%. In our data we have a high percentage of children due to our contract specifically with Children's Hospital in Newark. This is not illustrated.

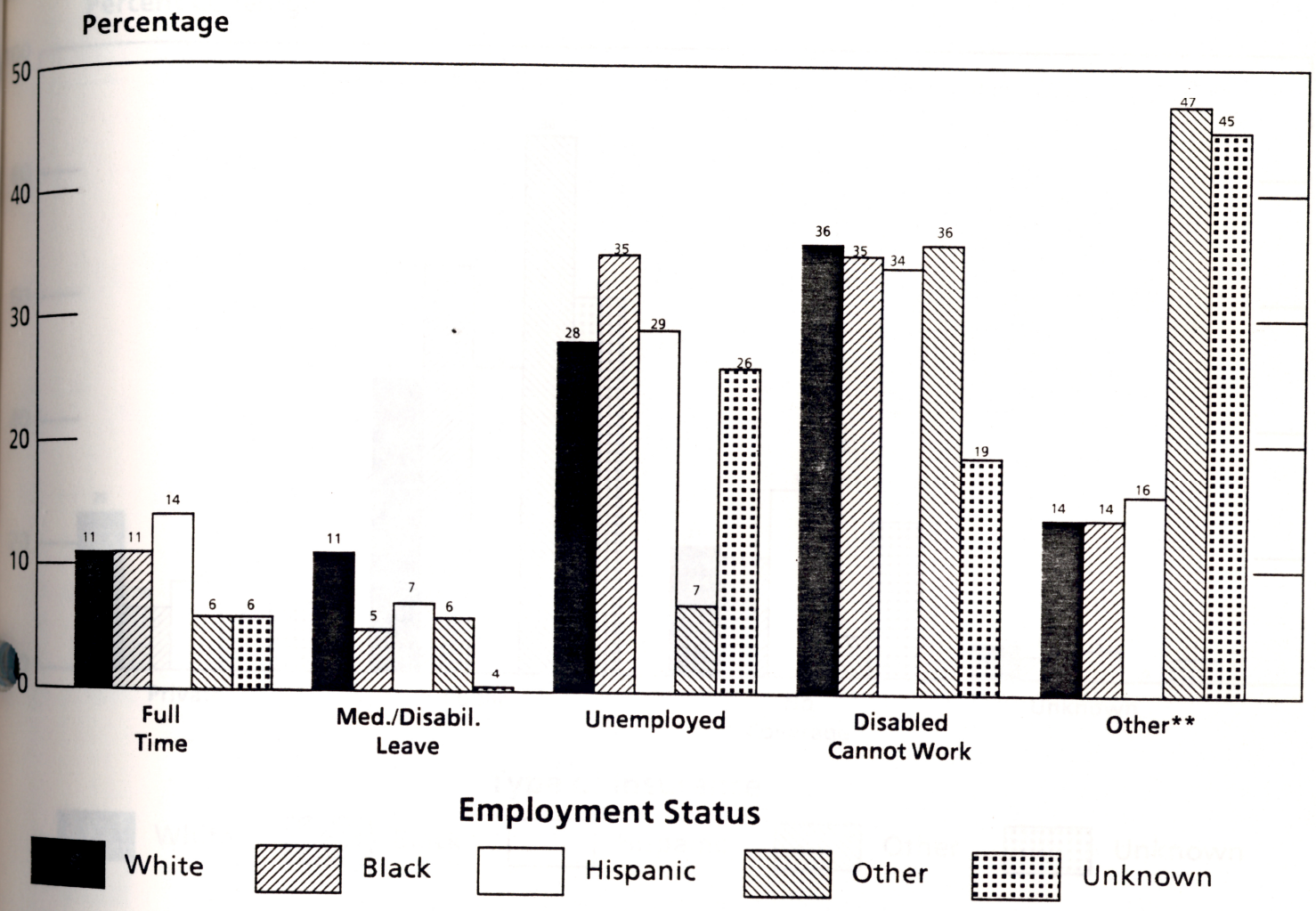
AIDS Hospital and Post-Hospital Support Program Client* Demographics



*Clients served 1987-1988
N = 1517

The ratio of males (men/boys) to females (women/girls) is fairly consistent across racial groups.

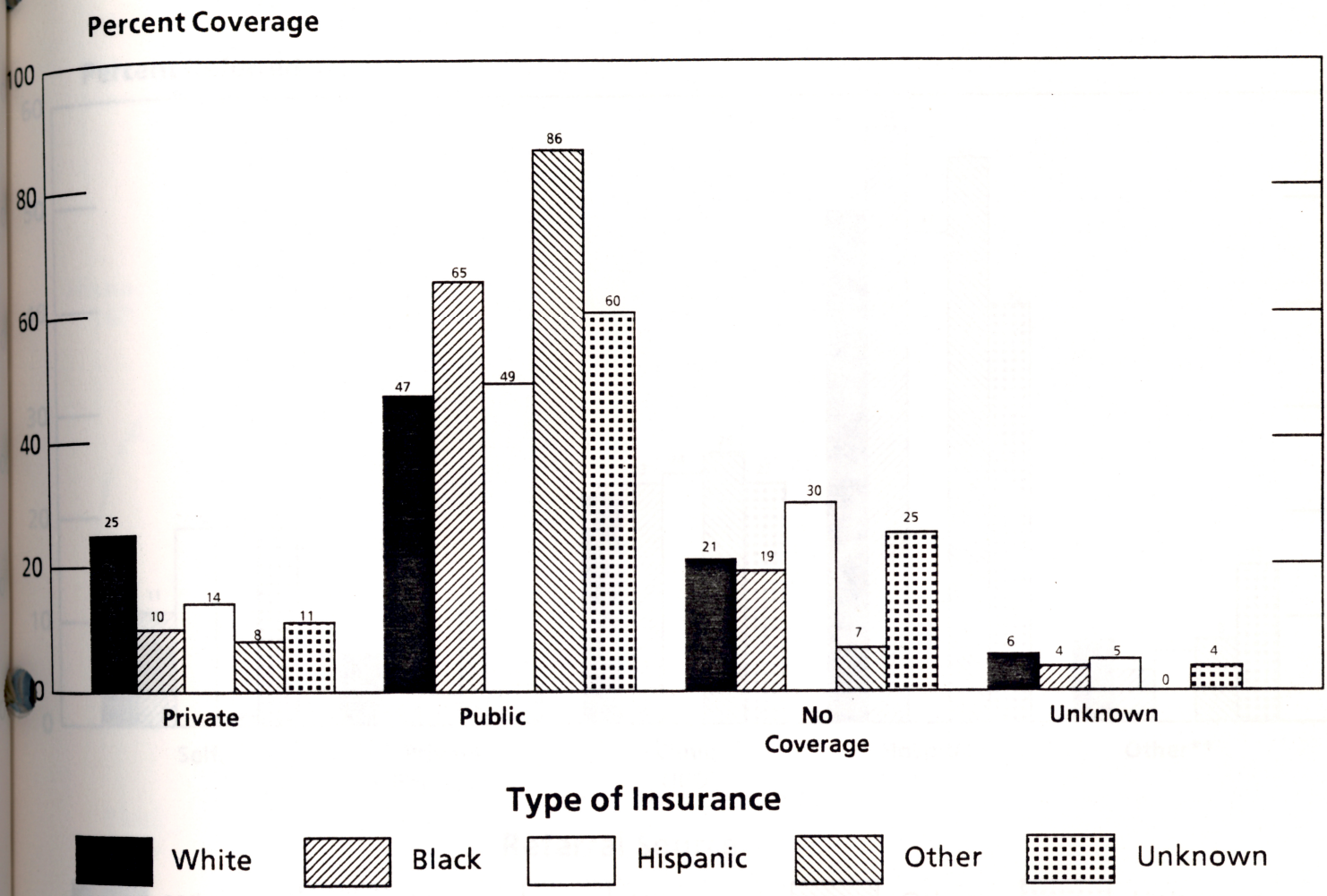
AIDS Hospital and Post-Hospital Support Program Clients* by Employment Status



* Clients Served 1987-1988, N = 1517
** Other = not coded, part time children and unknown.

If we look at additional information on the population served, we find differences in employment status by race. The Black population has a higher percentage of unemployed then Whites and Hispanics. We see that a higher percentage of Whites are on medical disability leave, suggesting that Whites have been employed on a more frequent basis in the past.

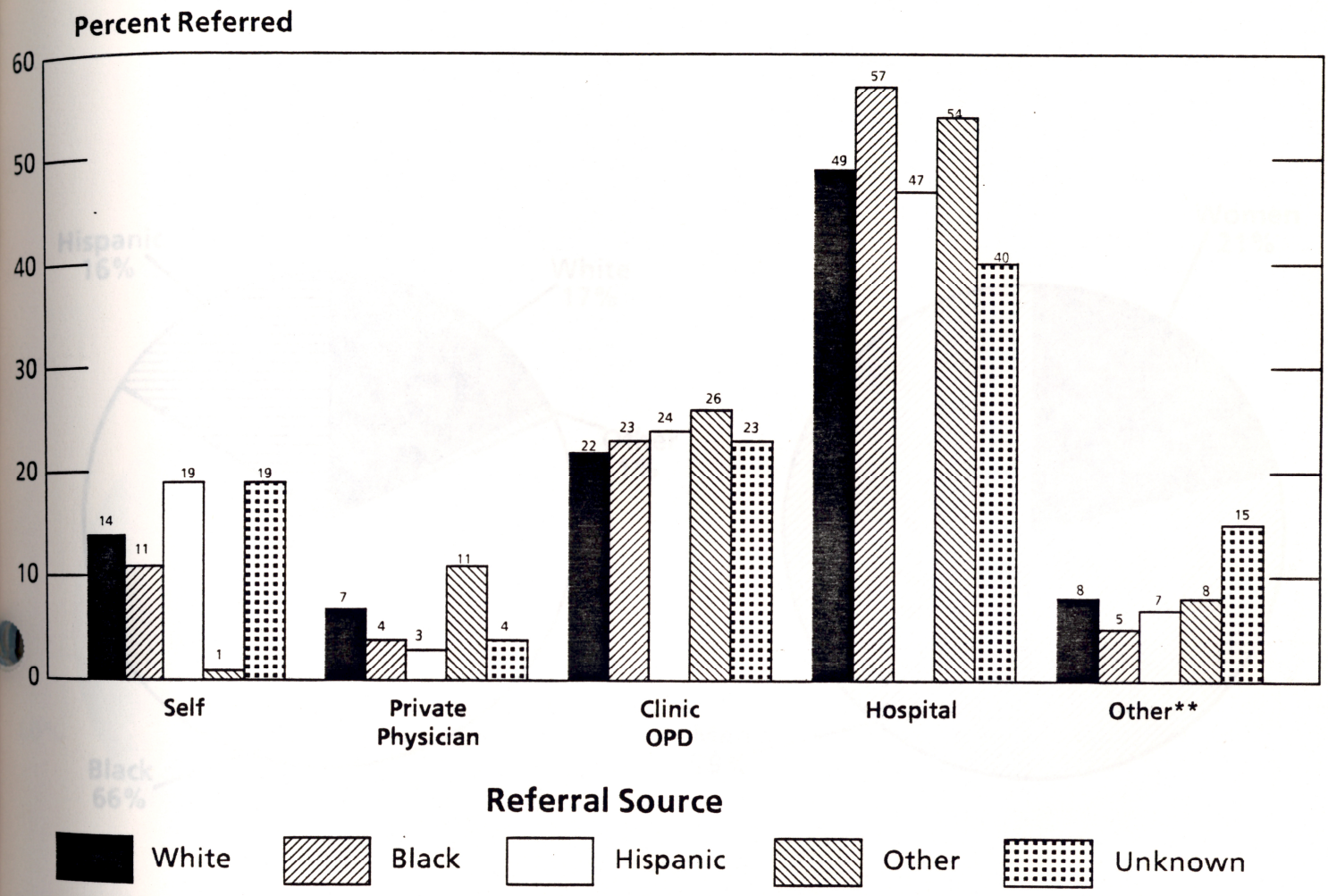
AIDS Hospital and Post-Hospital Support Program Clients* by Health Insurance Status



* Clients Served 1987-1988, N = 1496, 21 persons with dual coverage excluded (1%).

There are striking differences in the type of insurance clients have across racial groups. Whites have higher percentage of private insurance, Blacks have a higher percentage of public insurance and Hispanics have a higher percentage of no coverage.

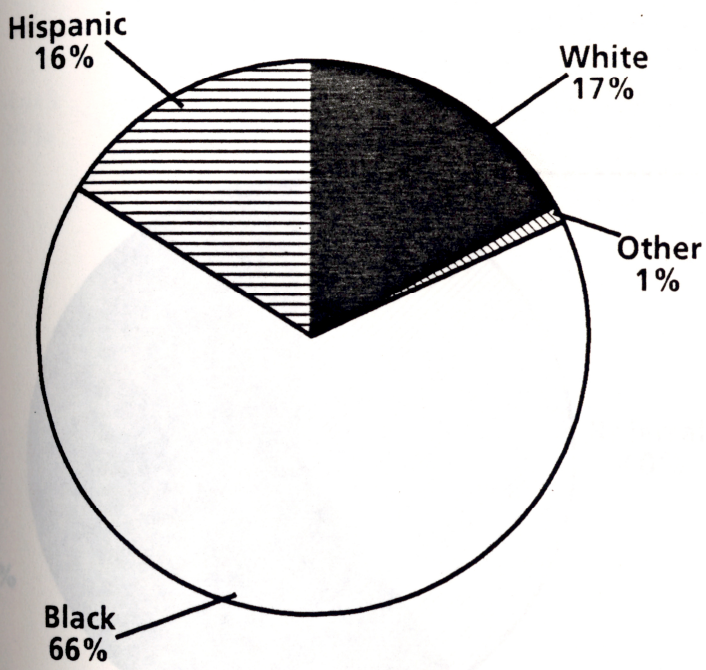
AIDS Hospital and Post-Hospital Support Program Clients* by Referral Source



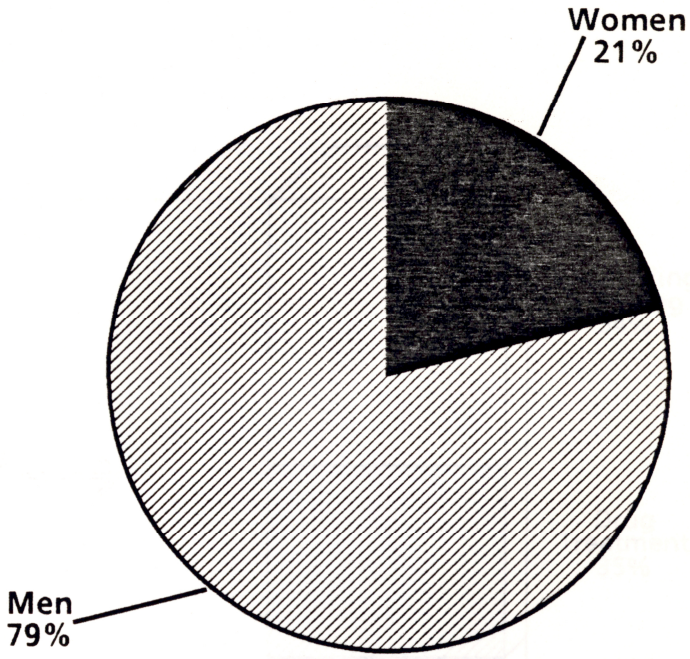
* Clients Served 1987-1988
** Other = dentist, community health agency, other and unknown.

A higher percentage of Whites were referred by their private physician. Also, a higher percentage of Blacks were referred from hospital emergency rooms and inpatient beds. This suggests a heavy reliance on hospitals as a source of primary health care.

AIDS Community Support Program
Drug Treatment Coupon Program*
1987 - 1988



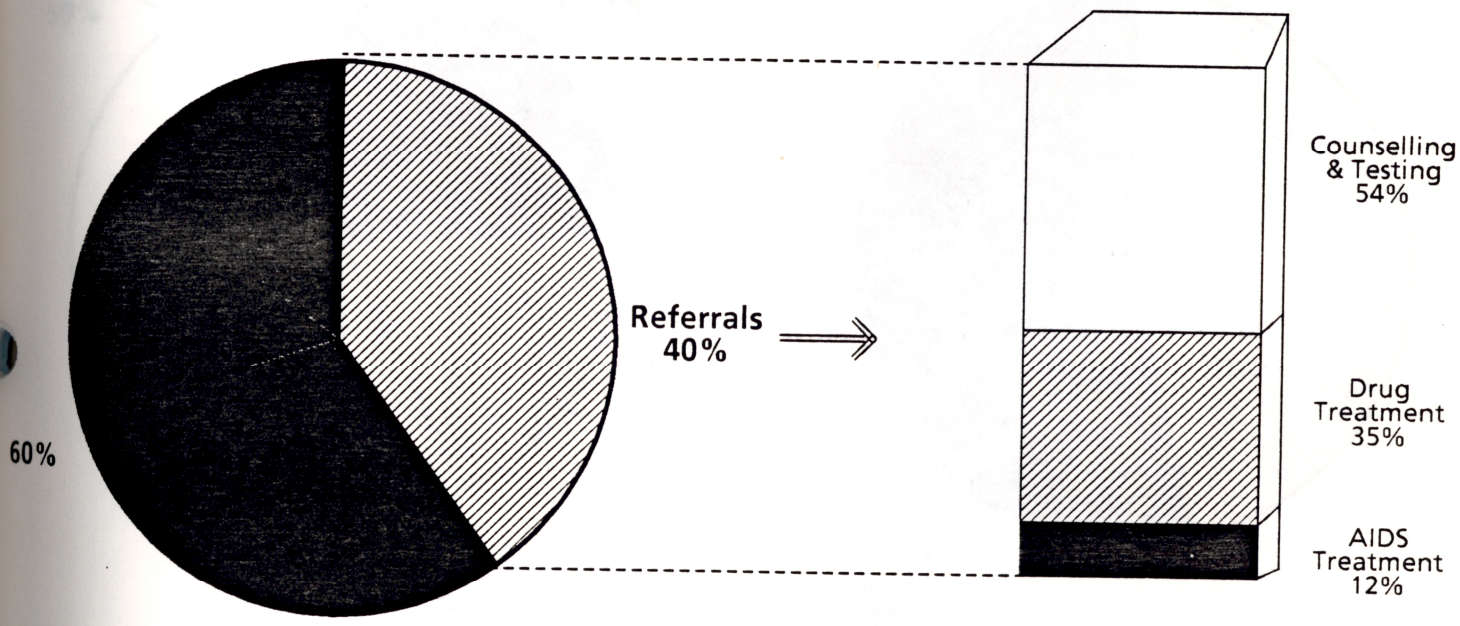
RACE/ETHNICITY



GENDER

*837 of 970 coupons were redeemed.
- 23% went on to Methadone Maintainance.
- 44% had no previous Treatment at all.

AIDS Community Support Program
Mobile Health Van*
Client Referrals

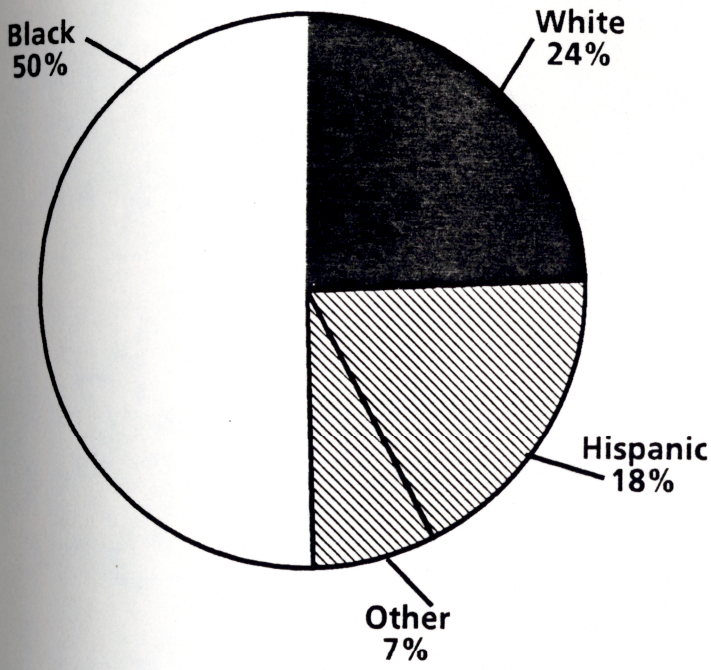


Mobile Van Contacts

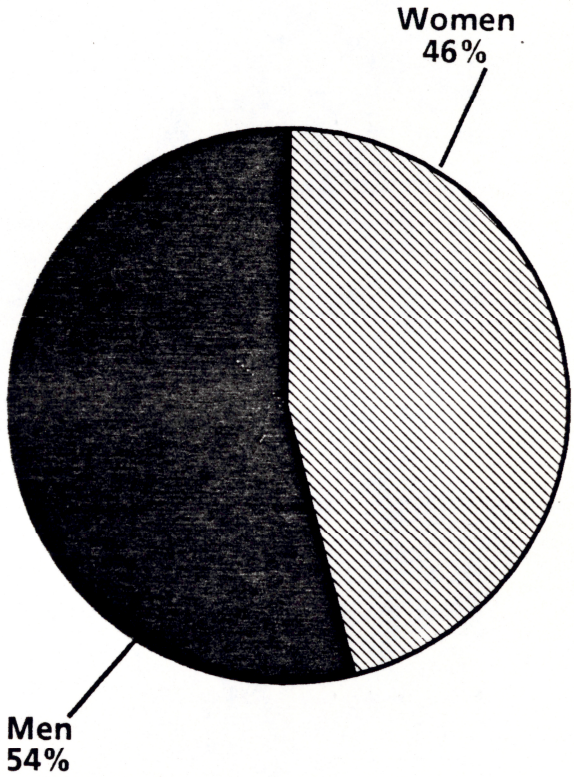
Van Referrals

*1/88 - 6/88, N = 1171

AIDS Community Support Program
Mobile Health Van*
Client Demographics



RACE/ETHNICITY



GENDER

*1/88 - 6/88, N = 1171
83% of clients are 26 years or older

Maternal and Child Health

Background

- Fertility rates for Non-White young adolescents ages 10-14 were 7 times greater than the rate for White young adolescents. Fertility rates for Non-White females, ages 15-19 yrs., were 3 times greater than the rate for similar White females.

- A total of 109,000 family planning clients were served in 1985. Of this total 52% were White, 27.7% Black and 13.6% Hispanic. In 1984 the estimated need for family planning services was 385,000. However, only 108,000 were serviced, or approximately 28% of the estimated need.

- The very low birth weight rate for Whites is 9.4 births per 1,000 in comparison to 27.5 births per 1,000 for Blacks. The relative risk of very low birthweight (less than 1500 grams) is 2.9 times higher for Black infants.

- In 1987, the Non-White infant mortality rate was 18.7 per 1,000 live births in comparison to the 7.1 per 1,000 rate for White infants.

- In 1986, Non-White infants were at 5 times relative risk for dying of an infectious diseases than White infants.

- Genetic Service clients for 1987 were 71% White, 15% Black, 11% Hispanic and 1% Asian.

- Sickle Cell Disease occurs in one of every four hundred New Jersey Black newborns.

- It is estimated through newborn screening, that 50-70 cases of Sickle Cell Disease will be identified annually in New Jersey.

- The estimated number of Black children in New Jersey with Sickle Cell Disease are as follows: less than 5 years of age = 258, ages 5 years - 19 years = 824.

- National estimates project that sickle cell disease occurs at a .31% rate in Black infants.

- Black and Hispanic pregnant women clients and pediatric clients account for more than 70% of the total WIC client population.

- 1980 pediatric hospitalization rate per 1,000 admitted for Non-White children/White children, ages 1-4 years, was 186 and 67.6 respectively.

- There are higher rates of hospitalization across all age groups for Non-White children, in comparison to White children in New Jersey, but in no other age group is the difference as marked as it is for children 1 to 4 years of age.

- Data from the second National Health and Nutrition Examination Survey (NHANES II) conducted in the United States between 1976 and 1980 showed that 4% of children between 6 months and 5 years of age had elevated lead blood levels. The prevalence of elevated blood levels was higher in Black children (12.2%) than whites (2%).

- The NHANES II Survey also showed:

  - There was a significant interaction between the degree of urbanization and race.

  - In central cities the percentage of children with elevated blood levels was significantly higher among Blacks (18.6%) than among Whites (4.5%).

  - Even in smaller urban and rural areas 10.2% of blacks had elevated blood levels as compared with fewer than 2% among Whites.

- New Jersey has defined its highest degree of urbanization as greater than 60,000 persons with greater than 5% of the population under 5 years of age being Black.

- The top six counties classified as high risk, based on the application of the NHANES methodology to 157 New Jersey municipalities are: Essex, Hudson, Passaic, Camden, Union and Mercer.

- Jersey City specific data for a 1985-86 measles outbreak indicated that the incidence of measles for Hispanics was 4 per 1,000 population as compared to 0.8 per 1,000 for all other populations.

- Despite existing reporting methods, according to various health professionals throughout the State, immunization non-compliance still remains in geographic subsections of New Jersey.

Program Description

The Maternal and Child Health Unit

- has responsibility for programs which target services to reproductive aged women and their children. A brief description on each program follows.

Family Planning

- provides funds for contraceptive information and counseling.

Maternal and Infant Health

- provides via contract quality prenatal care to effect a reduction in maternal and infant mortality. MIH funded services are targeted to cities with the greatest perinatal needs. Population in these areas include a large number of minority and low-income groups.

Child Health Program

- develops a network of services for healthy and sick children through the Well Child Clinics, Comprehensive Pediatric Primary Care Services, the New Jersey Child Health Regional Network (health professionals training) and the State Sudden Infant Death Syndrome Resource Center. A major endeavor has been to encourage local health department and pediatric primary care project participation in the Medicaid/EPSDT program and HealthStart initiative. As more "working poor" families become Medicaid-eligible through HealthStart, and more Medicaid-eligible families are served, the low-income minority population is receiving more comprehensive services.

Dental Health Program

- implemented a mobile dental clinic for care of migrant children.

Accident Prevention and Poison Control

- implemented a training program aimed at identifying children at high risk of abuse, neglect and lead poisoning. Note: discussion is found in the Injury Section (Section 6).

HealthStart

- a program begun in February 1988, assures poor pregnant women and their children of quality care from certified physicians, specialists and speciality clinics. Health support services are case coordination, nutrition assessment and counseling, social-psychological assessment and counseling, health education, and home visits for certain patients. Pediatric services include all the preventive, routine visits that are recommended for children (up to age 2) and "continuity of care".

Special Child Health Services

- supports a statewide network of case managers and health care agencies to serve handicapped or chronically ill children. Newborn screening and follow-up for sickle cell disease is expected to be added to the existing inborn errors of metabolism screening program by January 1989.

Women, Infants and Children Services (WIC)

- provides vouchers to purchase food for pregnant and breast feeding women, their infants and children.

Emergency Medical Services

- supports the training of personnel prepared to respond to injuries and life threatening illnesses and works with the New Jersey State Police in providing an aeromedical response program for New Jersey residents and visitors. Note: Additional information is found in the Access to Care Section.

Age Specific Fertility Rates by Race and Age, 1986*

	10-14	15-19	15-44
Non-White	3.05	68.60	65.39
All Races	0.93	34.54	60.97
White**	0.43	22.48	58.71

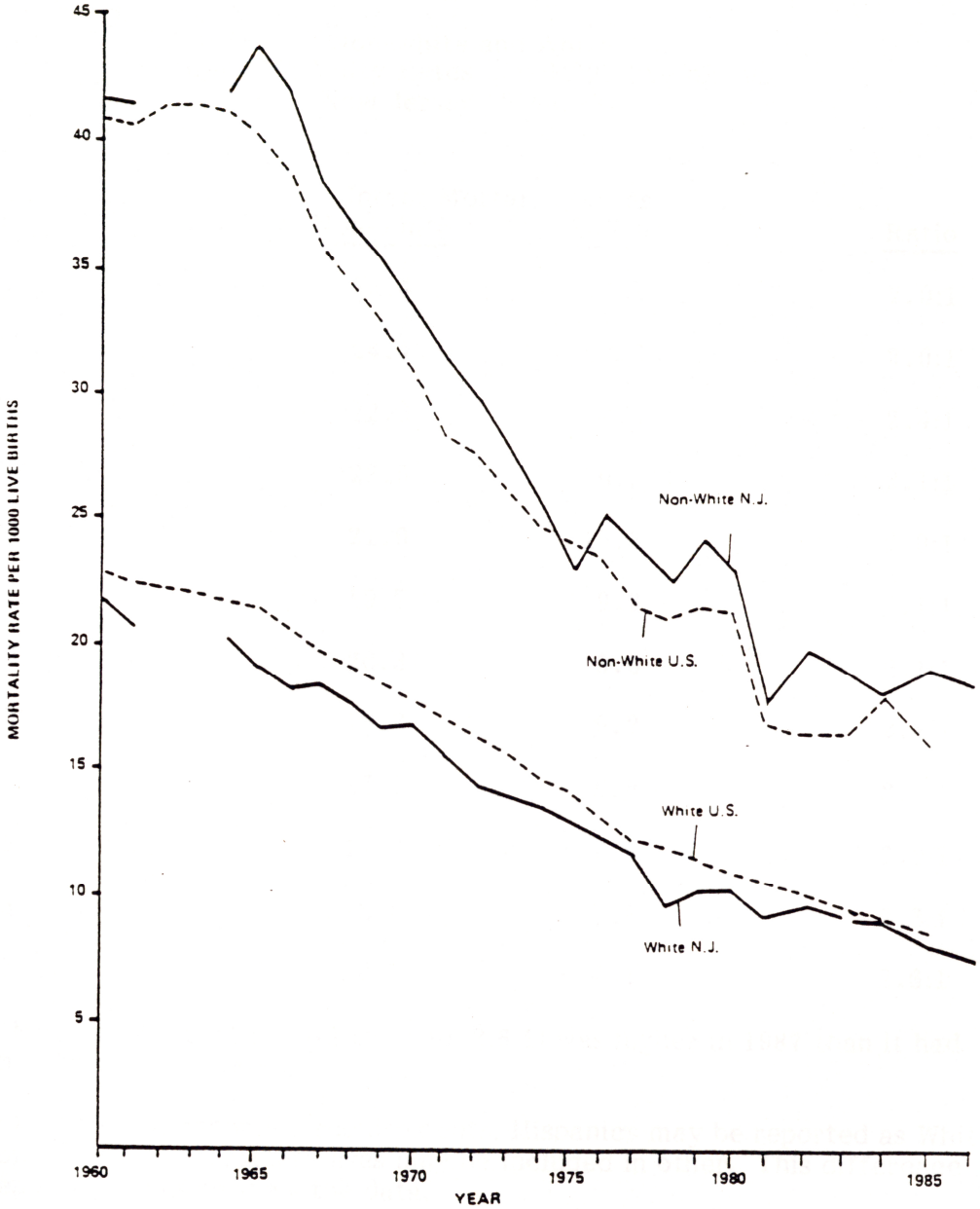
Resident Births by Age Group (15-19), Race and Marital Status

	Number of Births	% Unmarried
All Races	10,116	80.0%
White	5,256	67.2%
Black	4,726	94.9
Other	61	68.9

* Age specific fertility rates are the number of all live births to women in age groups per 1,000 women estimated to be in that age group.

** The majority of the Hispanic popluation are included in the White population.

INFANT MORTALITY
UNITED STATES AND NEW JERSEY by Race
1960 - 1986



NOTE: Race was not recorded in New Jersey in 1962 and 1963

It is significant to note that the mortality rate in New Jersey for Non-White infants is higher than the United States rate for Non-White infants; however, the rate for New Jersey White infants is lower than the national White infant mortality rate.

Non-white and White
Infant Mortality Rates (per 1,000 live births)
New Jersey 1976-1987

Year	Infant Mortality Rates Non-white	White	Ratio
1976	25.4	12.7	2.0:1
1977	24.4	12.2	2.0:1
1978	22.6	9.6	2.4:1
1979	22.5	10.5	2.1:1
1980	21.0	10.3	2.0:1
1981	19.7	9.3	2.1:1
1982	20.3	9.6	2.1:1
1983	19.3	9.2	2.1:1
1984	17.9	9.0	2.0:1
1985	18.7	8.9	2.0:1
1986	18.0	7.8	2.3:1
1987	18.7	7.1	2.6:1

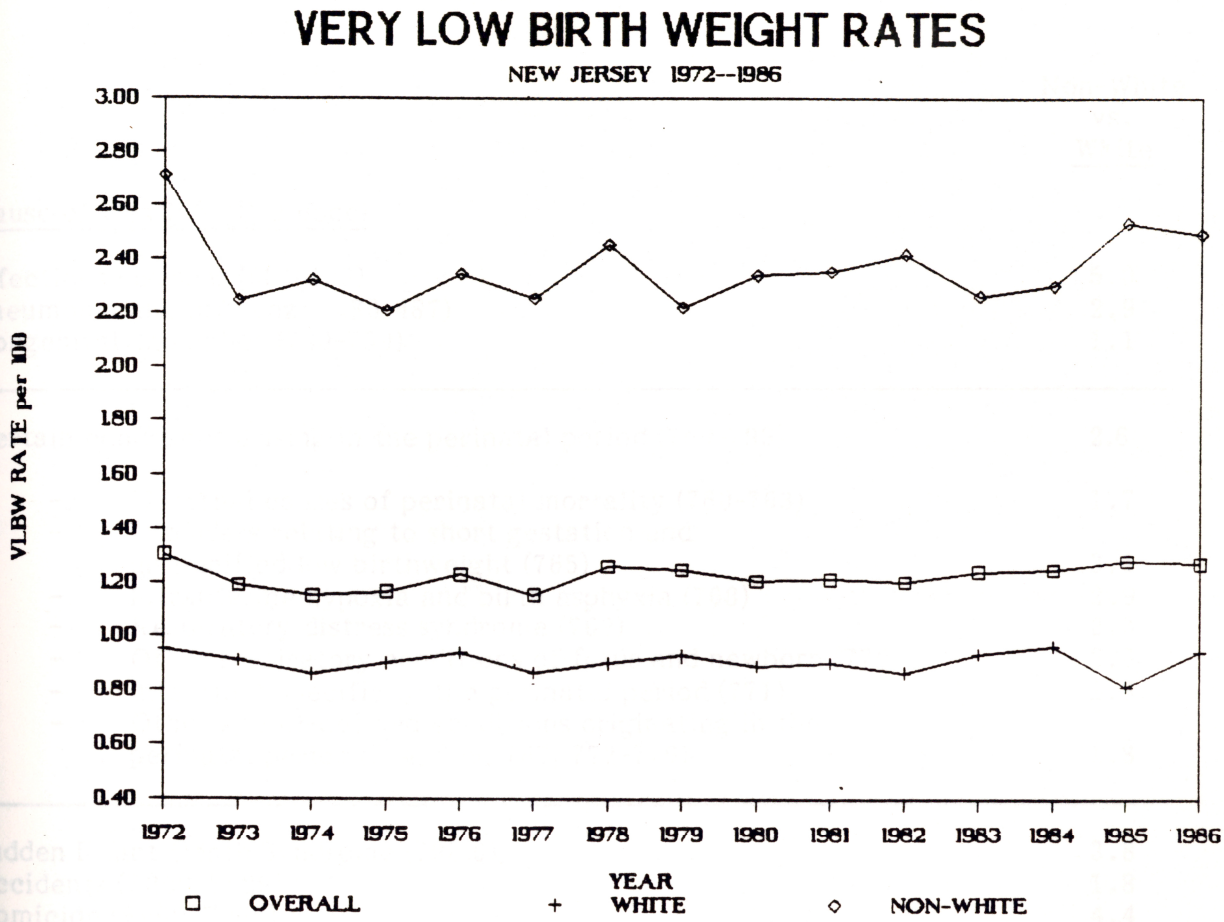
The Non-white infant mortality ratio (2.6:1) was higher in 1987 than it had been in the past 12 years.

Due to different reporting requirements, Hispanics may be reported as White in some cases and in other cases may be included in other. This difference in reporting tends to skew the data.

Definition:

Non-White: Black, Hispanic and other minorities

White: White, Hispanics



Although the rate for White and Non-White very low birth weight rates stayed relatively stable, there continues to exist a large disparity between the White and Non-White rate.

RELATIVE RISK FOR SELECT CAUSES OF INFANT MORTALITY
NEW JERSEY RESIDENTS, 1986

Cause of Death (ICD-9 code)	Non-White vs. White
Infectious diseases (001-139)	5.0
Pneumonia and influenza (480-487)	2.9
Congenital anomalies (740-759)	1.1
Certain conditions arising in the perinatal period (760-799)	2.6
- Maternal causes of perinatal mortality (760-763)	1.7
- Disorders relating to short gestation and unspecified low birthweight (765)	3.1
- Intrauterine hypoxia and birth asphyxia (768)	2.9
- Respiratory distress syndrome (769)	2.3
- Other respiratory conditions of fetus and newborn (770)	2.6
- Infections specific to the perinatal period (771)	2.8
- Other and ill-defined conditions originating in the perinatal period (764, 766, 767, 772-779)	1.8
Sudden Infant Death Syndrome (798.0)	3.8
Accidents (E800-E929)	1.8
Homicide (E960-E968)	4.4
All other causes	2.0
Total	2.3

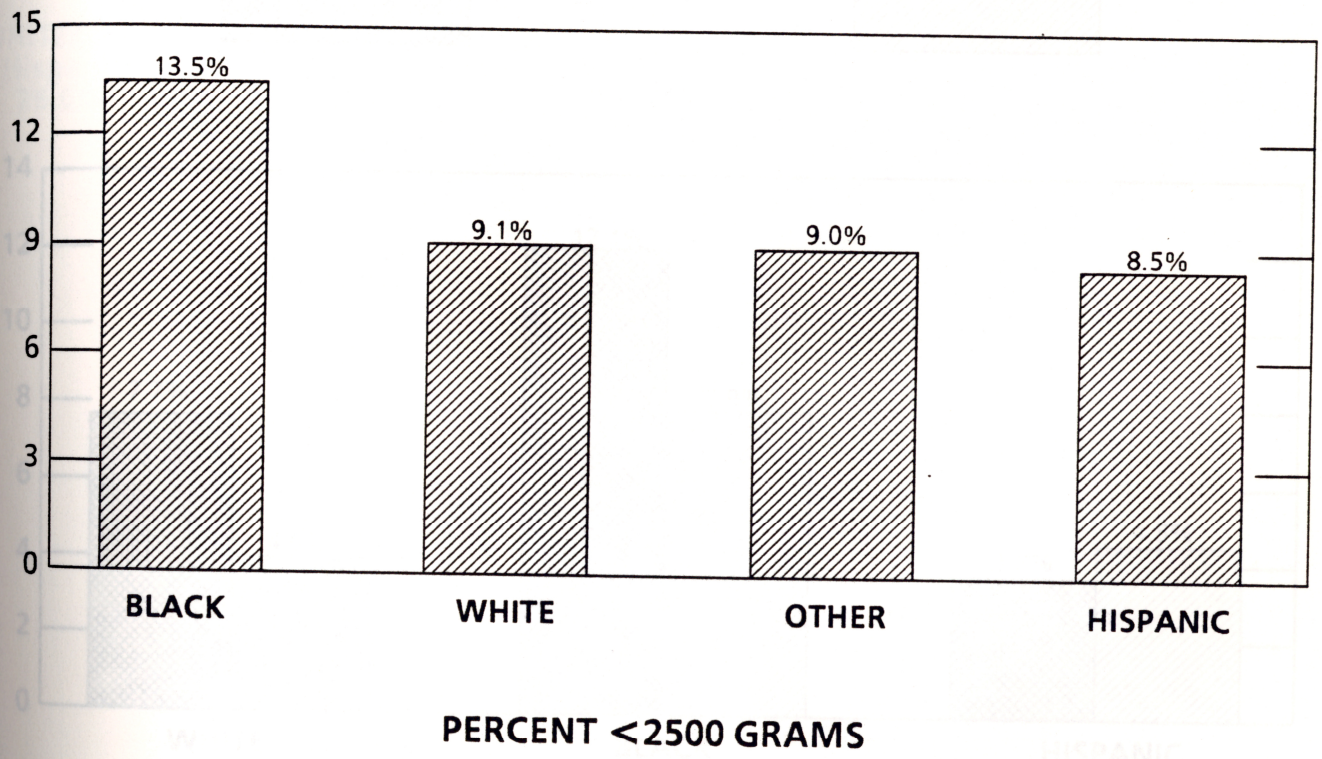
RELATIVE RISK FOR SELECT CAUSES OF INFANT MORTALITY NJ RESIDENTS, 1987

Cause of Death (ICD-9 Code)	Non-White vs. White
AIDS	14.2
Infectious Diseases	5.8
Pneumonia and Influenza	3.3
Congenital Anomalies	1.3
Certain conditions arising in the perinatal period (760-779)	3.3
- Maternal causes of perinatal mortality	1.8
- Disorders relating to short gestational unspecific low birthweight	4.1
- Intrauterine hypoxia and birth asphyxia	5.5
- Other respiratory conditions of fetus and newborn	2.8
- Infections specific to the perinatal period	3.1
- Other and ill-defined conditions originating in the prenatal period	1.8
Sudden Infant Death Syndrome	2.7
Accidents	2.5
Homicide	2.5
Total	2.6

With the exception of sudden infant death syndrome and homicide, the relative risk of all other of infant mortality increased between 1986 and 1987.

NEW JERSEY STATE WIC PROGRAM
1987 PEDIATRIC NUTRITION SURVEILLANCE

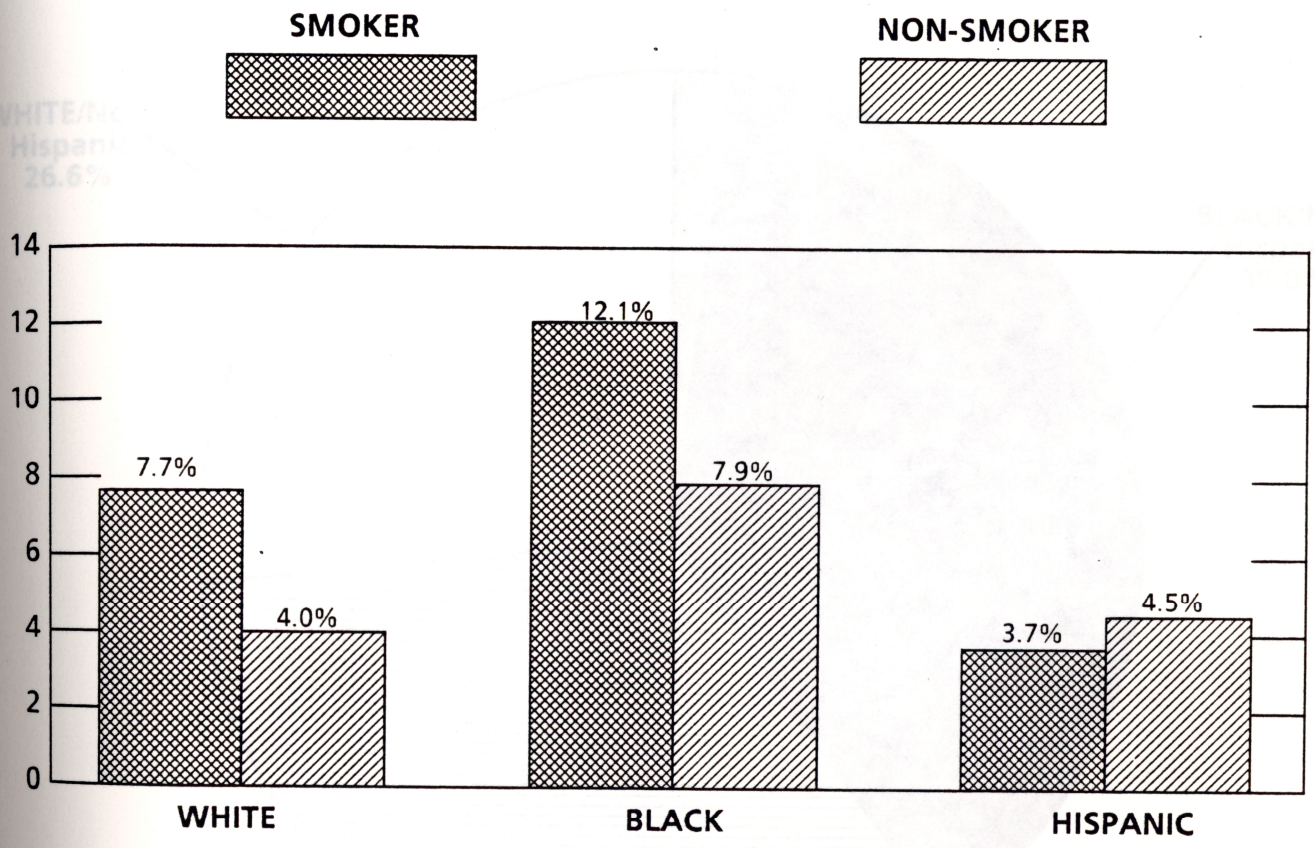
LOW BIRTHWEIGHT BY ETHNIC GROUP



√ = 117,126 (WIC clients only)

NEW JERSEY STATE WIC PROGRAM
1987 PREGNANCY NUTRITION SURVEILLANCE

PREVALENCE OF LOW BIRTHWEIGHT (<2500 grams) BY SMOKING STATUS AND ETHNICITY

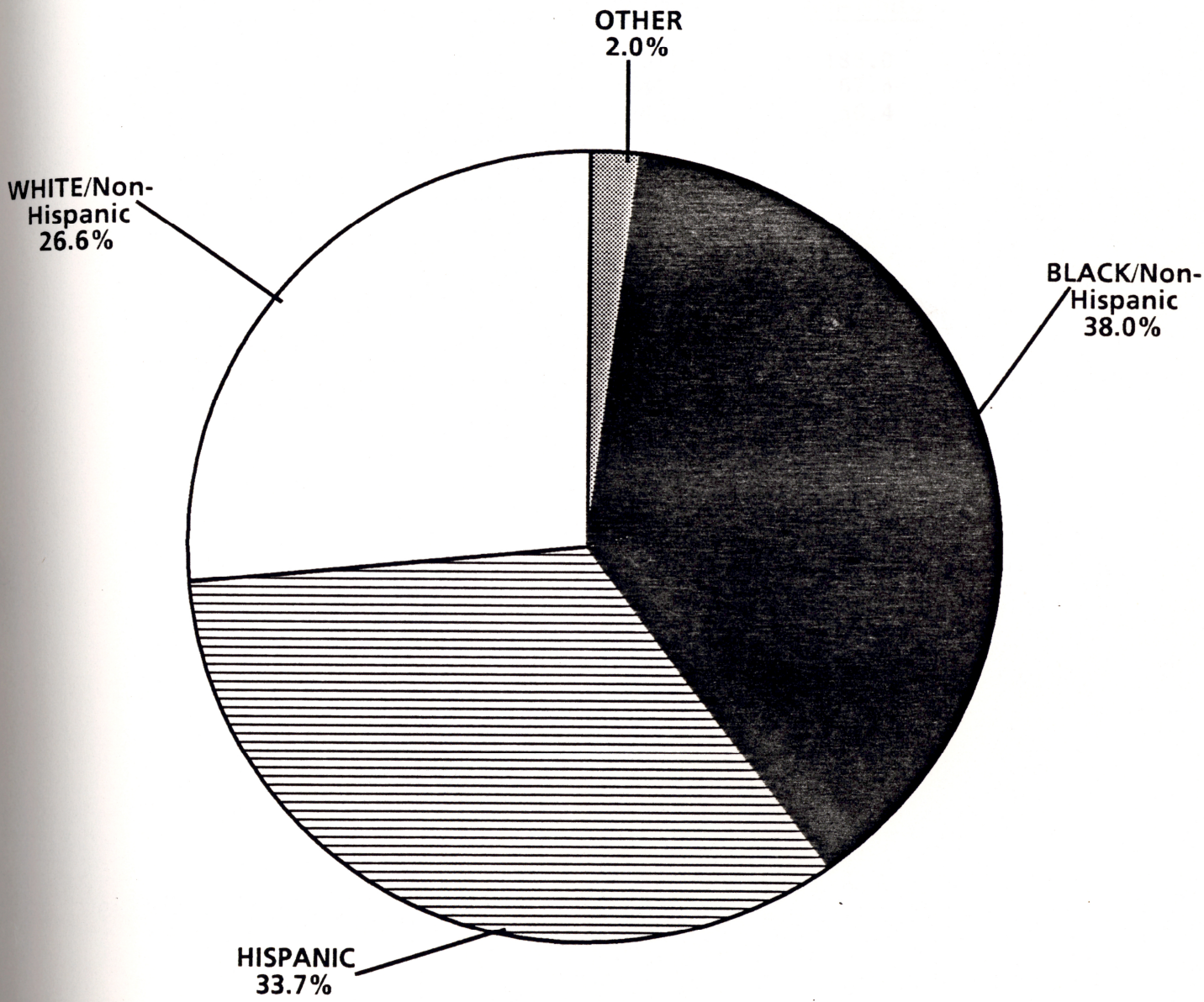


√ 6,163 = total births

This chart also includes very low birth weight (<1500 grams.)

NEW JERSEY STATE WIC PROGRAM
1987 PREGNANCY NUTRITION SURVEILLANCE

ETHNIC DISTRIBUTION



N = 6,534 Other: Vietnamese, Haitian, Portuguese, and American Indian.

It is significant to note that although the majority of participants served by WIC are minority; WIC still only serves 37% of the estimated Statewide need.

1980 Rate of Pediatric Admissions into Hospitals in NJ by Age Group and Race

Age Group	Race	
	White	Non-White
1-4	67.6	186.0
5-14	41.2	67.5
15-17	45.3	56.4

Chronic and Communicable Diseases

Background

Chronic Diseases

Cancer

- Black males experienced a steady increase (peaking in 1984) in lung and prostate cancer incidence from 1979-1985.

- During the seven year period, Hispanic men experienced a steady increase in the top three cancer sites, and notable increases in lung and prostate cancer.

- Hispanic women showed an increase in incidence rates for all sites.

- Differences by specific sites reveal the Black male rates are higher than those in White males for cancers of oral/pharynx and esophagus.

- Cervical cancer rates sharply increased for Hispanic women during 1984-85.

- Breast cancer rates were highest among White and Black females.

- Incidence and mortality rates remain highest among Black females with a notable increase in rates among the Hipanic female population.

- Rectal cancer incidence and mortality rates increased among White and Black males and a sharp increase was also noted in Hispanic males.

Diabetes

- In 1985, the hospitalization rate for diabetes for Non-Whites was 1 to 2 1/2 times higher than Whites. The rates are higher for Non-Whites for both sexes and at all ages.

- The crude rate of amputation for Non-Whites is higher than that for Whites in each year from 1979-1985. Of particular interest is the increase in the rate of amputation for the period 1982-1985 for Non-White males.

Renal

- According to CDC statistics, the prevalence of End Stage Renal Disease (ESRD) in Blacks is 1.5 times the rate of Whites.

- As of June, 1988, the racial composition of chronic dialysis patients was 57.5% White, 39.8% Black and 2.6% Other/Unknown.

- Of patients entering dialysis 7/1/87 - 6/30/88, by primary diagnosis of hypertension, 56.8% were White and 41.8% were Black. The predominant categories of hypertension were: malignant hypertension, unspecified and hypertensive renal disease.

Organ Transplantation

- In 1986, Non-Whites comprised 42% of patients who received renal dialysis and therefore potentially could benefit from kidney transplantation. However, only 24% of transplant recipients were Non-White.

- According to a 1988 Gallup poll, Hispanics reported a willingness to donate less frequently than White. Two-thirds of those Hispanics aware of transplantation agreed with the statement that greater awareness of organ donation is needed in the Hispanic community given the high evidence of diabetes and the many that would benefit from pancreatic transplantation.

Cardiovascular and Hypertension

- Of the total newly diagnosed hypertensives screened in targeted public health programs during 1978-1986 minorities (i.e., Black, Hispanic and Others) comprised 39.6% of the total.

- Cardiovascular mortality rates, based on a 3 year average (1985, 86, 87) were higher for Non-White males than White Males, 45-64 years, and higher for Non-White females than White females within the same age category.

Communicable Diseases

Sexually Transmitted Diseases

- The rate of primary and secondary syphilis has remained 25-30 times higher in Non-White than in Whites from 1983 - 1987.

- A total of 25 women delivered babies with congenital syphilis from 1984 - 1987. Twenty (80%) of the women were Black, 4 (16%) Spanish surnamed and one (4%) White.

- The rate of gonorrhea has remained 50 - 80 times higher in Non-Whites than in Whites from 1983 - 1987.

- Minorities are over represented in the rate of STD. For gonorrhea there may be a bias due to under reporting by the more economically advantaged that seek private treatment.

- Rates for syphillis are considered accurate because of the very active and aggressive surveillance and screening mechanisms that are implemented in the state.

Infection

- Infection mortality rates, based on a 3 year average were higher for Non-White males and females than for White males and females.

Tuberculosis

- The rate of TB was highest for the Asian/Pacific Islander population in 1986 and 1987. Rates for Asian/Pacific Islanders were thirteen times higher than Whites. Rates for Blacks was seven times higher than Whites.

Immunization

- Jersey City specific data for a 1985-86 measles outbreak indicated that the incidence of measles for Hispanics was 4 per 1,000 population as compared to 0.8 per 1,000 for all other populations.

- Despite existing reporting methods, according to various health professionals throughout the State, immunization non-compliance still remains in geographic subsections of New Jersey.

Refugee

- The two primary origins for refugees arriving 1984-1987 were Vietnam and Poland, and by 1988, the number of Soviet Jewish refugees had increased significantly, almost surpassing the Vietnamese refugees.

- From 1984-1988, 10.5% - 14.5% of all Indochinese tested for Hepatitis B were positive. This compares to rates of 1.0% - 4.8% Hepatitis B positivity among the non-Indochinese who were tested.

- In 1987 and 1988, 124 cases of Class B (non-active) TB were referred by the federal quarantine stations to the NJ Refugee Program. Ultimately 17 of this individuals were treated.

Program Description

Chronic Disease Prevention and Control

- Responsibility for preventing or minimizing the extent of cancer (including tobacco use control), stroke, heart disease and injuries, through a variety of educational strategies that promote favorable changes for the major identifiable risk factors such as smoking, dietary fat, high blood pressure, etc.

- Responsibility for serving the elderly and chronically ill by contracting to local provider programs that involve diabetes, renal diseases, hemophilia and Alzheimer's disease.

- Minority-focused activities include:

  - Diabetes Control Program (DCP) staff participation on the American Diabetes Association Minority Task Force.

  - DCP staff participation at national conferences on diabetes.

  - Tracking individuals with hypertension and diabetes.

  - Smoking Cessation Program (SCP) participation on the American Cancer Society's, NJ Affiliate Minority Task Force.

  - Consultation to local health departments in developing cancer screening and smoking control programs targeted to minority populations.

  - SCP administering four, one year grants to local health departments to conduct smoking cessation programs for minority and low-income pregnant women.

  - Data collection and analysis of diabetes or hypertension as a primary diagnosis of end stage renal disease.

  - Reimbursement for medication and nutrition supplements for any minority patient meeting the agency income criteria.

  - Funding 2 ESRD Prevention grants in areas of high incidence (i.e., Trenton and Bridgeton). High incidence is defined by diabetes-related hospital discharges and hospitalization, and medical indigency.

Organ Transplantation

- Responsibility for implementing a multifaceted program promoting public awareness and organizing the retrieval of human organs and tissues for transplantation.

- Minority focused activities include administering a contract for the organization, training and equipping of a statewide network of volunteer public awareness coordinators. This network will make available to local communities and special populations (including minorities, college students and clergy) the educational resources to stimulate awareness about organ transplantation and the Assured Option Law. The Assured Option Law requires hospitals to offer the opportunity of donation to the next of kin of all medically suitable candidates.

Chronic Disease and Research Unit

- Responsibility to collect and evaluate data on New Jersey cancer incidence, treatment and survival.

- Minority focused activities include providing data on high risk groups and etiologic risk factors associated with cancer in New Jersey in order to target public health programs, cancer control and prevention. The identification of high risk populations is accomplished by descriptive, analytic epidemiologic studies of specific cancers.

Communicable Disease Control Services

- Responsibility for:

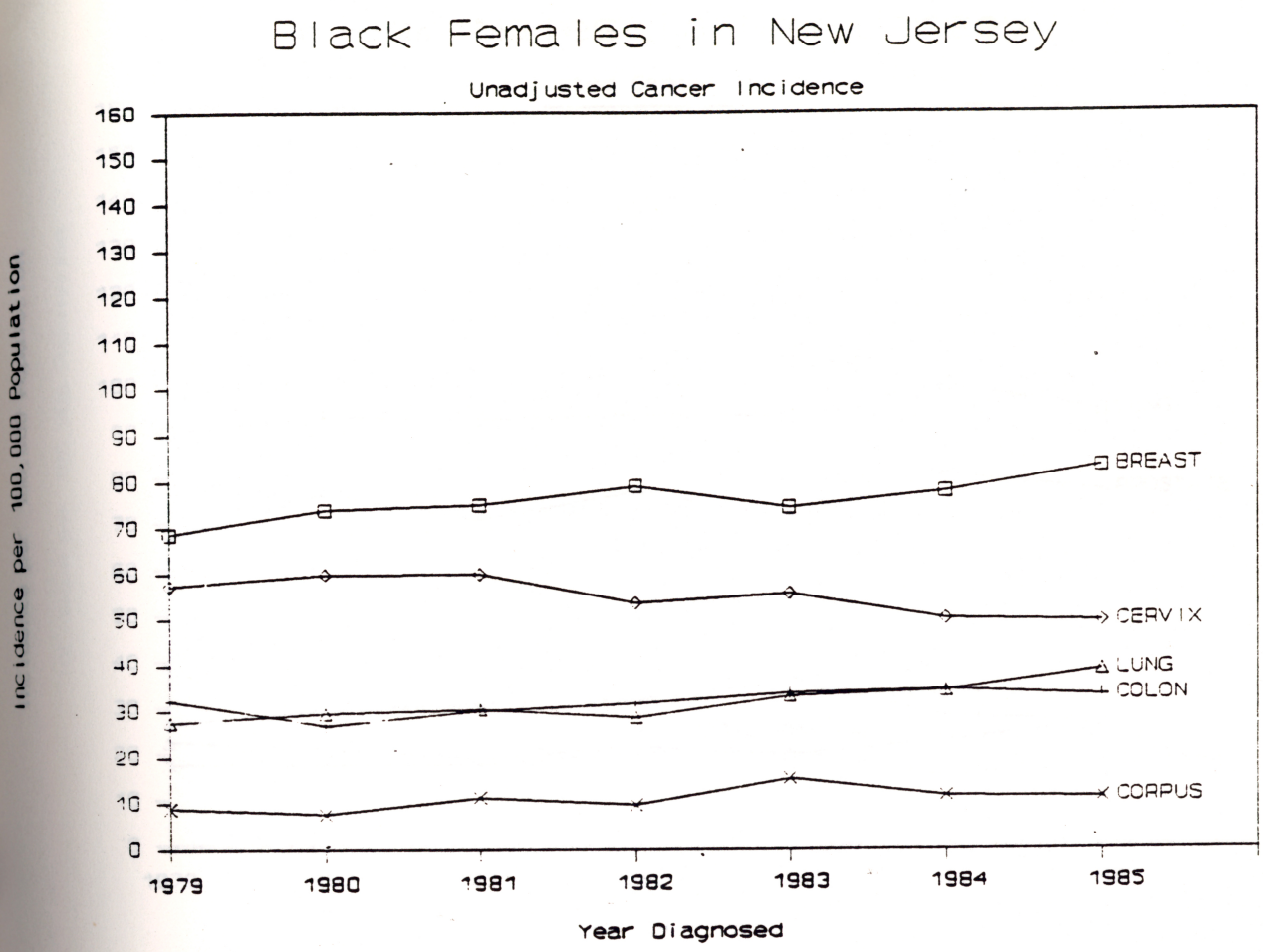
  - ensuring and maintaining immunization compliances for all children.

  - controlling sexually transmitted diseases (STD) and tuberculosis.

  - enhancing and maintaining a state communicable disease morbidity surveillance system, including the refugee population.

  - The STD program serves a distinct minority population although it is not specifically targeted to the minority population. Field staff are housed in the following high morbidity areas: Paterson, Newark, East Orange, Jersey City, New Brunswick, Elizabeth, Camden and Atlantic City.

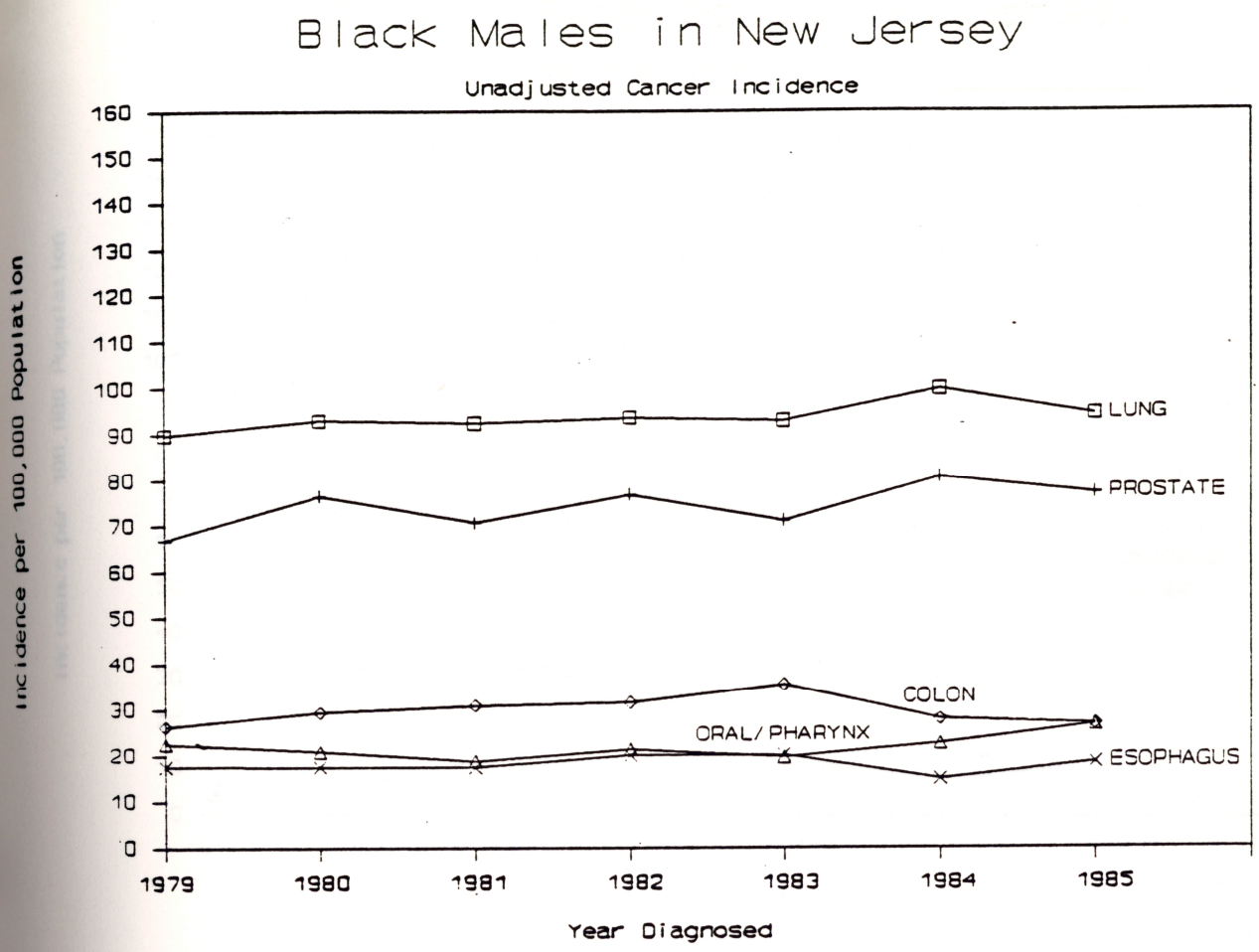
  - The refugee program is specifically targeted to ethnic populations entering New Jersey. The primary objectives of the program are to ensure that these individuals receive comprehensive health assessments and to prevent the occurrence of new cases of communicable diseases, such as TB, Hepatitis B, and STDs.



UNADJUSTED INCIDENCE RATES (PER 100,000) FOR SELECTED CANCERS

BLACK FEMALES	1979	1980	1981	1982	1983	1984	1985
BREAST	68.57	73.83	74.83	78.90	74.23	77.79	83.15
COLON	32.32	26.81	30.14	31.68	33.76	34.55	33.34
CERVIX	57.38	59.81	59.87	53.56	55.52	50.11	49.41
LUNG	27.55	29.49	30.34	28.62	33.15	34.35	38.96
CORPUS U.	8.91	7.63	11.28	9.61	15.25	11.52	11.25

Highlights:
Black Females show a steady increase for cancers of the Breast and Lung. It is anticipated that this will become even more marked once crude rates are age-adjusted.

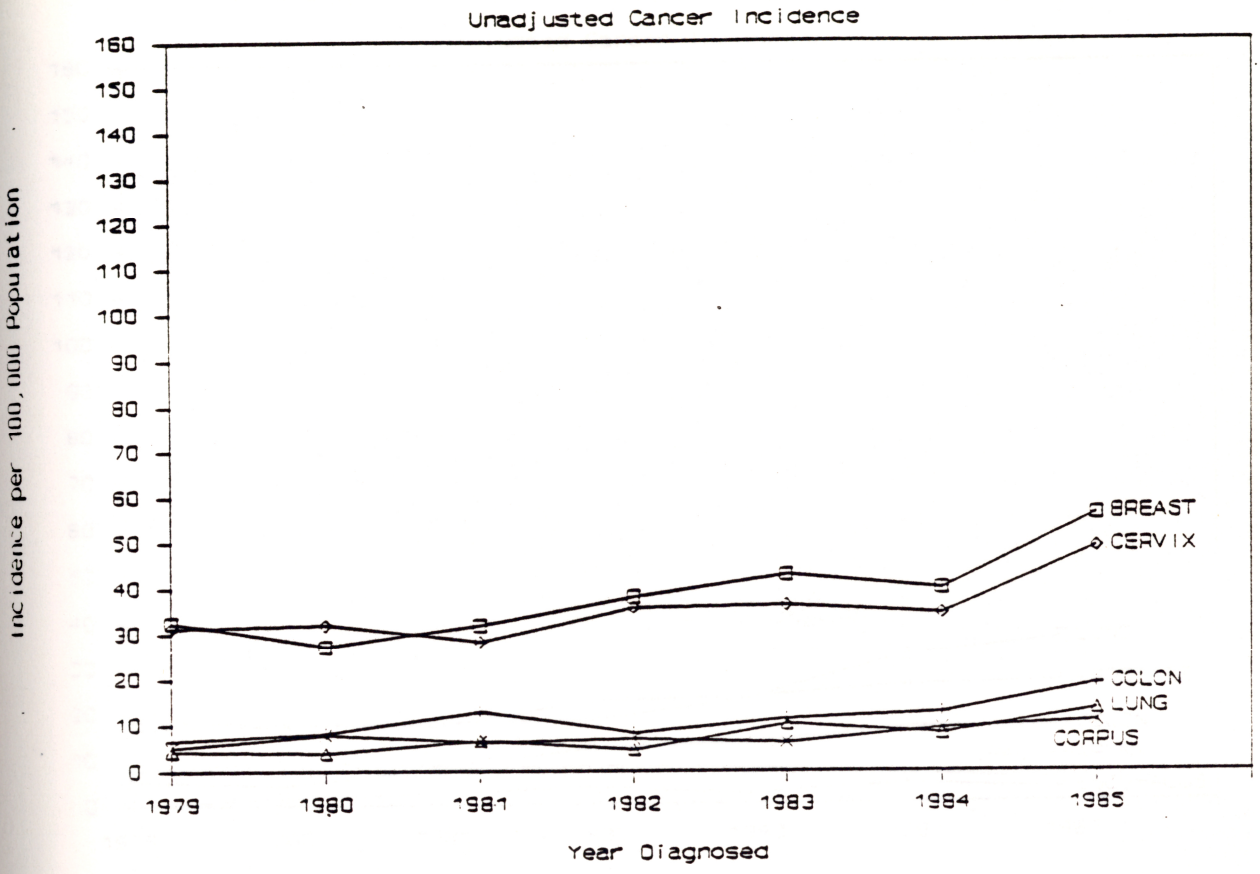


UNADJUSTED INCIDENCE RATES (PER 100,000) FOR SELECTED CANCERS

BLACK MALES	1979	1980	1981	1982	1983	1984	1985
LUNG	89.84	92.99	92.44	93.58	92.87	99.68	94.25
PROSTATE	66.78	76.42	70.57	76.69	70.93	80.44	76.97
COLON	26.38	29.34	30.81	31.43	35.23	27.82	26.73
ORAL/PHARYNX	22.58	20.82	18.82	21.34	19.60	22.49	26.50
ESOPHAGUS	17.59	17.51	17.41	19.93	20.07	14.84	18.43
BLADDER	10.22	8.52	10.35	11.02	11.43	7.88	6.91
STOMACH	12.83	11.59	17.17	13.84	13.30	13.91	13.37
RECTUM	10.22	9.70	13.17	11.73	10.73	13.91	13.83

Highlights:
Black Male rates for cancer of the Esophagus and Oral/Pharynx area are higher than those for White, Hispanic and Other Non-White Males.

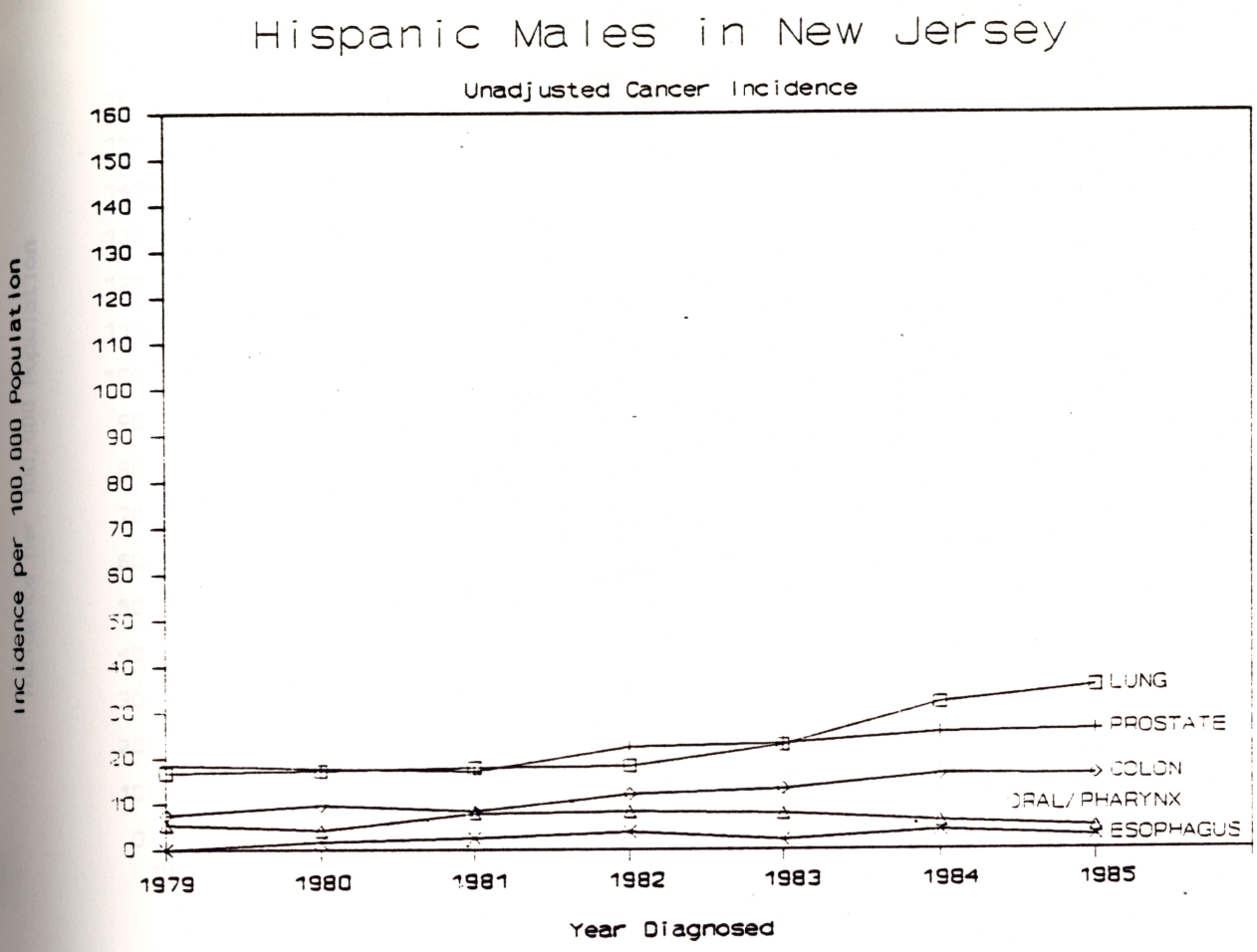
Hispanic Females in New Jersey



Unadjusted Incidence Rates (per 100,000) for Selected Cancers

HISPANIC FEMALES	1979	1980	1981	1982	1983	1984	1985
BREAST	32.56	27.28	31.83	38.01	42.88	39.89	56.21
COLON	6.75	8.30	12.97	8.23	11.31	12.78	18.86
CERVIX	31.37	32.02	28.30	35.66	36.26	34.47	48.89
LUNG	4.37	3.95	6.68	4.70	10.14	8.13	13.47
CORPUS U.	5.16	7.91	6.29	7.05	6.24	9.30	10.78

Highlights:
Hispanic women showed an overall increase in incidence rates for all sites, and of particular interest is the sharp increase in the rates for 1984-1985. This may become even more marked once rates are age-adjusted.

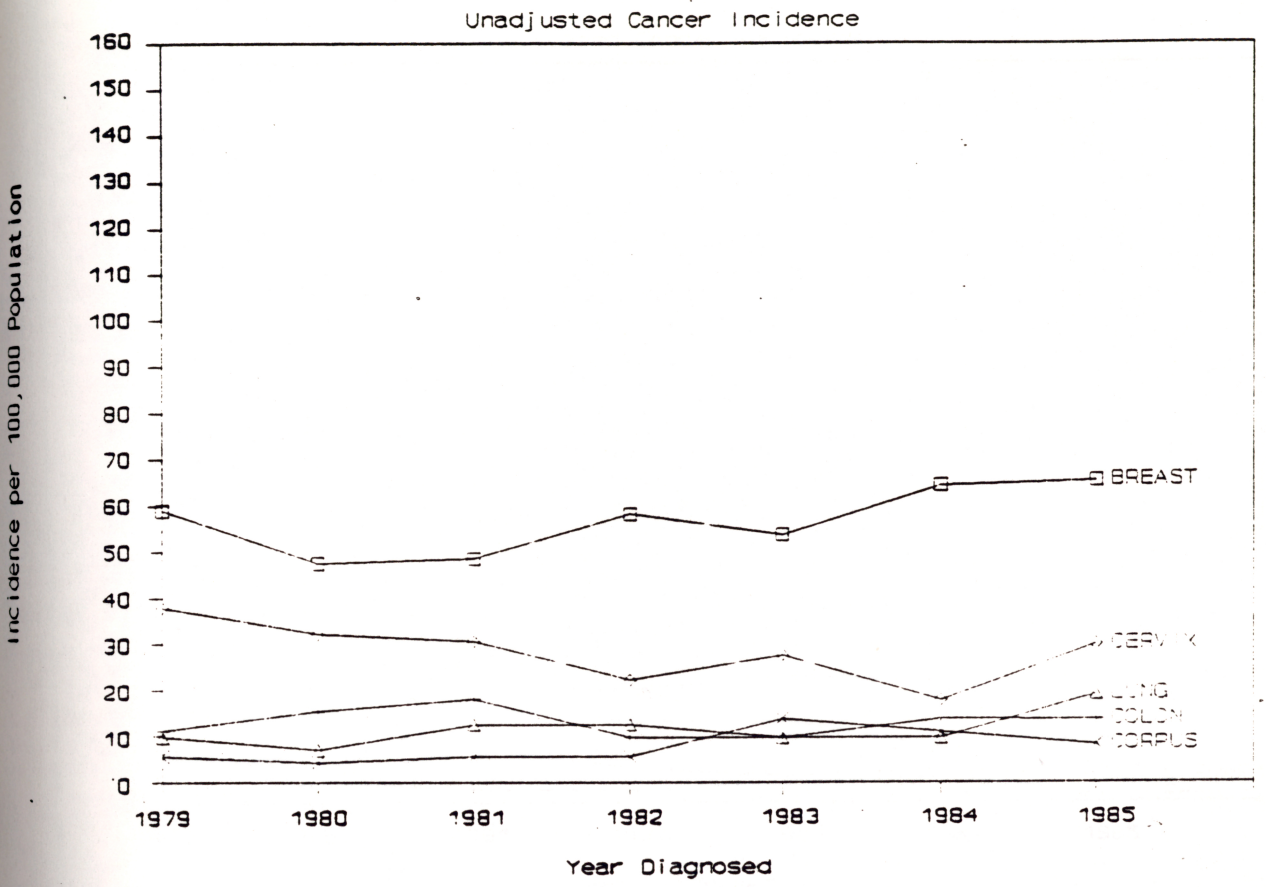


UNADJUSTED INCIDENCE RATES (PER 100,000) FOR SELECTED CANCERS

HISPANIC MALES	1979	1980	1981	1982	1983	1984	1985
LUNG	16.82	17.16	17.89	18.26	22.70	31.99	35.47
PROSTATE	18.50	17.58	17.06	22.40	23.12	25.43	26.09
COLON	7.57	9.63	8.32	12.03	13.21	16.40	16.31
ORAL/PHARYNX	5.47	4.19	7.91	8.30	7.84	6.15	4.89
ESOPHAGUS	0.00	1.67	2.50	3.73	2.06	4.10	2.85
BLADDER	7.99	8.79	8.32	12.86	13.21	11.48	9.78
STOMACH	4.62	5.02	7.49	7.88	5.78	11.48	8.56
RECTUM	6.31	4.60	5.83	5.81	4.13	4.92	10.60

Highlights:
The particular interest of this table is the notable increase in the rate of cancer of the Lung among Hispanic Males. This should be more prominent once age-adjusted.

Other Non-White Females in New Jersey

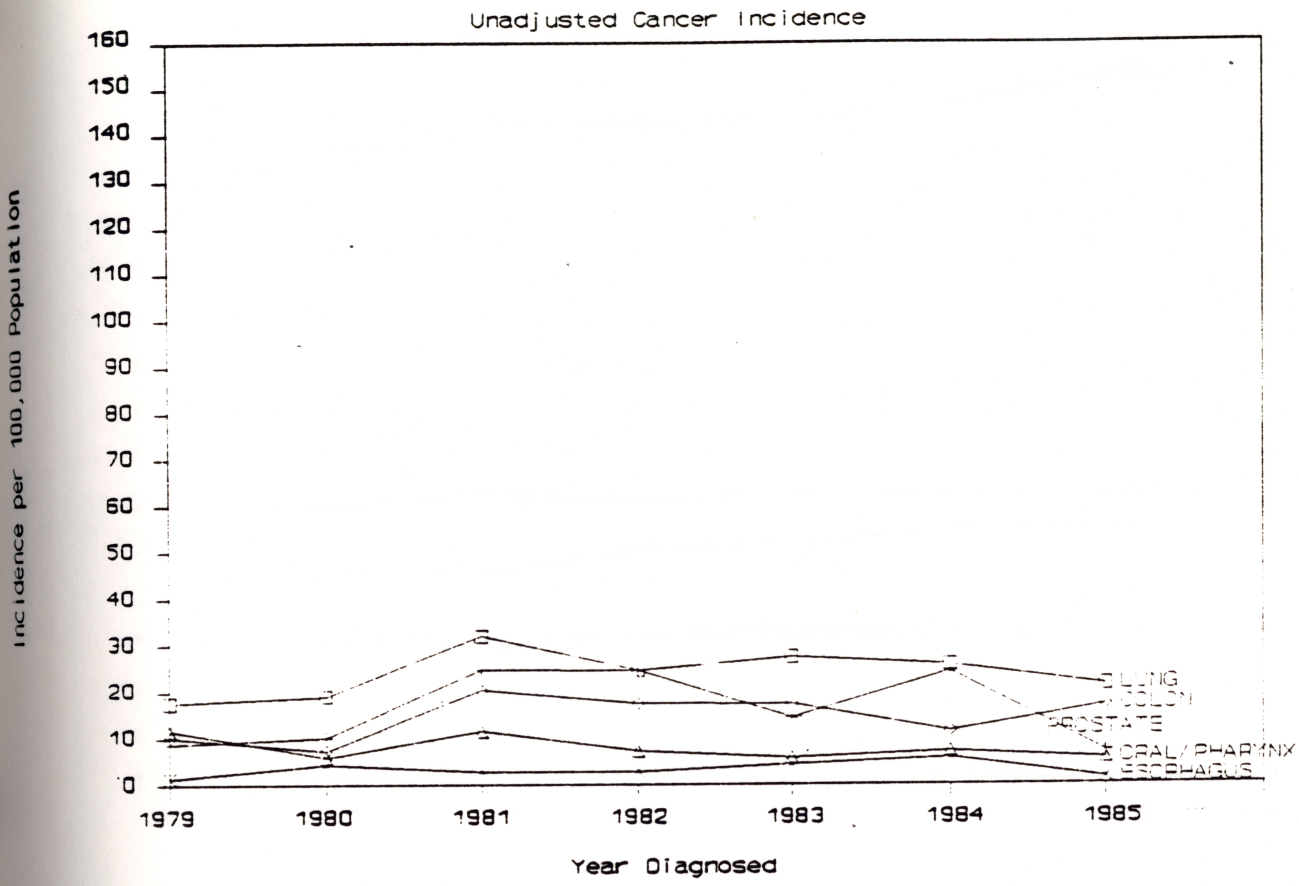


Unadjusted Incidence Rates (per 100,000) for Selected Cancers

OTHER NW FEMALES	1979	1980	1981	1982	1983	1984	1985
BREAST	58.99	47.54	48.65	58.21	53.78	64.39	65.37
COLON	11.24	15.38	18.07	9.70	9.65	13.70	13.62
CERVIX	37.92	32.16	30.58	22.18	27.58	17.81	29.96
LUNG	9.83	6.99	12.51	12.47	9.65	9.59	19.06
CORPUS U.	5.62	4.19	5.56	5.54	13.79	10.96	8.17

Highlights:
Noted increasing pattern for cancers of the Lung and Cervix.

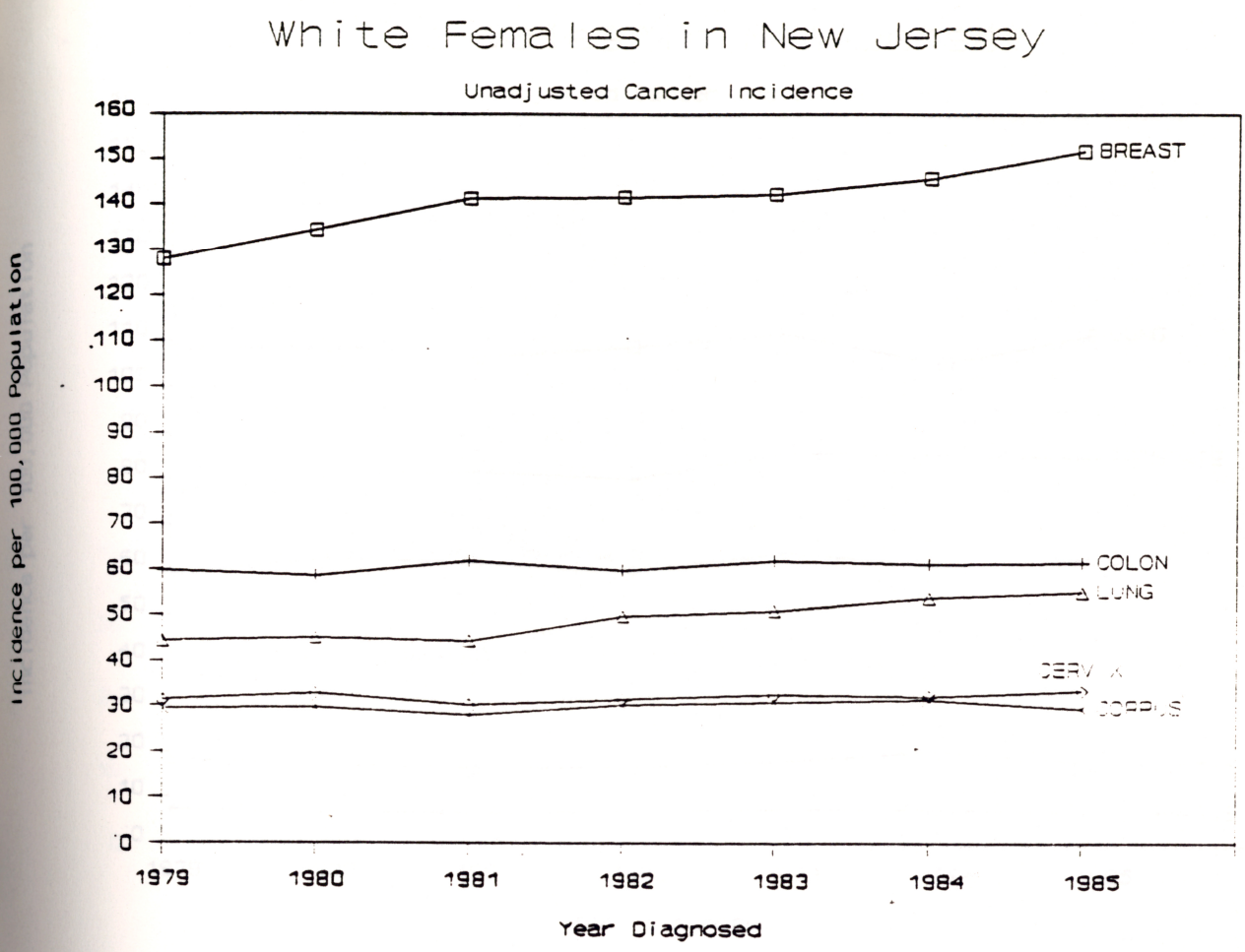
Other Non-White Males in New Jersey



Unadjusted Incidence Rates (per 100,000) for Selected Cancers

OTHER NW MALES	1979	1980	1981	1982	1983	1984	1985
LUNG	17.64	19.03	32.01	24.66	27.42	25.81	21.38
PROSTATE	8.82	10.24	24.73	24.66	14.43	24.38	7.13
COLON	10.29	7.32	20.37	17.41	17.32	11.47	17.10
ORAL/PHARYNX	11.76	5.85	11.64	7.25	5.77	7.17	5.70
ESOPHAGUS	1.47	4.39	2.91	2.90	4.33	5.74	1.43
BLADDER	5.88	7.32	13.09	8.70	10.10	8.60	8.55
STOMACH	10.29	11.71	7.27	13.06	17.32	4.30	12.83
RECTUM	8.82	5.85	8.73	4.35	12.99	2.87	1.43

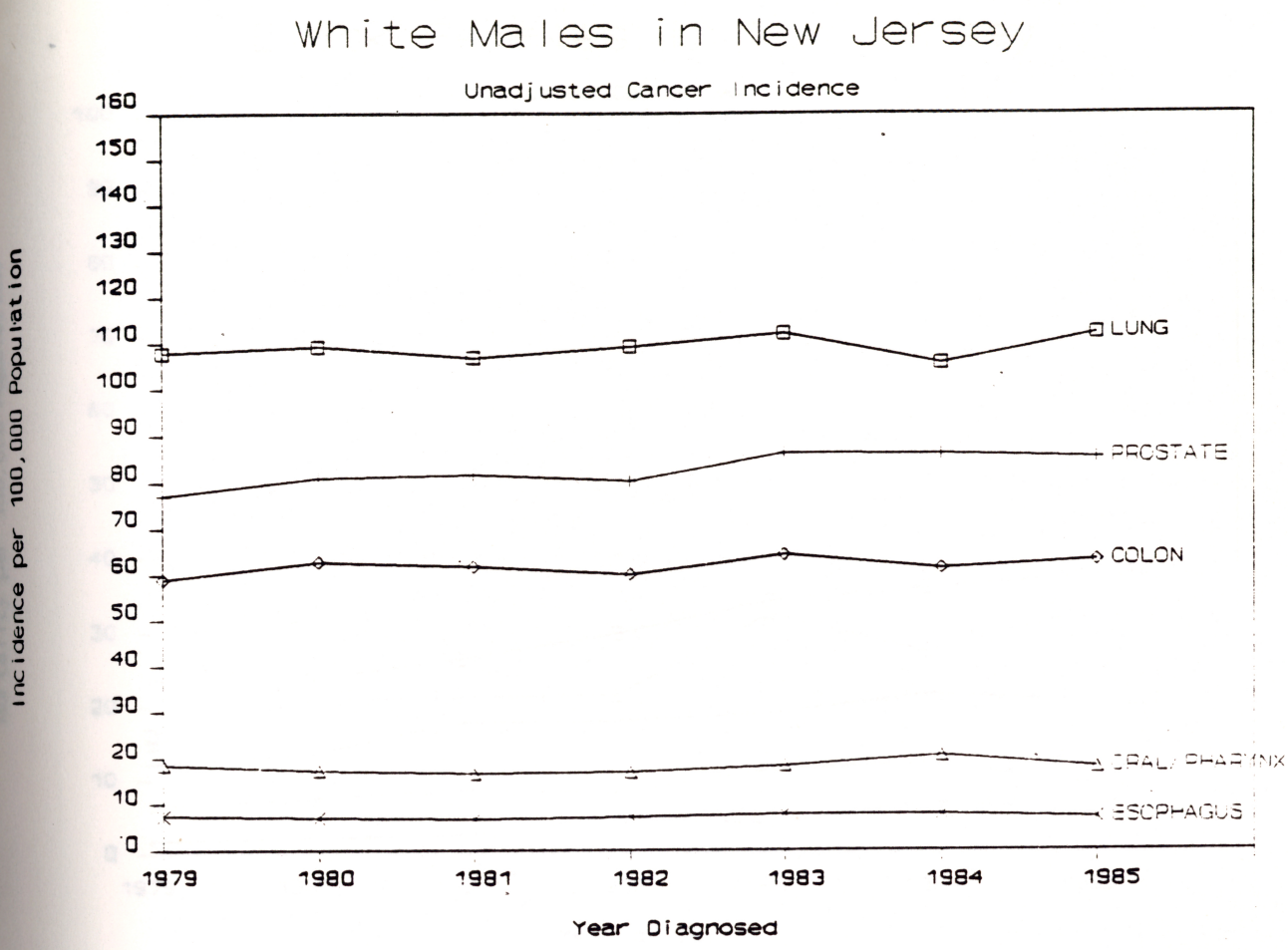
Highlights:
The numbers in this group are too small to draw any real conclusion about small year to year fluctuations.



Unadjusted Incidence Rates (per 100,000) for Selected Cancers

WHITE FEMALES	1979	1980	1981	1982	1983	1984	1985
BREAST	127.87	134.32	141.30	141.71	142.19	145.74	151.80
COLON	59.81	58.52	61.73	59.68	61.86	61.07	61.38
CERVIX	31.15	32.54	29.98	31.24	32.32	31.91	33.08
LUNG	44.32	44.98	44.26	49.67	50.79	53.70	54.90
CORPUS U.	29.39	29.56	27.81	30.12	30.62	31.17	29.17

Highlights:
Of particular interest in this table is the increasing trend in the incidence rates of cancers of the Breast and Lung in White Females.

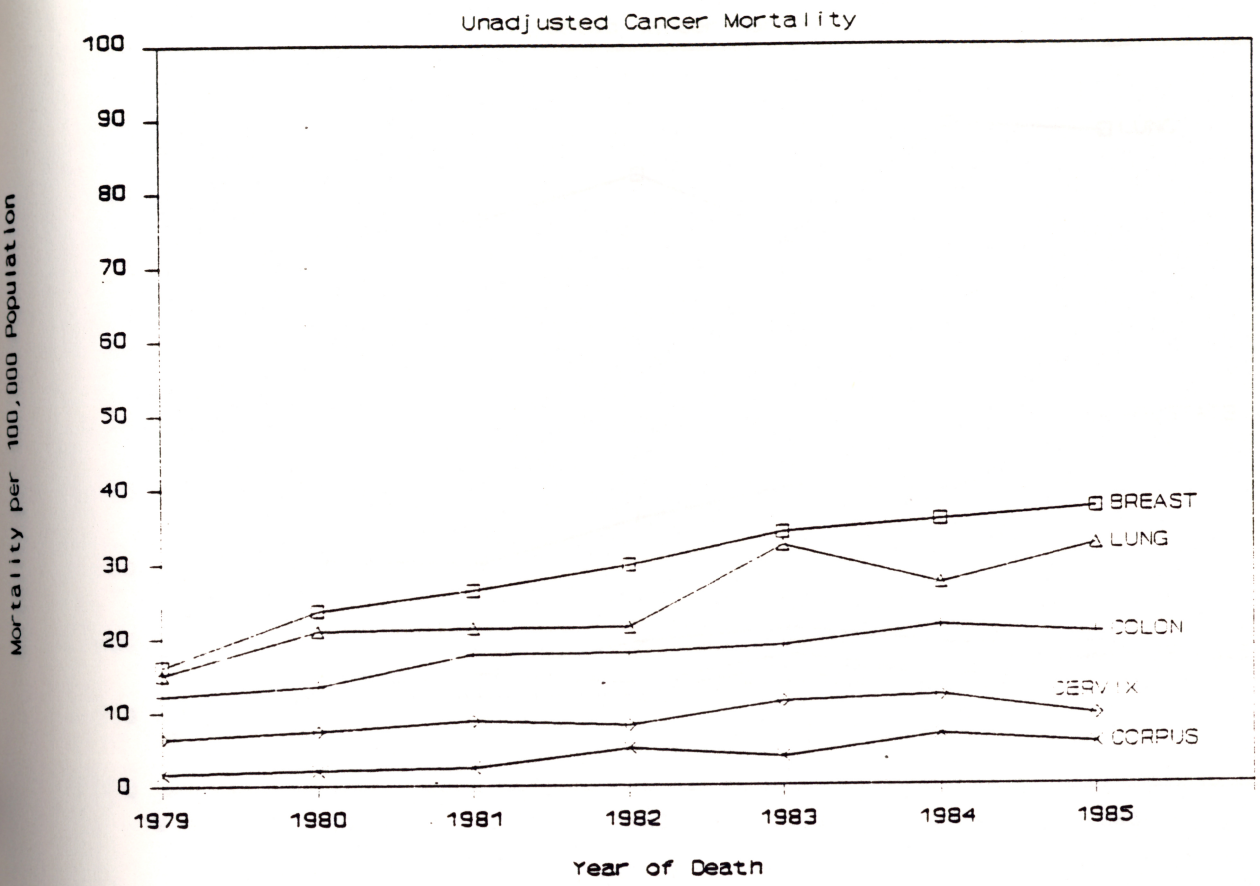


Unadjusted Incidence Rates (per 100,000) for Selected Cancers

WHITE MALES	1979	1980	1981	1982	1983	1984	1985
LUNG	107.88	109.29	106.85	109.25	112.04	105.61	112.17
PROSTATE	77.15	80.98	81.64	80.23	86.08	85.94	85.12
COLON	58.96	62.87	61.75	60.09	64.25	61.35	63.03
ORAL/PHARYNX	18.48	17.26	16.66	16.93	18.22	20.44	17.92
ESOPHAGUS	7.41	6.99	6.77	7.07	7.74	7.62	7.02
BLADDER	43.20	44.54	41.65	42.03	44.80	42.17	40.77
STOMACH	16.37	17.26	15.03	15.02	16.53	16.87	15.07
RECTUM	25.57	27.88	26.45	27.07	28.03	28.82	32.82

Highlights:
Rates for White Males for cancer of the Lung have remained relatively stable at a very high level.

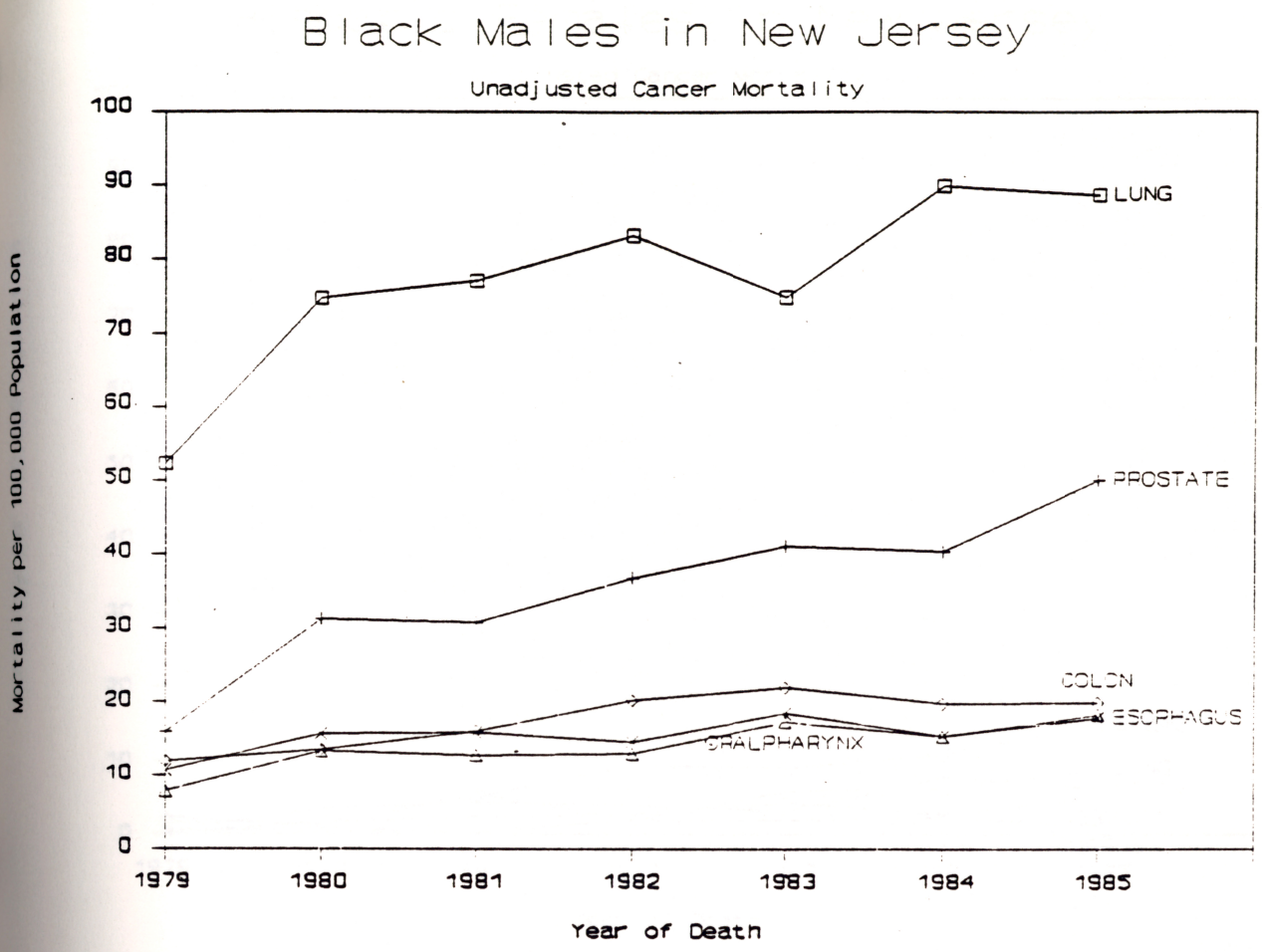
Black Females in New Jersey



UNADJUSTED MORTALITY RATES (PER 100,000) FOR SELECTED CANCERS

BLACK FEMALES	1979	1980	1981	1982	1983	1984	1985
BREAST	16.16	23.72	26.45	29.84	34.17	35.76	37.36
COLON	12.22	13.61	17.84	17.99	18.91	21.62	20.49
CERVIX	6.42	7.42	8.82	8.18	11.39	12.12	9.44
LUNG	15.12	21.04	21.32	21.46	32.34	27.28	32.34
CORPUS U.	1.66	2.06	2.46	5.11	3.86	6.87	5.62

Highlights:
Steady increase in mortality rates from Breast and Lung cancer among Black Females from 1979 to 1985.

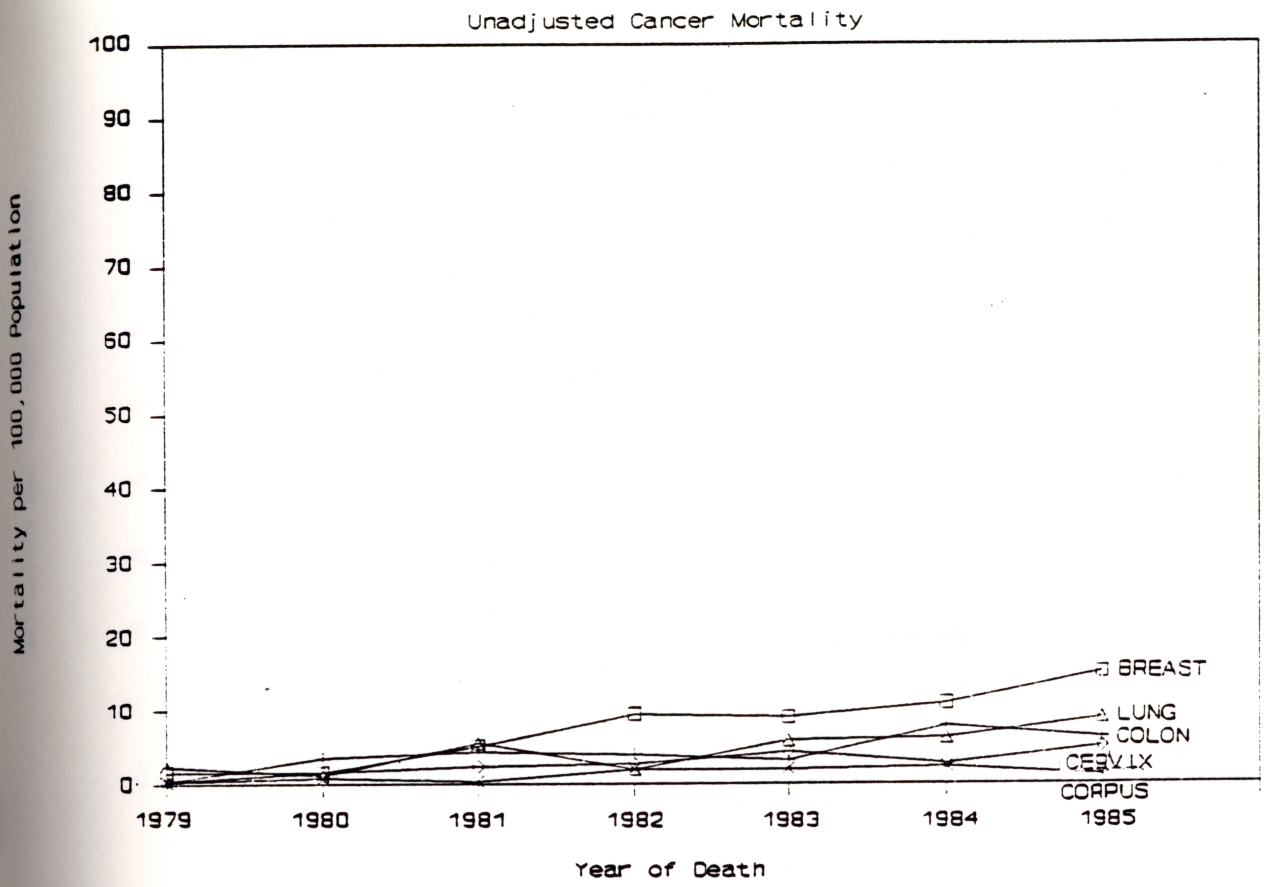


UNADJUSTED MORTALITY RATES (PER 100,000) FOR SELECTED CANCERS

BLACK MALES	1979	1980	1981	1982	1983	1984	1985
LUNG	52.29	74.77	77.15	83.26	74.90	89.94	88.72
PROSTATE	15.92	31.23	30.81	36.82	41.07	40.34	50.00
COLON	11.88	13.49	16.00	20.17	21.93	19.70	19.82
ORAL/PHARNYX	7.84	13.25	12.70	12.90	17.27	15.30	18.20
ESOPHAGUS	10.69	15.62	15.76	14.54	18.43	15.30	17.74
BLADDER	2.85	3.08	4.94	6.10	7.47	6.95	5.53
STOMACH	8.56	7.10	12.47	13.84	10.50	10.20	13.37
RECTUM	3.09	5.68	4.23	5.39	6.77	8.58	8.76

Highlights:
Mortality rates for Lung cancer among Black Males show steady increasing pattern, this may be even more pronounced once the rates are age adjusted.

Hispanic Females in New Jersey

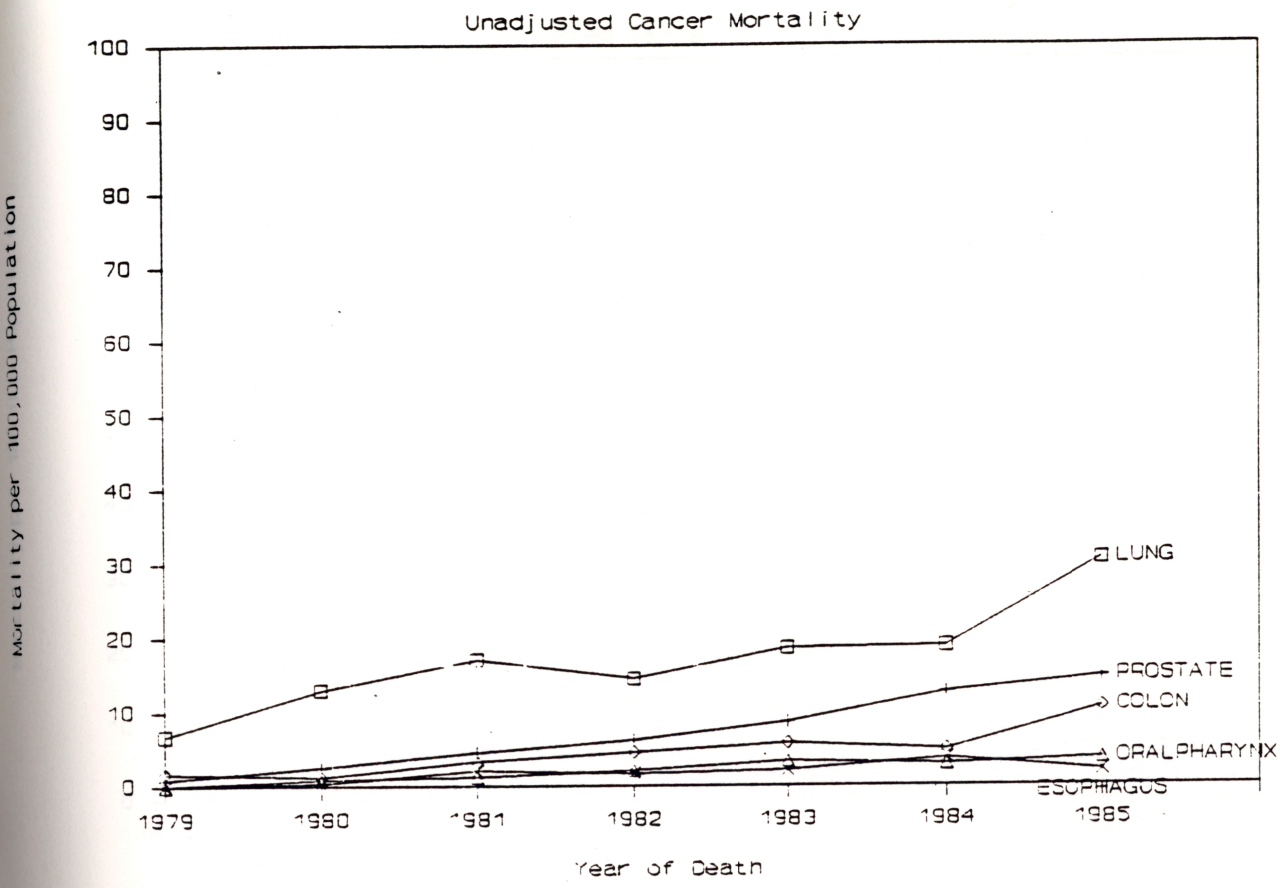


Unadjusted Mortality Rates (per 100,000) for Selected Cancers

HISPANIC FEMALES	1979	1980	1981	1982	1983	1984	1985
BREAST	1.59	1.58	5.11	9.40	8.97	10.84	15.01
COLON	0.40	3.56	4.32	3.92	3.12	7.75	6.16
CERVIX	0.40	1.58	2.36	2.74	4.29	2.71	5.00
LUNG	2.38	1.19	5.50	1.96	5.85	6.20	8.85
CORPUS U.	0.40	0.79	0.39	1.96	1.95	2.32	1.15

Highlights:
Breast cancer mortality rates among Hispanic Females have shown an increasing trend. Rates for Lung cancer show some increasing pattern.

Hispanic Males in New Jersey

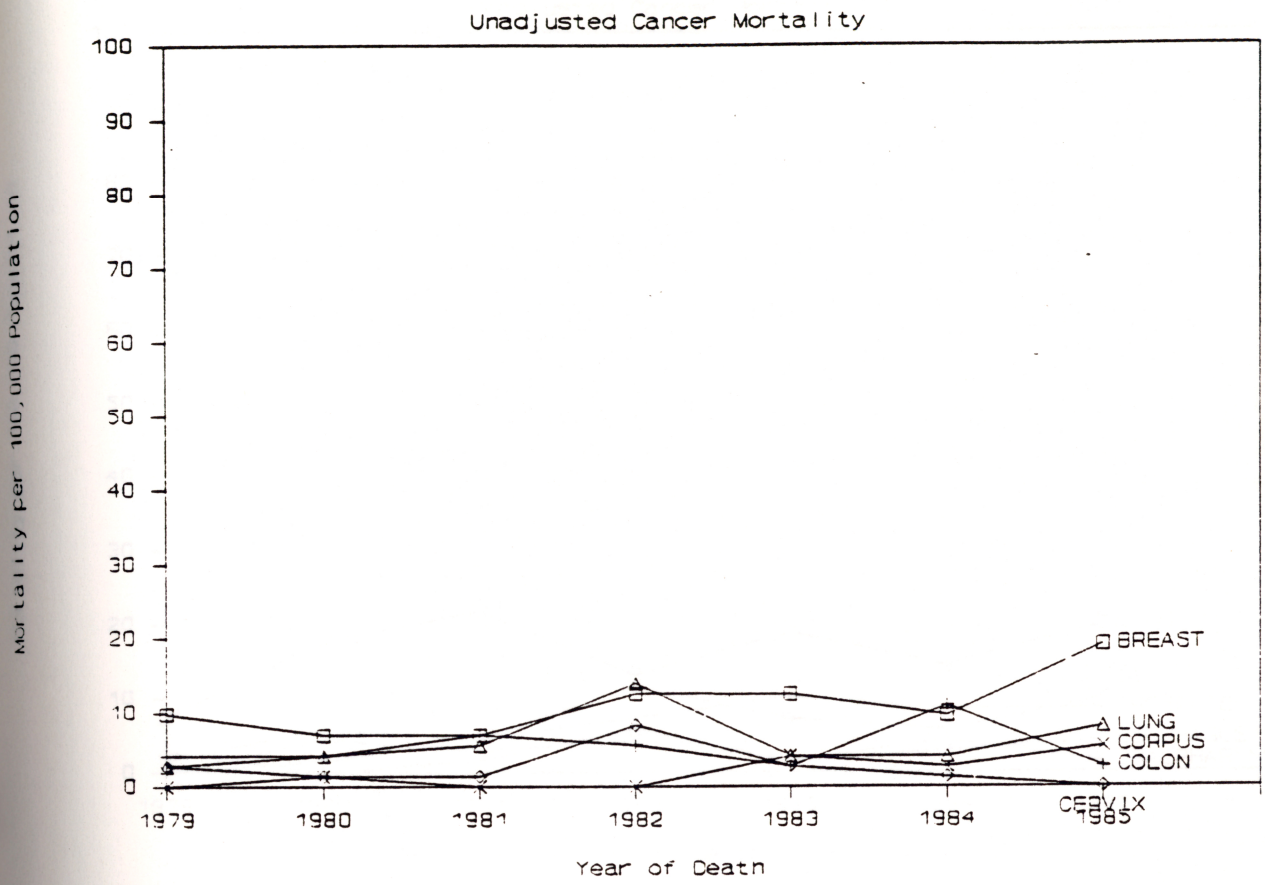


Unadjusted Mortality Rates (per 100,000) for Selected Cancers

HISPANIC MALES	1979	1980	1981	1982	1983	1984	1985
LUNG	6.73	12.98	17.06	14.52	18.57	18.86	30.57
PROSTATE	0.84	2.51	4.58	6.22	8.67	12.71	14.68
COLON	1.68	1.26	3.33	4.56	5.78	4.92	10.60
ORAL/PHARNYX	0.00	0.84	1.25	2.07	3.30	2.87	3.67
ESOPHAGUS	0.00	0.42	2.08	1.66	2.06	3.69	2.04
BLADDER	0.84	0.84	1.66	1.24	5.37	2.87	3.26
STOMACH	1.68	4.19	5.83	4.56	4.13	8.20	4.08
RECTUM	0.84	2.09	2.08	1.66	2.89	1.64	6.52

Highlights:
A increasing trend in Lung cancer mortality rates is noted.

Other Non-White Females in New Jersey

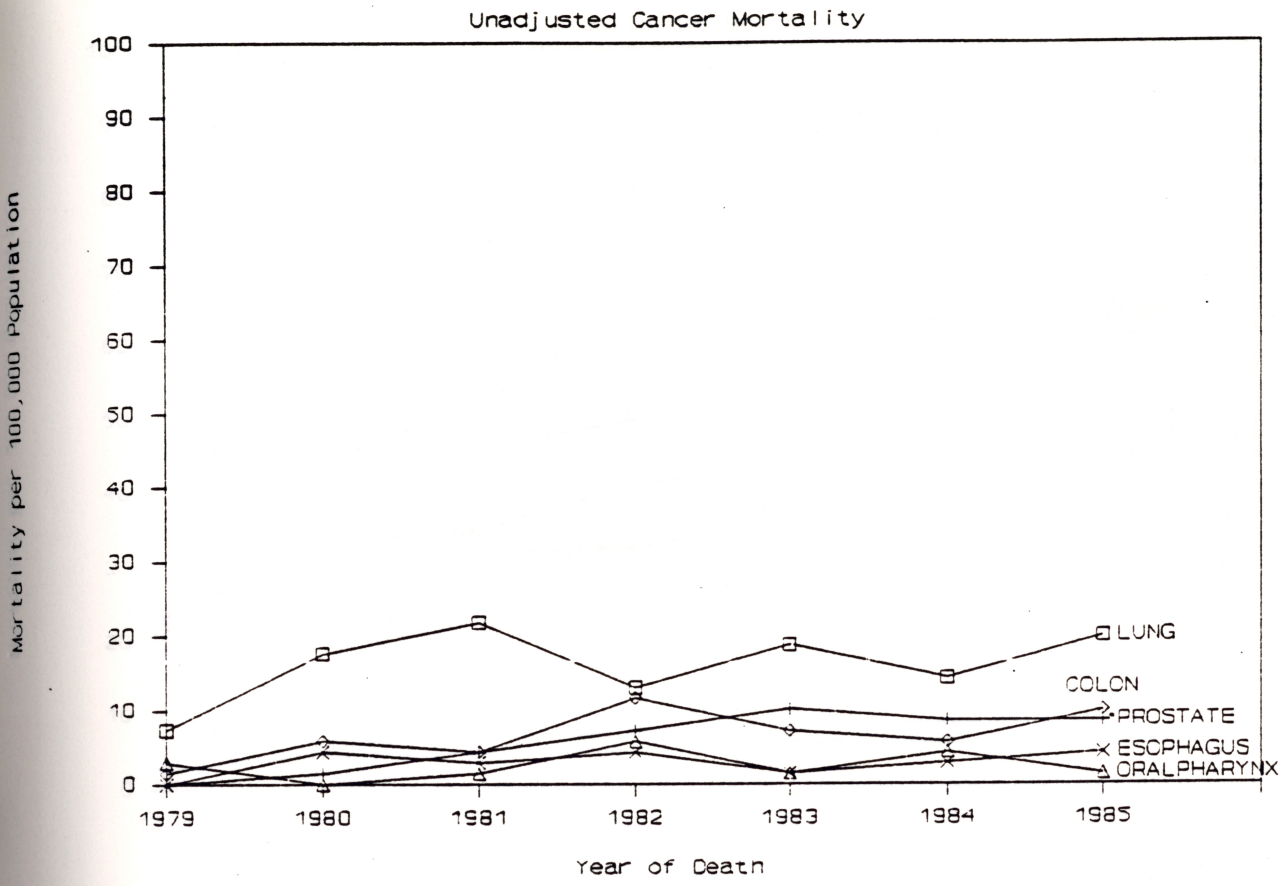


UNADJUSTED MORTALITY RATES (PER 100,000) FOR SELECTED CANCERS

OTHER NW FEMALES	1979	1980	1981	1982	1983	1984	1985
BREAST	9.83	6.99	6.95	12.47	12.41	9.59	19.06
COLON	4.21	4.19	6.95	5.54	2.76	10.96	2.72
CERVIX	2.81	1.40	1.39	8.32	2.76	1.37	0.00
LUNG	2.81	4.19	5.56	13.86	4.14	4.11	8.17
CORPUS U.	0.00	1.40	0.00	0.00	4.14	2.74	5.45

Highlights:
Mortality rates among Other Non-White Females show fluctuation in crude data. It is difficult to interpret year to year variation given the relatively small numbers in this group.

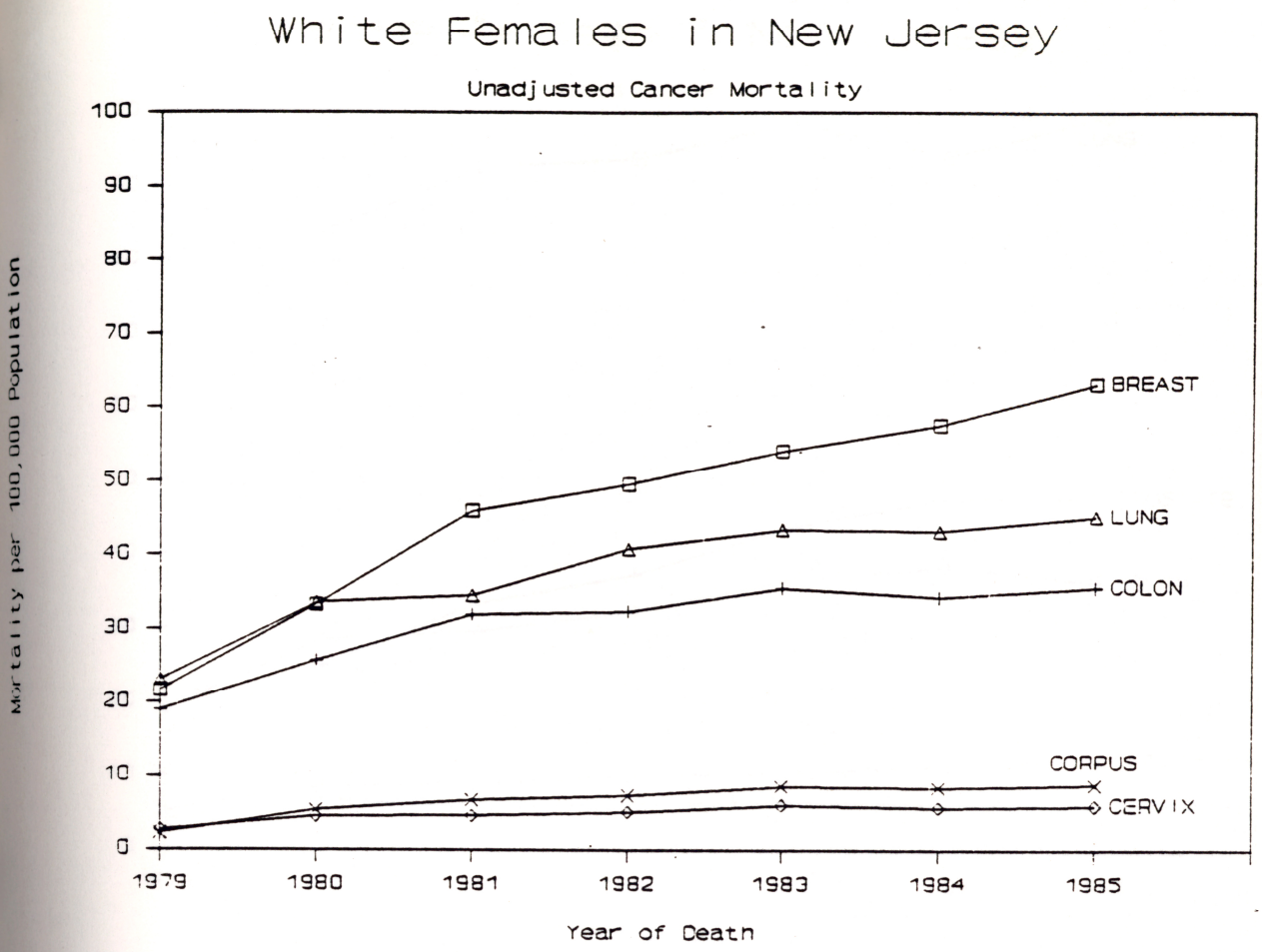
Other Non-White Males in New Jersey



Unadjusted Mortality Rates (per 100,000) for Selected Cancers

OTHER NW MALES	1979	1980	1981	1982	1983	1984	1985
LUNG	7.35	17.56	21.82	13.06	18.76	14.34	19.95
PROSTATE	0.00	1.46	4.36	7.25	10.10	8.60	8.55
COLON	1.47	5.85	4.36	11.61	7.22	5.74	9.98
ORAL/PHARNYX	2.94	0.00	1.45	5.80	1.44	4.30	1.43
ESOPHAGUS	0.00	4.39	2.91	4.35	1.44	2.87	4.28
BLADDER	1.47	0.00	2.91	1.45	2.89	4.30	1.43
STOMACH	2.94	4.39	0.00	8.70	14.43	5.74	7.13
RECTUM	1.47	1.46	1.45	4.35	2.89	2.87	2.85

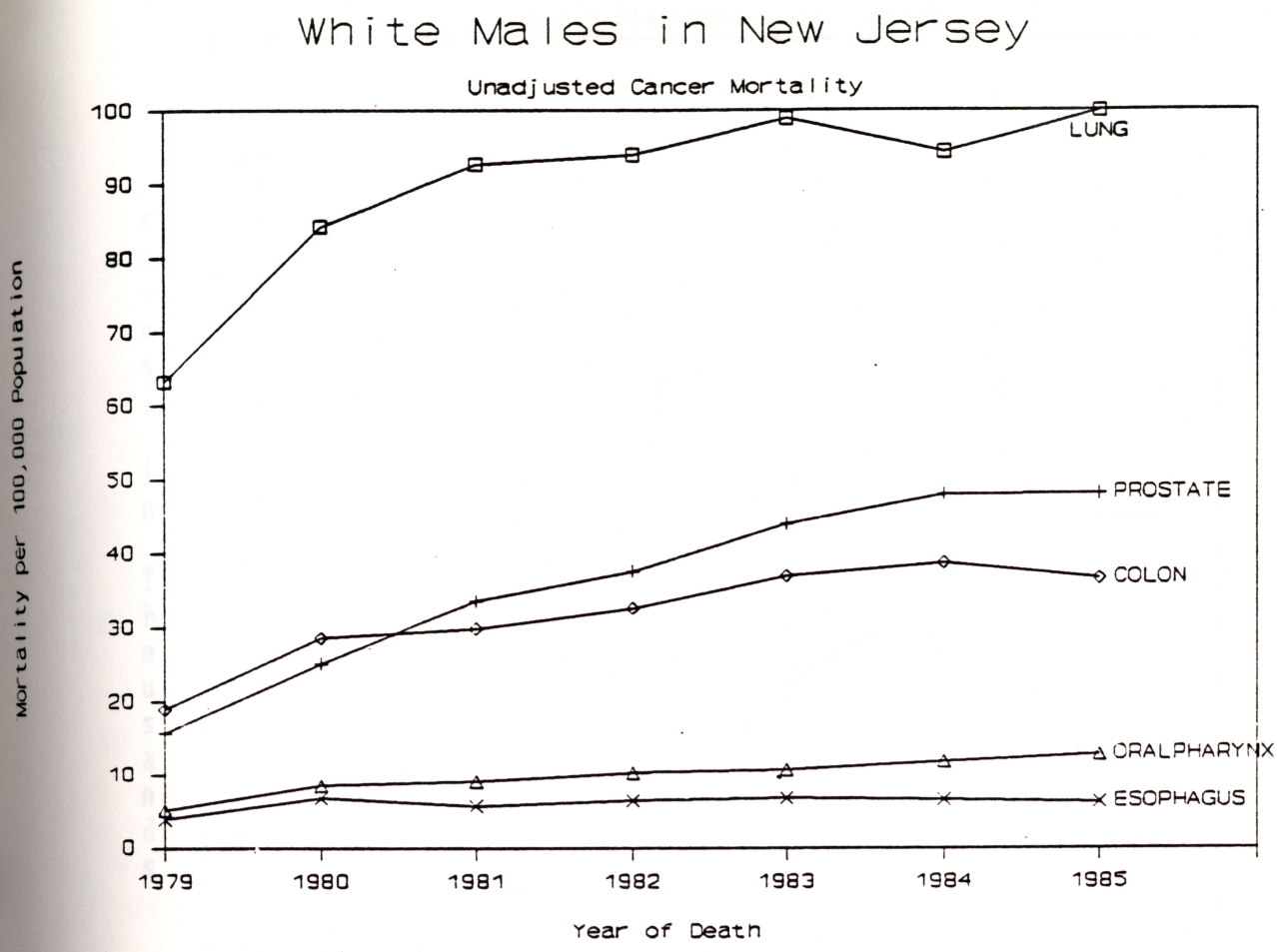
Highlights:
Fluctuating pattern is difficult to interpret in this group because of relatively small numbers, and without adjusting for age.



UNADJUSTED MORTALITY RATES (PER 100,000) FOR SELECTED CANCERS

WHITE FEMALES	1979	1980	1981	1982	1983	1984	1985
BREAST	21.71	33.27	45.91	49.54	54.02	57.56	63.18
COLON	18.95	25.75	31.89	32.35	35.52	34.25	35.59
CERVIX	2.76	4.57	4.61	5.12	6.07	5.74	5.93
LUNG	23.07	33.60	34.52	40.78	43.35	43.16	45.10
CORPUS U.	2.26	5.40	6.75	7.38	8.59	8.40	8.83

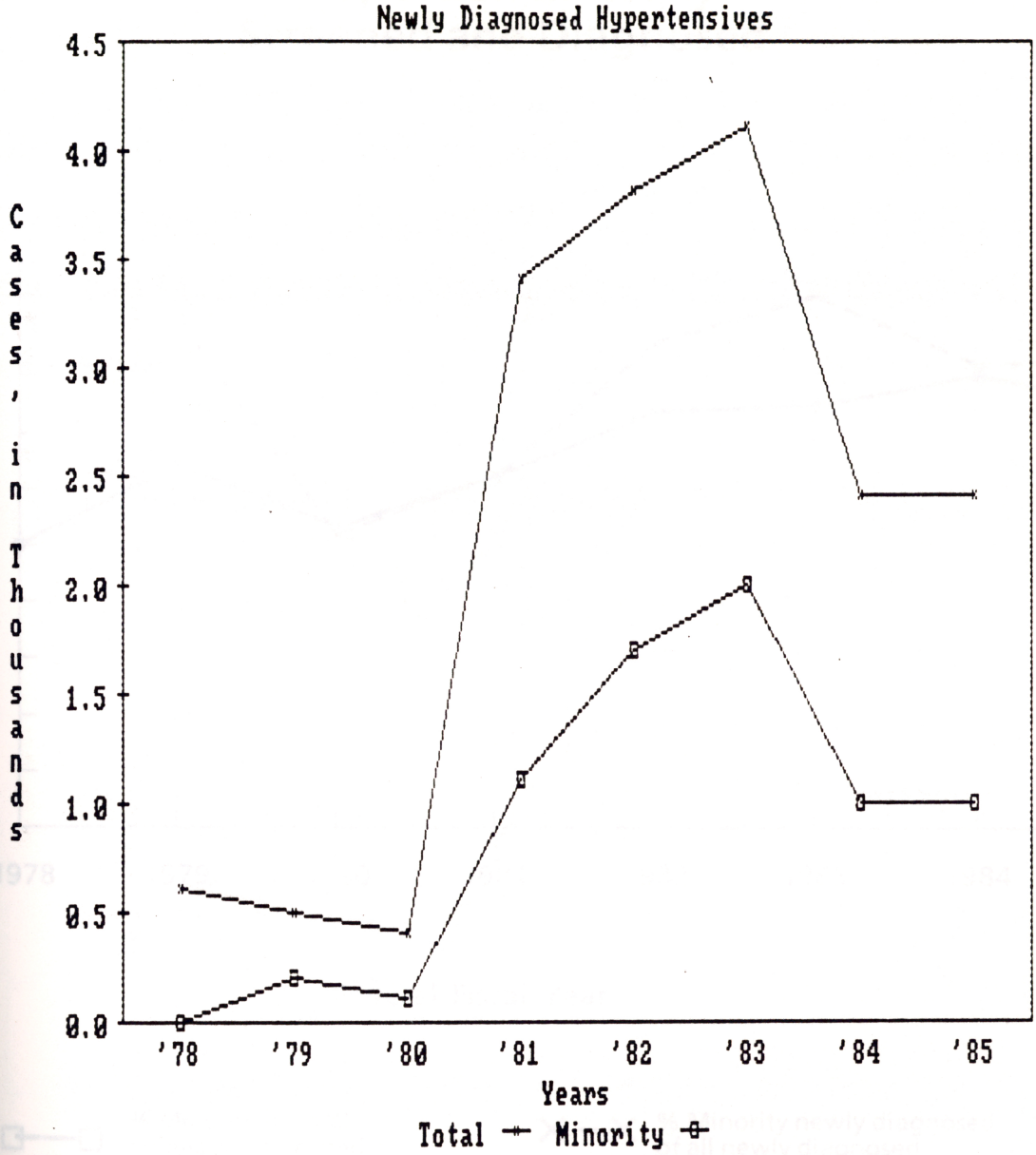
Highlights:
Breast and Lung cancer mortality rates have increased steadily from 1979 to 1985. The cancer mortality rates for other sites have been essentially stable since 1983.



UNADJUSTED MORTALITY RATES (PER 100,000) FOR SELECTED CANCERS

WHITE MALES	1979	1980	1981	1982	1983	1984	1985
LUNG	63.22	84.30	92.67	93.91	98.81	94.26	99.81
PROSTATE	15.72	25.14	33.54	37.54	43.92	47.93	47.96
COLON	18.95	28.53	29.81	32.55	36.85	38.67	36.50
ORAL/PHARNYX	5.19	8.56	9.08	10.21	10.66	11.77	12.75
ESOPHAGUS	3.94	6.78	5.74	6.43	6.82	6.57	6.25
BLADDER	7.92	12.12	13.93	17.11	18.18	17.40	20.49
STOMACH	8.17	11.80	13.22	12.09	14.38	13.21	13.58
RECTUM	6.05	10.31	12.97	13.68	15.93	16.94	19.41

Highlights:
Lung and Prostate cancer mortality rates among White Males show steady increasing pattern to 1983, followed by a leveling off phase. Rectal cancer mortality increased steadily from 1979-1985.

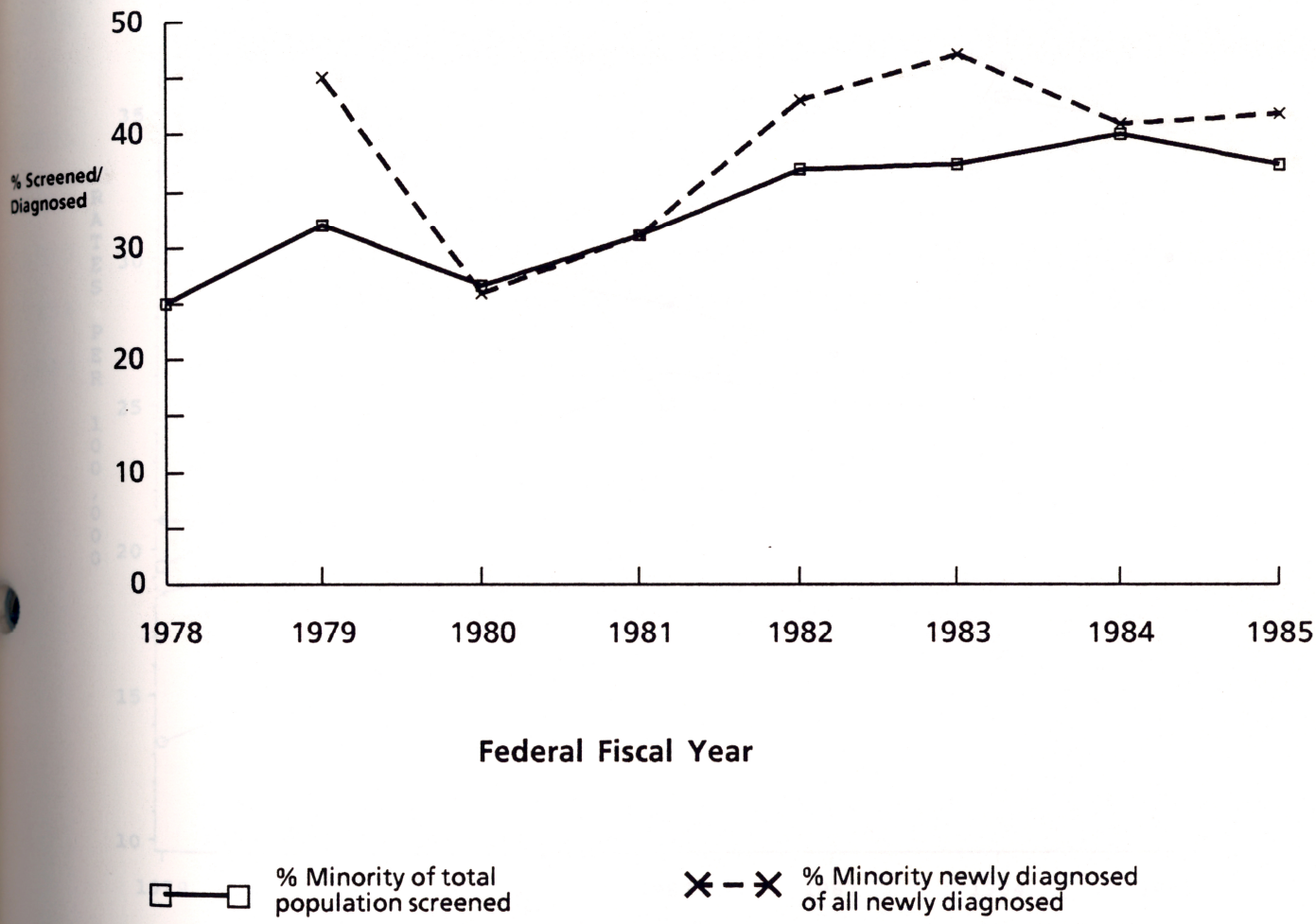


This Graph reflects two things:

1. Peak level of funding for community based hypertension screening was in years 1981-1983.

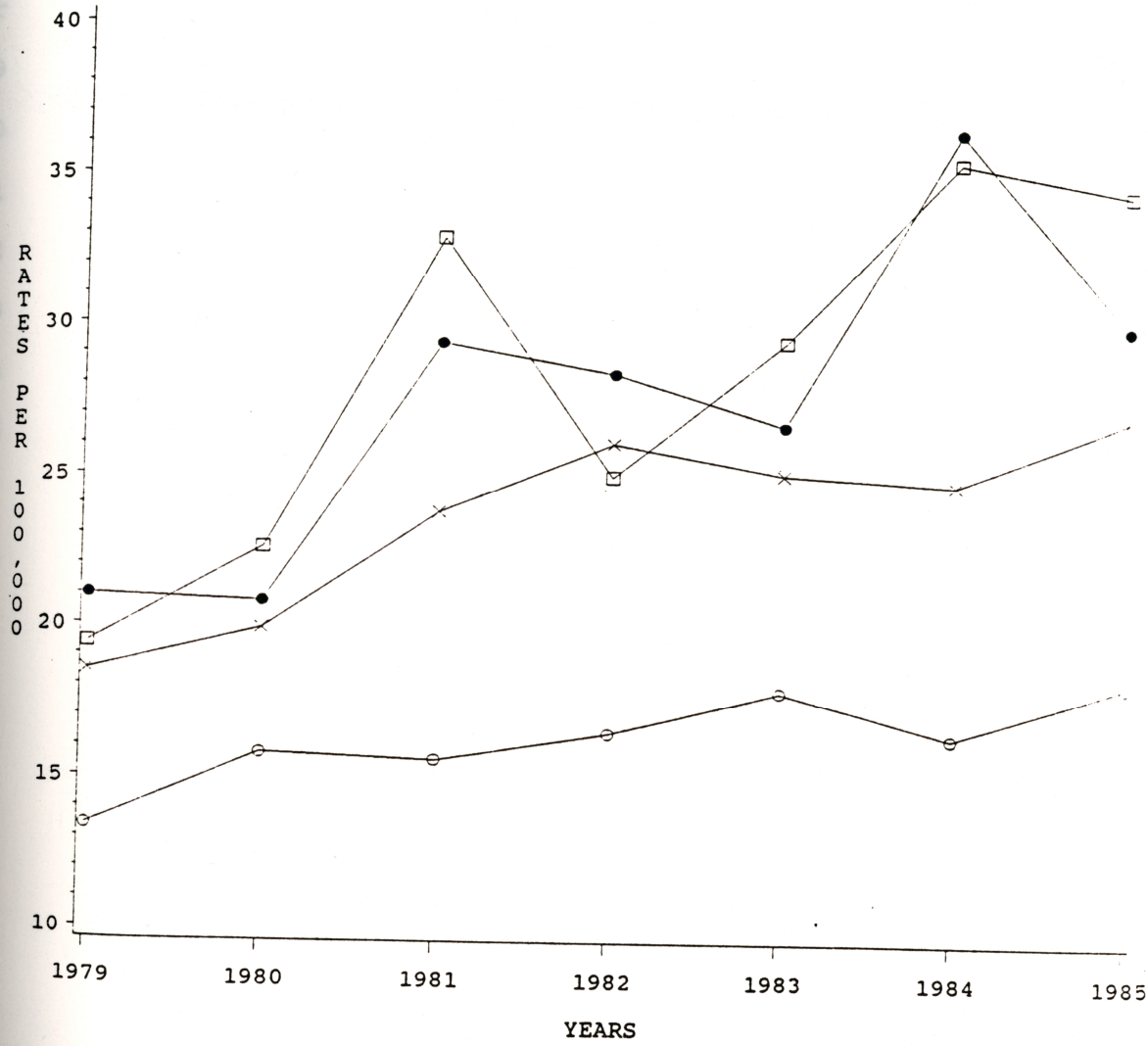
2. High proportion of minorities diagnosed is more reflective of targeting of public screening programs than it is of a higher prevalence of hypertension in the minority community. However, national data indicates a significantly higher prevalence of hypertension in these high risk groups.

Proportion Minority Screened and Diagnosed



NOTE: Even with high risk communities, we are finding more undiagnosed minority hypertensives than we are of non-minority.

New Jersey Diabetes Related Lower Extremity Amputations
Crude Rates Per 100,000 Population
1979 – 1985



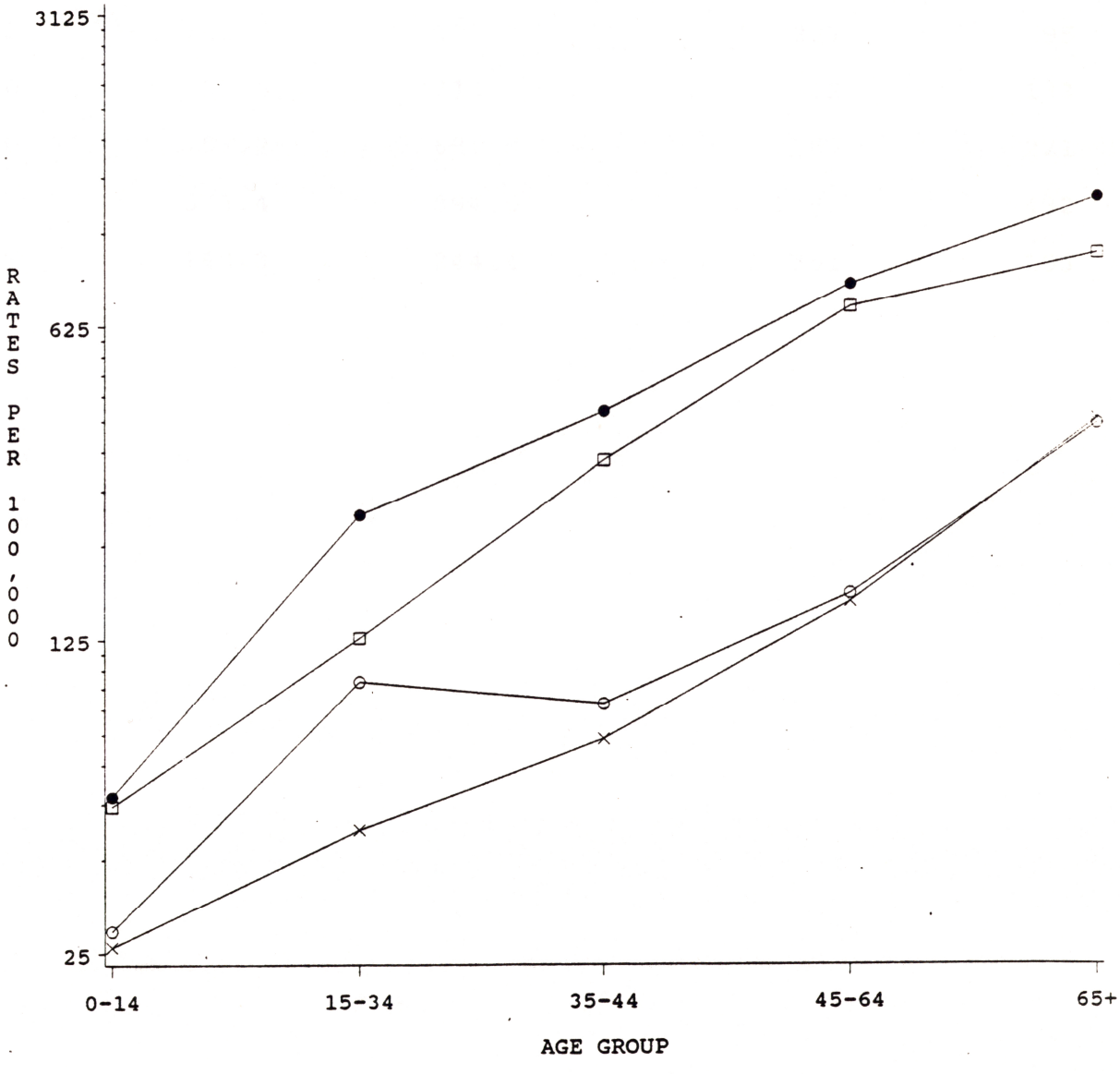
X – White Male
Circle – White Female
Square – Non – White Male
Dot – Non – White Female

The high rates seen in non-white males and females reflect the increase in diabetes in the minority population.

New Jersey Diabetes Related Lower Extremity Amputations
Crude Rates Per 100,000 Population
1979 – 1985

Year	White Male	White Female	Non-White Male	Non-White Female
1979	18.5	13.4	19.4	21.0
1980	19.9	15.8	22.6	20.8
1981	23.8	15.6	32.9	29.4
1982	26.1	16.5	25.0	28.4
1983	25.1	17.9	29.5	26.7
1984	24.8	16.4	35.5	36.5
1985	27.0	18.2	34.5	30.0

New Jersey Hospitalization Discharges
With a Principal Discharge
Diagnosis of Diabetes
Crude Rates Per 100,000 Population
1985

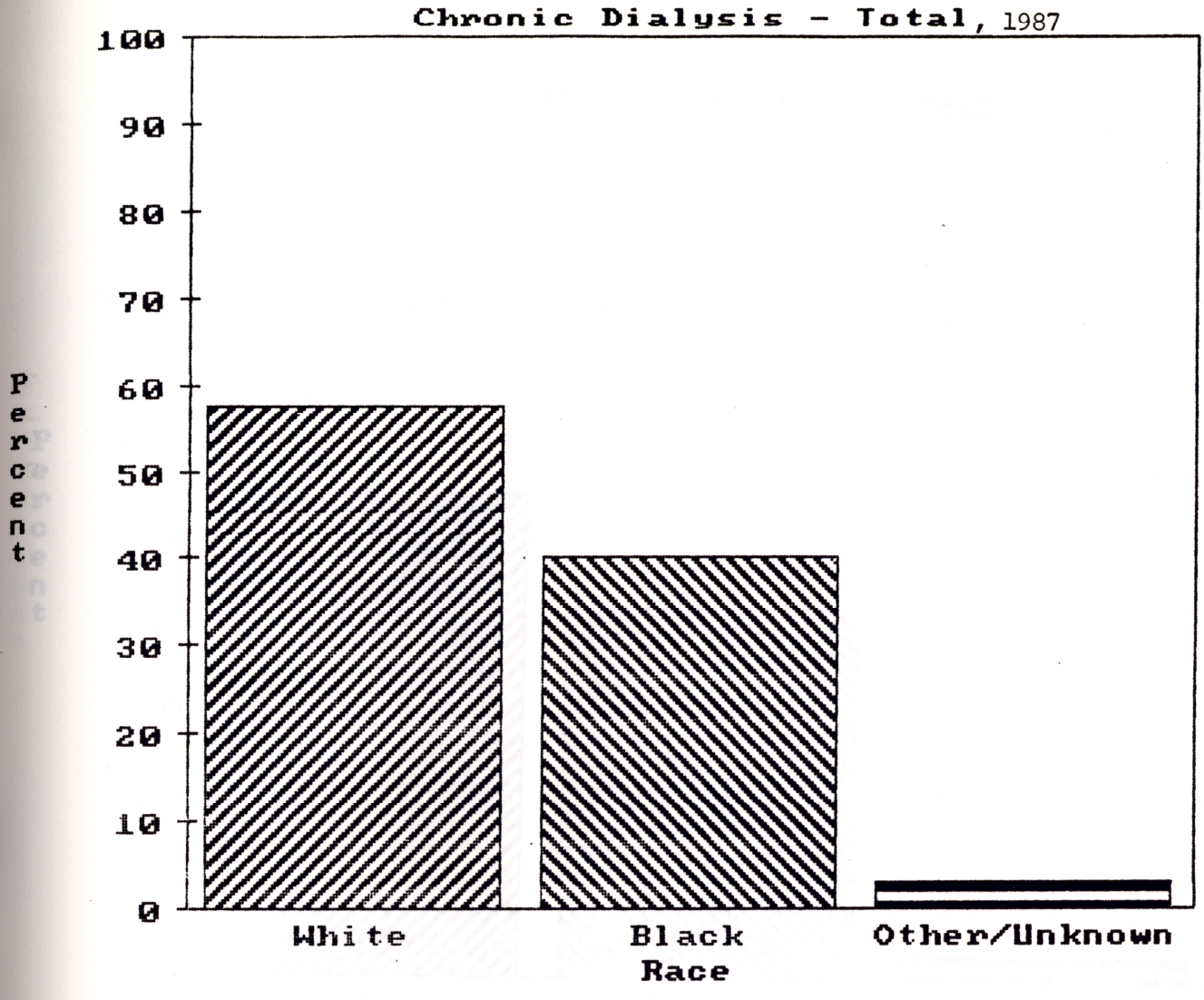


X - White Male
Circle - White Female
Square - Non-White Males
Dot - Non-White Female

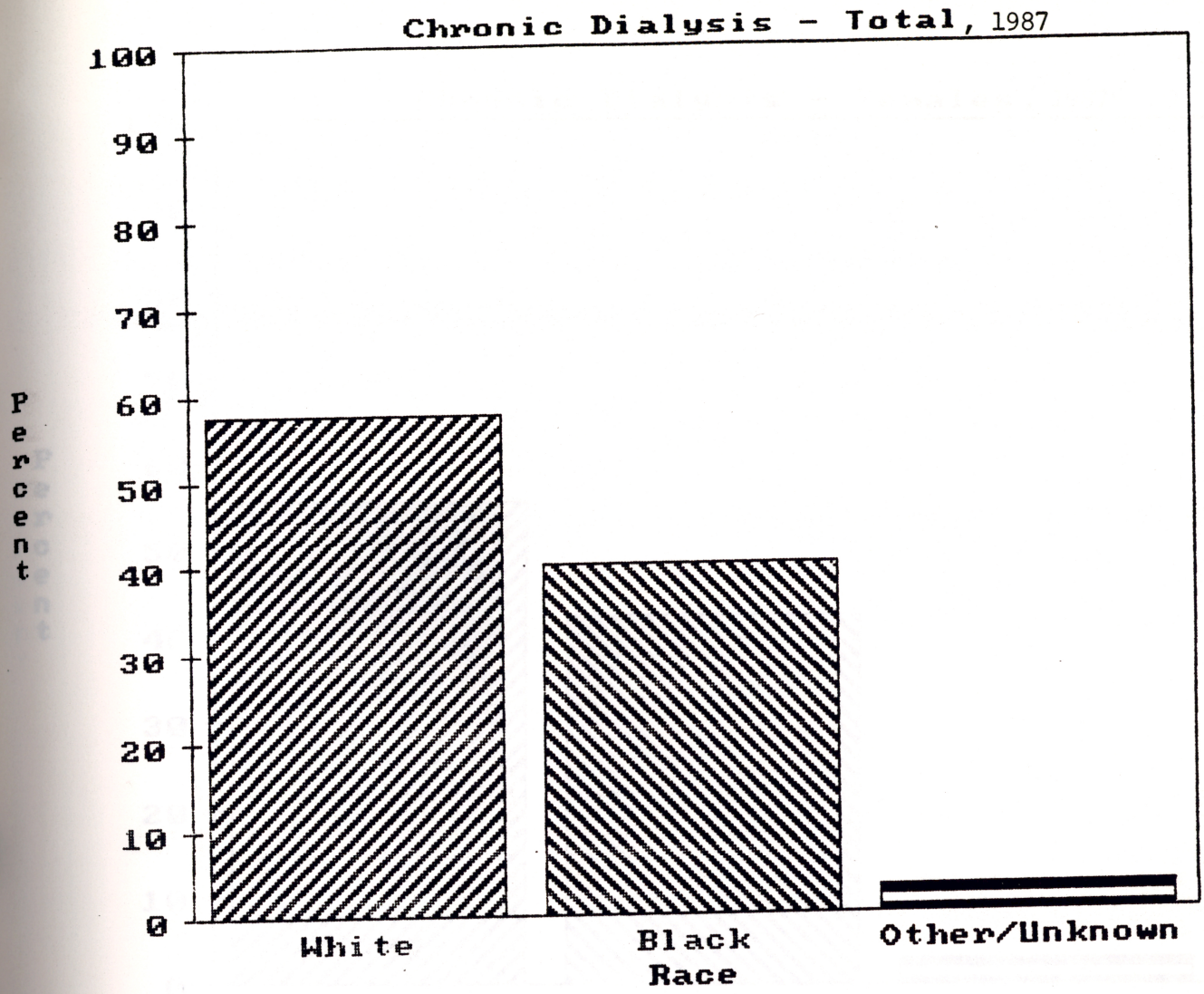
* At every age, both non-white males and females have higher rates of diabetes.

New Jersey Hospitalization Discharges
With a Principal Discharge
Diagnosis of Diabetes
Crude Rates Per 100,000 Population
1985

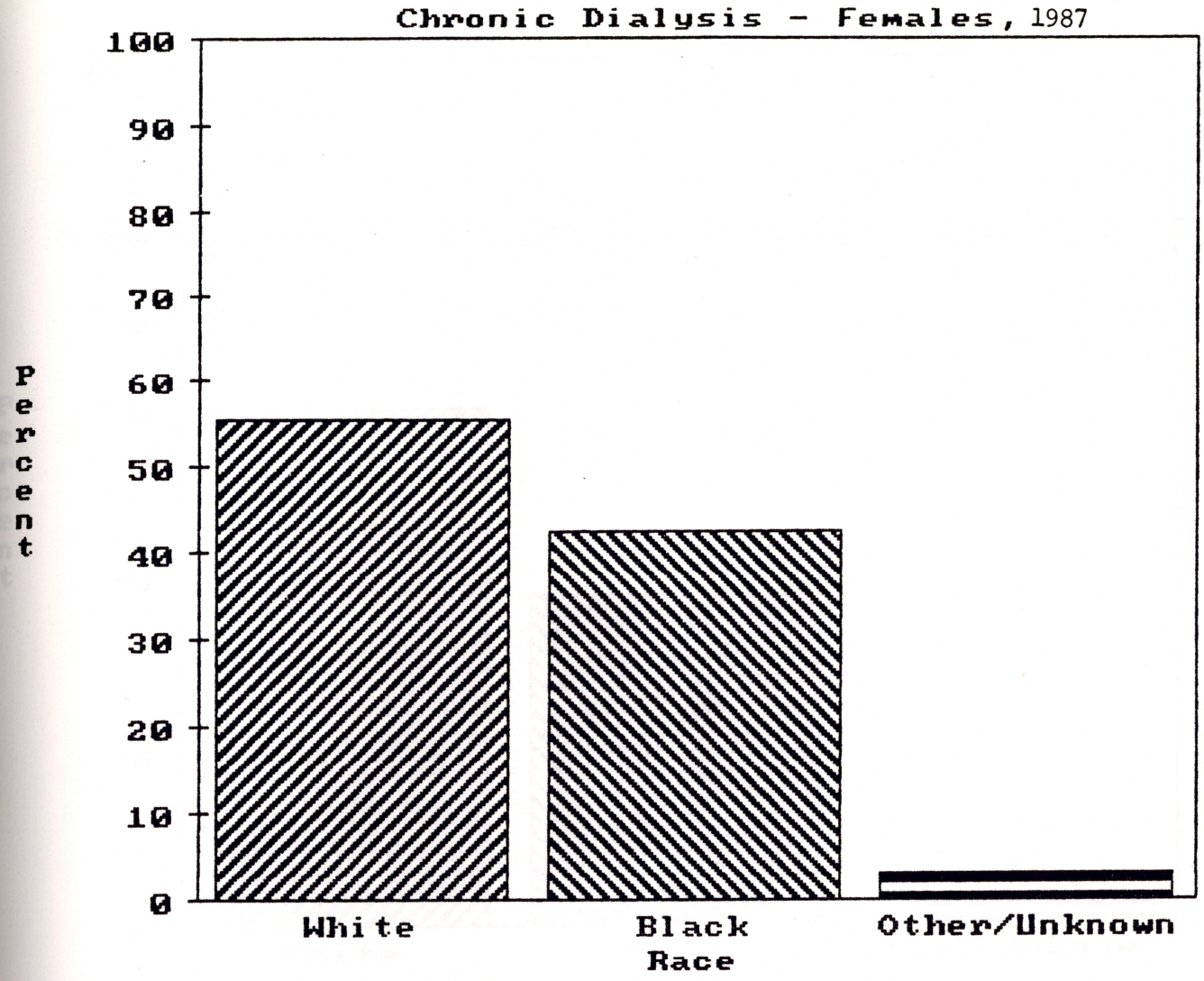
ge Group	White Male	White Female	Non-White Male	Non-White Female	Total
0-14	25.8	28.0	53.3	56	33
15-34	47.2	100.5	125.7	237	95
35-44	75.0	89.6	313.3	402	133
45-64	150.6	157.2	683.8	767	221
65+	383.2	373.4	894.5	1195	432
Total	105.8	140.3	244.4	351	153

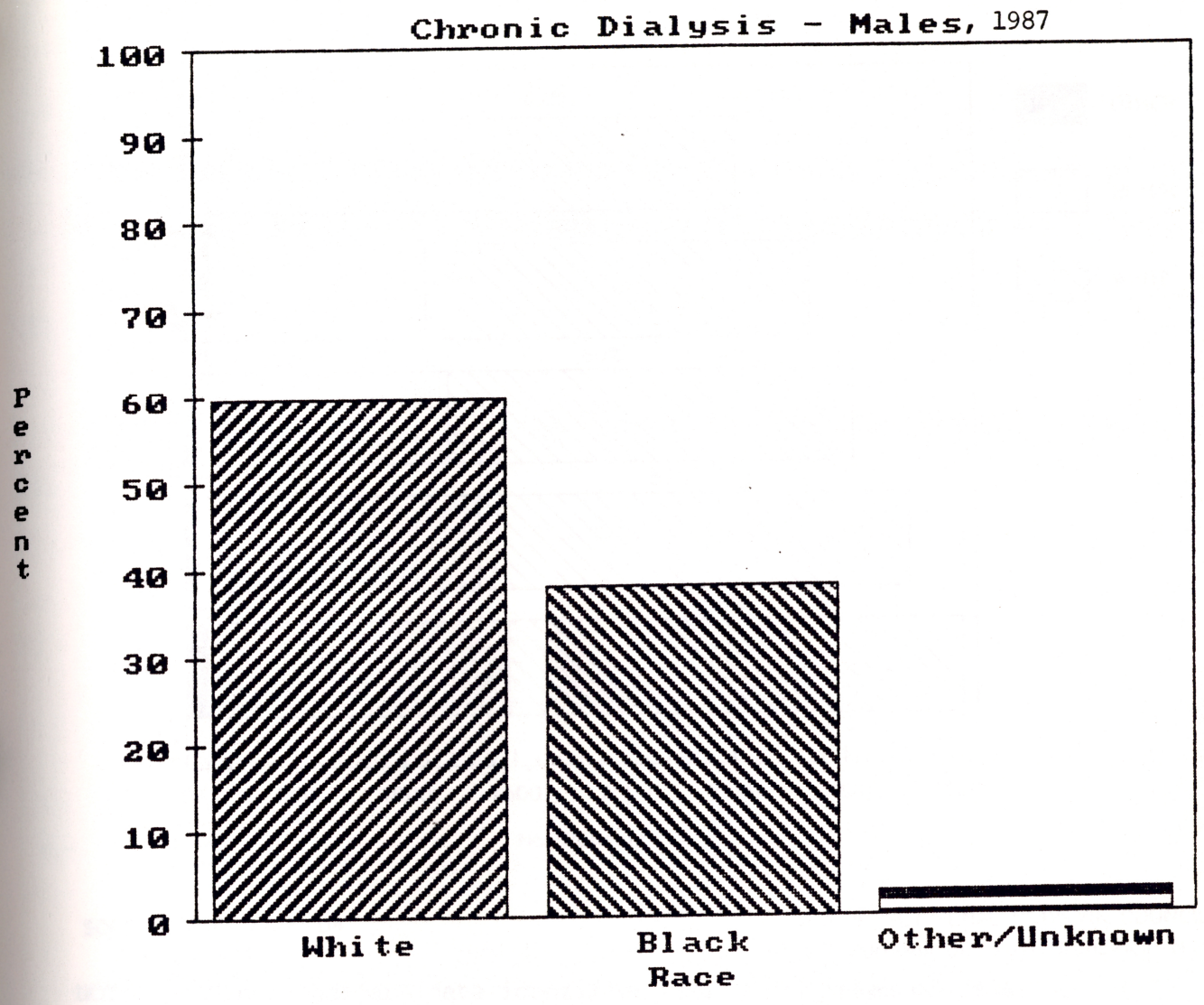


For black males and females high proportion of black race identified relative to their proportion of population indicates the higher incidence of renal failure among this minority group.

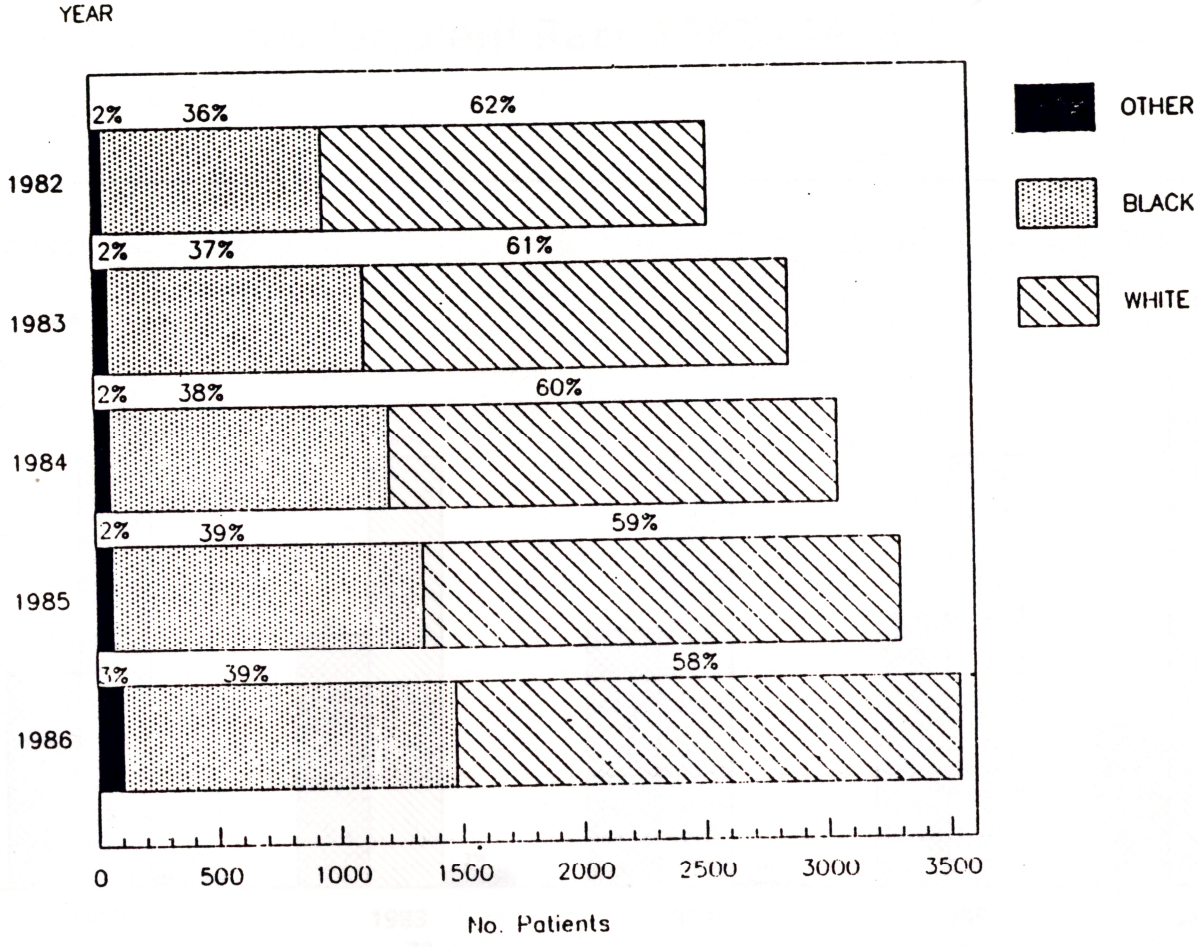


For black males and females high proportion of black race identified relative to their proportion of population indicates the higher incidence of renal failure among this minority group.


Chronic Dialysis - Females, 1987
100
90
80
70
60
50
40
30
20
10
0
Percent
White
Black
Other/Unknown
Race


Chronic Dialysis - Males, 1987
100
90
80
70
60
50
40
30
20
10
0
Percent
White
Black
Other/Unknown
Race

DIALYSIS PATIENT DISTRIBUTION BY RACE
NEW JERSEY: 1982 - 1986

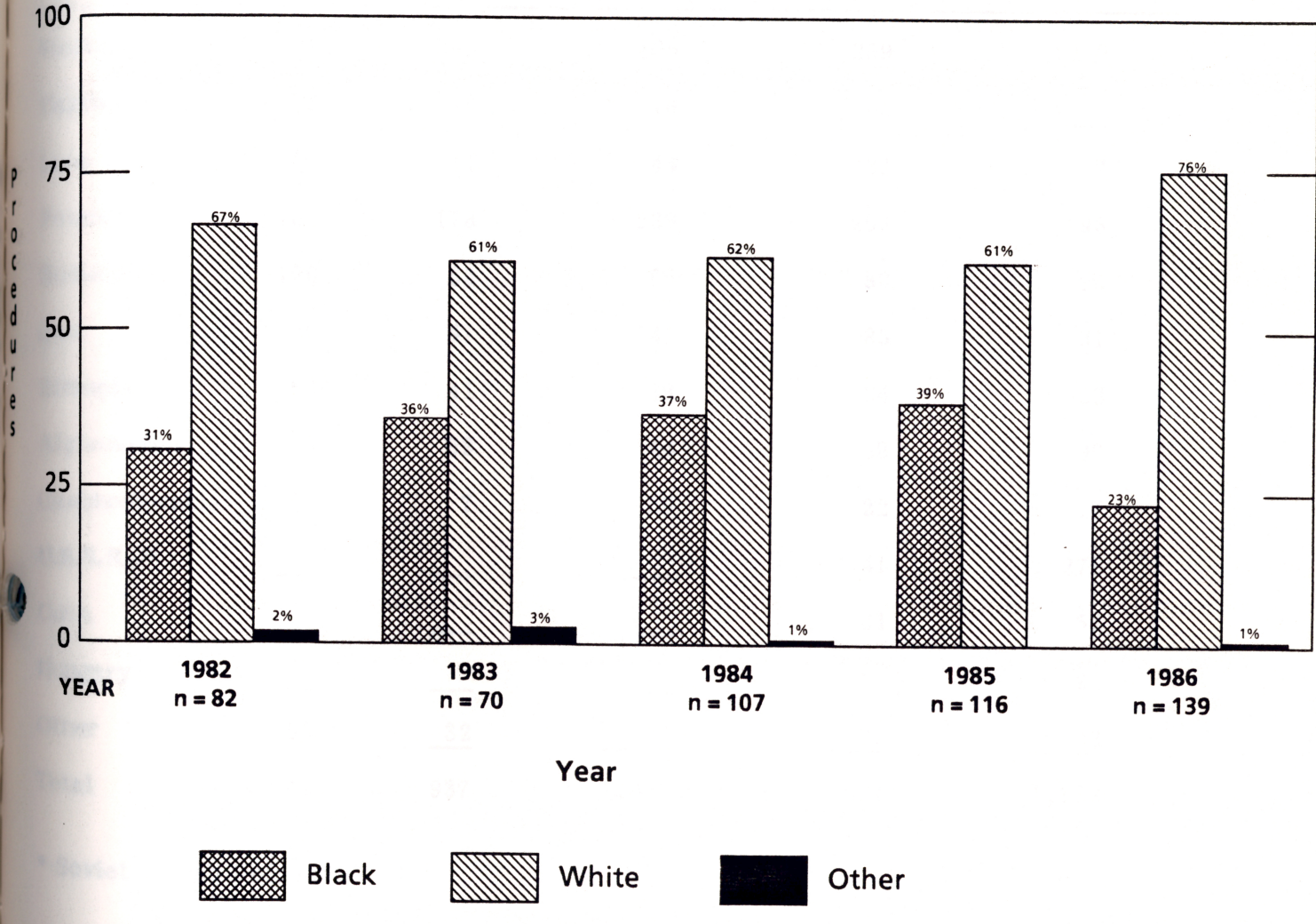


SOURCE: HCFA 2728-U4

NEW JERSEY RENAL NETWORK COUNCIL
4 Cornwall Dr., East Brunswick, N.J.

NOTE: Since medicare data identifies nearly all cases of renal failure, the high proportion of black or non-white renal failure patients relative to their population size indicates a dramatically higher risk for renal failure among these minority groups.

Transplants Performed in New Jersey By Recipient Race 1982 - 1986



*Source: HCFA-2728-U4
HCFA-2745-U3

NEW JERSEY RENAL NETWORK COUNCIL
4 Cornwall Dr., East Brunswick, NJ

NOTE: Underlying cause of renal failure and patient's age and other health conditions should be the key determinants in transplantation. These factors should be taken into consideration when interpreting this graph.

Refugee Arrivals By Country
of Origin, New Jersey
Fiscal Years 1984-1988

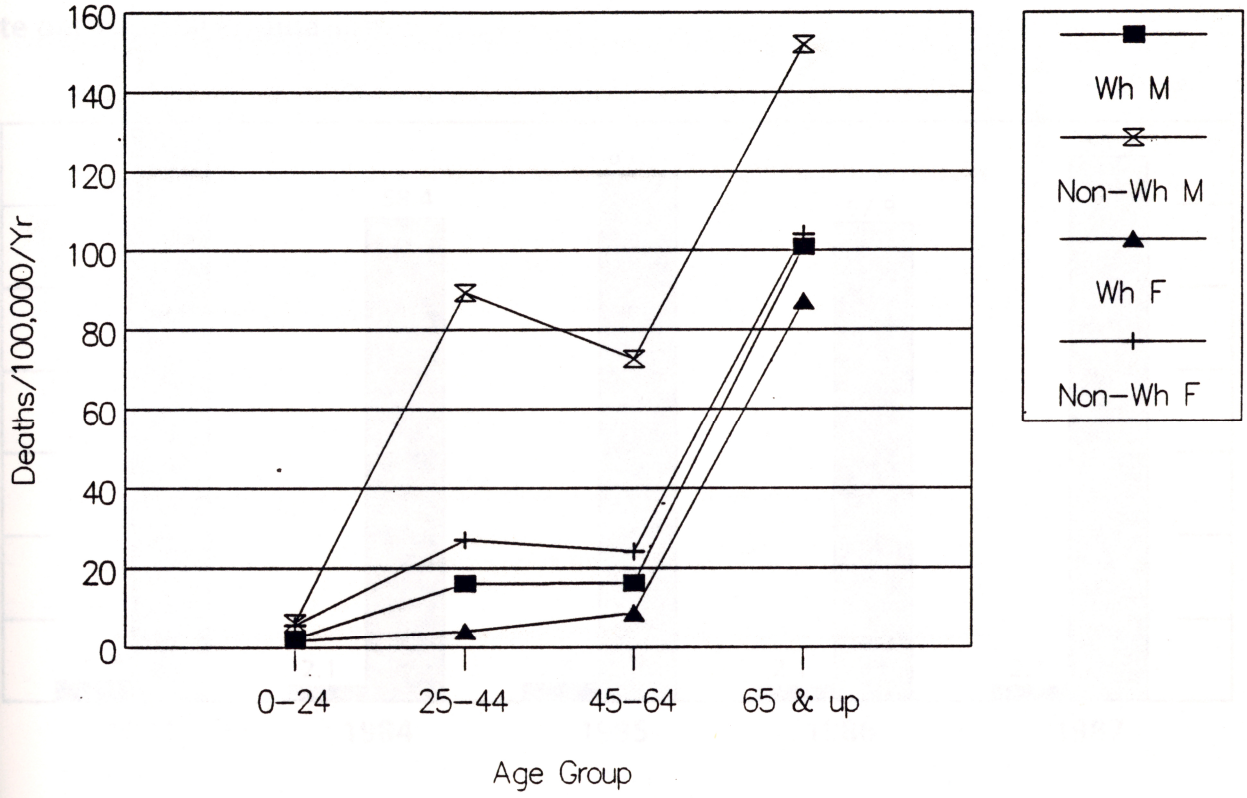
Origin	FY 84	FY 85	FY 86	FY 87	FY 88
Vietnam	368	368	405	269	299
Cambodia	85	119	16	1	—
Laos	34	11	44	31	7
Poland	161	178	239	263	195
Romania	100	65	65	80	90
Iran	89	47	41	85	91
Ethiopia	56	41	38	24	23
Afghanistan	52	69	44	68	90
Czechoslovakia	21	7	59	22	17
U.S.S.R. *	—	—	—	41	275
Cuba	—	—	—	31	52
Hungary	—	—	—	24	21
Other	53	32	57	22	22
Total	1,019	937	1,008	961	1,182

* Soviet Jewish Refugees

Hepatitis B Carriers (Infected/tested) Indochinese and Non-Indochinese Refugees, NJ FY 1984-1988

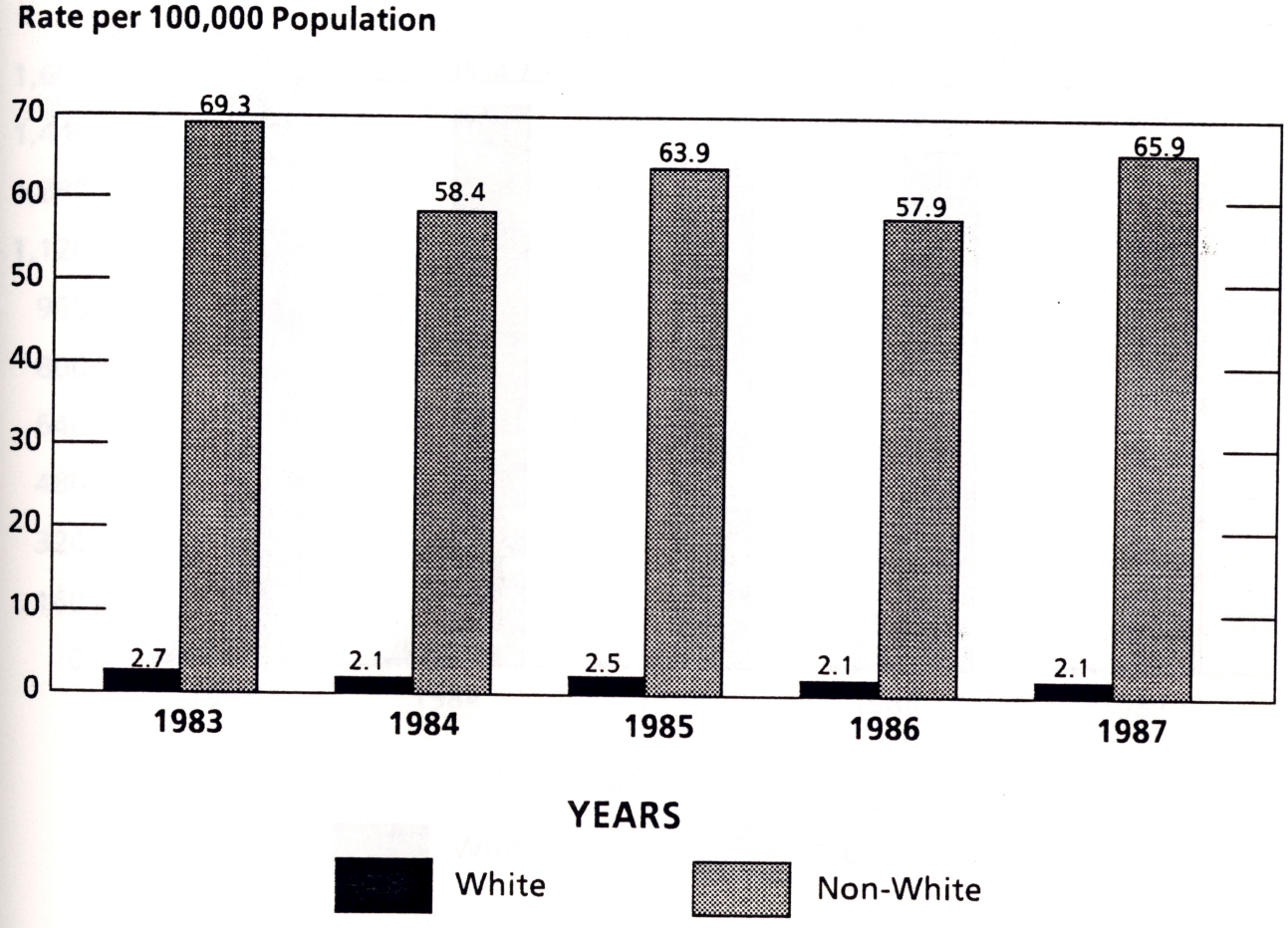
Refugee	1984 Infected/ Tested	1985 I/T	1986 I/T	1987 I/T	1988 I/T
Indo-Chinese	22/208	24/229	47/328	30/242	27/186
Percent Infected	10.6	10.5	14.3	12.4	14.5
Non-Indo Chinese	9/186	5/163	2/197	9/136	2/162
Percent Infected	4.8	3.1	1.0	6.6	1.2

Infection Mortality by Age, Race, and Sex



Based on the three year average, death due to infection is highest among Non-white males followed by Non-white females.

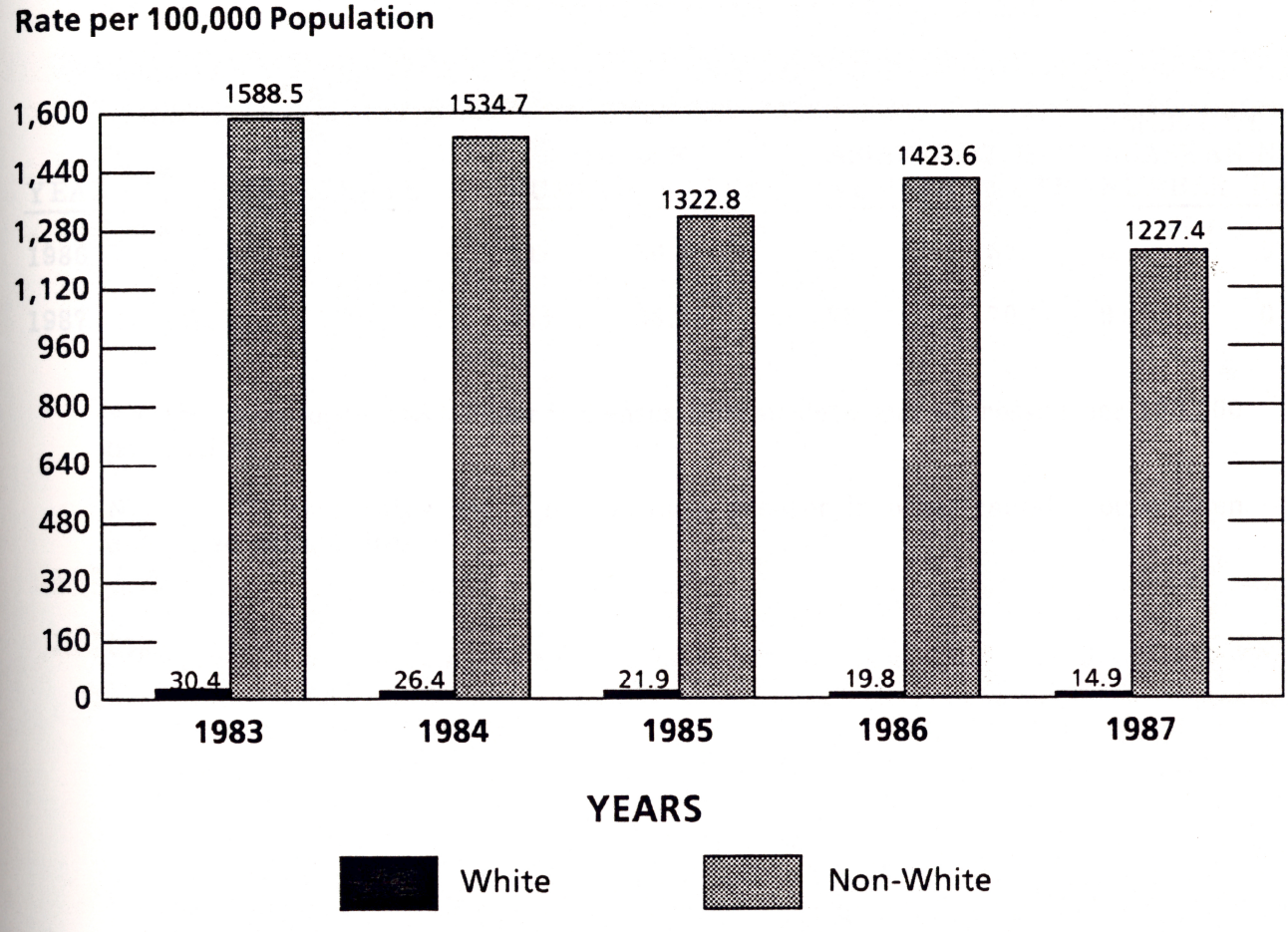
Reported Primary and Secondary Syphilis Case Rates* By Race New Jersey, 1983-1987



*Rates are computed using 1980 Federal Census Bureau data and are expressed as per 100,000 population. Non-white rates computed on black population. White rates were computed on the remainder of the population.

NOTE: Primary and Secondary syphilis rates among non-whites are 25 to 30 times greater than those reported for whites. Gonorrhea rates among non-whites are 50 to 80 times greater than those reported for whites.

Reported Gonorrhea Case Rates*
By Race (Where Stated)
New Jersey, 1983-1987



*Rates are computed using 1980 Federal Census Bureau data and are expressed as per 100,000 population. Non-white rates computed on black population. White rates were computed on the remainder of the population.

NOTE: Primary and Secondary syphilis rates among non-whites are 25 to 30 times greater than those reported for whites. Gonorrhea rates among non-whites are 50 to 80 times greater than those reported for whites.

REPORTED TUBERCULOSIS CASES

AND CASE RATES* BY RACE

NEW JERSEY, 1986 and 1987

YEAR	WHITE NUMBER	WHITE RATE	BLACK NUMBER	BLACK RATE	ASIAN/PAC. IS. NUMBER	ASIAN/PAC. IS. RATE	AMER NAT ALASKAN NAT NUMBER	AMER NAT ALASKAN NAT RATE
1986	333	5.4	337	36.4	54	52.2	0	0
1987	322	5.3	353	38.2	73	70.5	0	0

*Rates based upon 1980 Federal Census Bureau data and expressed per 100,000 population.

NOTE: TB case rates are 7 to 13 times greater in other racial groups when compared with Whites.

Background

- The overall rate of fatal unintentional injuries during 1983 - 1986 was higher for Blacks in comparison to Whites (including Hispanics), 3.9 and 2.4 per 100,000 civilian, non-institutional employed population, respectively.

- The average annual frequency of hospitalization for persons with chemical and dust related lung disease as a primary diagnosis during 1983 - 1986 was highest for Blacks and lowest for Hispanics, 1.84 and .65 respectively per 100,000 population more than 18 years of age in comparison to a rate of 1.5 in Whites.

- A 1980-81 New Jersey study showed that among Non-Whites, 22% of the lung cancer cases were attributable to occupation, compared to only 9% among Whites. Source: International Journal of Cancer 42:851-856 (1988), Vineis, Thomas, Schoenberg, et al.

- The average annual frequency of hospitalization for lung conditions due to specific exposures as a primary diagnosis during 1983 - 1986 was highest for Blacks and lowest for Hispanics, 1.67 and 1.4. respectively, per 100,000 population more than 18 years of age, in comparison to a rate of 1.5 in Whites.

- The average annual frequency of hospitalization for persons with chemical poisonings as a primary diagnosis during 1983 - 1986 was highest for Blacks and Hispanics, 14.5 and 10.7, respectively, per 100,000 population more than 18 years of age, in comparison to a rate of 7.2 in Whites.

- Hispanics experienced the highest frequency of hospitalization for finger (including thumb) amputations in 1986. Blacks experienced the second highest rate, 29.28 and 16.82, respectively per 100,000 population more than 18 years of age. Finger amputations among Hispanics occurred at a rate 3 1/2 times that of Whites.

- The primary problems of migrant farmworkers are pesticide poisoning, enteric diseases, infectious diseases, infant mortality and psychological stress.

- Data from the second National Health and Nutrition Examination Survey (NHANES II) conducted in the United States between 1976 and 1980 showed that 4% of children between 6 months and 5 years of age had elevated lead blood levels. The prevalence of elevated blood levels was higher in Black children (12.2%) than whites (2%).

- The NHANES II Survey also showed:

  - There was a significant interaction between the degree of urbanization and race.

  - In central cities the percentage of children with elevated blood levels was significantly higher among Blacks (18.6%) than among Whites (4.5%).

  - Even in smaller urban and rural areas 10.2% of blacks had elevated blood levels as compared with fewer than 2% among Whites.

- New Jersey has defined its highest degree of urbanization as greater than 60,000 persons with greater than 5% of the population under 5 years of age being Black.

- The top six counties classified as high risk, based on the application of the NHANES methodology to 157 New Jersey municipalities are: Essex, Hudson, Passaic, Camden, Union and Mercer.

Program Description

Environmental Health Services

- Responsible for defining the sources of hazards facing New Jersey residents by taking measures to minimize exposure to potentially hazardous or toxic substances, through the development of studies and community organizations that examine suspected exposure of community residents to environmental hazards.

- Minority focused activities include, but are not limited to monitoring the exposure of children and adults to lead in the environment (i.e., paint, gasoline, dust/soil. Additional information on the Accident Prevention and Poison Control Program activities can be found in the Injury Subsection.

Asbestos Control Services

- The Asbestos Control Service (ACS) is responsible for the conduct of assessments to determine the persence and condition of asbestos-containing material; the certification of training firms and private consultants; providing advice and consultation to school officials, child day care center administrators, and managers of public facilities; carrying out a public outreach program for the general public; and maintaining a centralized data base on the status of asbestos-related activities in the State. The Service provides worker examinations in languages other than English and has historically focused its attention on inner city schools.

Occupational Health Services

- Responsible for such activities as: enforcement of workplace provisions of the New Jersey Right to Know Law; health provisions of the Public Employee Occupational Safety and Health Act; surveillance of occupational illness injuries and hazards.

- Minority focused activities include the development of educational materials in Spanish, and the coordination of a project to investigate the occurrence of pesticide poisonings among migrant farmworkers in southern New Jersey.

Fatal Unintentional Injuries By Race[1]

By Year (1983 - 1986)

	Race			
	White[2]		Black	
Year	No.	Rate[3]	No.	Rate
1983	80	2.5	10	3.2
1984	82	2.4	21	5.7
1985	85	2.5	6	1.5
1986	81	2.4	21	4.9
Total	328	2.4	58	3.9

[1]Sources for fatal unintentional injuries were death certificates and medical examiner reports. Race was based on death certificate data.

[2]Includes Hispanic origin.

[3]Rate per 100,000 civilian non-institutional employed population from Bureau of Labor Statistics, Geographic Profile of Employment and Unemployment, New Jersey (Years 1983 - 1986) (Table 12).

The overall rate of fatal unintentional injuries during 1983-1986 was higher for Blacks in comparison to Whites (including Hispanics), 3.9 and 2.4 per 100,000 civilian, non-nstitutional employed population, respectively.

Frequency of Hospitalization of Persons With Other Lung Conditions: 1983-1986 [1,2]

- Extrinsic allergic alveolites ICD code 495, 495.1, 495.2 , 4.95.3, 495.4, 495.7, 495.8.

- Bronchitis, pneumonitis, inflammation both acute and chronic and acute pulmonary edema due to fumes and vapors. ICD code 506.0, 506.1, 506.2, 506.3, 506.4 and 506.9.

- Pneumonitis due to inhalation of solids or liquids ICD codes 507.1 and 507.8.

- Respiratory conditions due to unspecified external agents ICD codes 508.8 and 508.9.

No. of persons greater than or equal to 18 years of age/No. of persons per 100,000 population greater than or equal to 18 years of age:

	1983	1984	1985	1986
White	50/1.14	74/1.68	61/1.38	72/1.63
Black	9/1.54	9/1.54	11/1.88	10/1.71
Hispanic	6/1.95	3/0.98	3/0.98	5/1.63

[1]Primary diagnosis

[2](Source of numerator: UB-82 hospital discharge file, source of denominator: 1980 U.S. Census).

The average annual frequency of hospitalization for persons with chemical and dust-related lung disease as a primary diagnosis during 1983-1986 was highest for Blacks and lowest for Hispanics, 1.67 and 1.4 respectively, per 100,000 population more than 18 years of age, in comparison to a rate of 1.5 in Whites.

Frequency of Hospitalizations of Persons with Chemical Poisonings [1,2]

petroleum products	ICD 981 and 981.0
benzene	ICD 982
carbon tetrachloride	ICD 982.1
carbon disulfide	ICD 982.2
chlorinated hydrocarbons	ICD 982.3
non-petroleum-based solvents	ICD 982.8
corrosive aromatics	ICD 983.0
acids	ICD 983.1
alkalies	ICD 983.2
caustic, unspecified	ICD 983.9
organic lead	ICD 984.1
mercury	ICD 985
arsenic	ICD 985.1
manganese	ICD 985.2
beryllium	ICD 985.3
antimony	ICD 985.4
cadmium	ICD 985.5
chromium	ICD 985.6
other specified metals	ICD 985.8
unspecifed metals	ICD 985.9
nitrogen oxides	ICD 987.2
sulfur dioxide	ICD 987.3
freon	ICD 987.4
chlorine	ICD 987.6
hydrogen cyanide	ICD 987.7
other gases	ICD 987.8
unspecified gas, fume, vapor	ICD 987.9
hydrogen cyanide	ICD 989
pesticides	ICD 939.2 and 989.4

No. of persons less than 18 years of age/No. of persons per 100,000 population greater than or equal to 18 years.

	1983	1984	1985	1986
White	312/7.10	310/7.05	348/7.92	305/6.94
Black	77/13.21	84/14.41	84/14.41	92/15.79
Hispanic	36/11.71	26/8.46	29/9.43	40/13.01

[1]Primary diagnosis

[2](Source of numerator: UB-82 hospital discharge file, source of denominator: 1980 U.S. Census).

The average annual frequency of hospitalization for persons with chemical and dust-related lung disease as a primary diagnosis during 1983-1986 was highest for Blacks and lowest for Hispanics, 14.5 and 10.7 respectively, per 100,000 population more than 18 years of age, in comparison to a rate of 7.2 in Whites.

Frequency of Hospitalizations of Persons for Finger (including thumb) Amputations: 1986 [1,2]

No. of persons greater than or equal to 18 years of age/No. of persons per 100,000 population greater than or equal to 18 years of age.

	1986
Whites	367/8.35
Blacks	98/16.82
Hispanics	90/29.28

[1]These data are only for primary diagnoses; we estimate that approximately 50% of these cases are due to an occupational injury, but the proportion may differ by race.

[2]Source of numerator: UB-82 hospital discharge file, Source of denominator: 1980 U.S. Census

Frequency of hospitalization for finger (including thumb amputation) among Hispanic occurred at a rate of 3 1/2 times that of Whites.

Injury

Background

Accident Prevention and Poison Control Program - Lead Poisoning

- Data from the second National Health and Nutrition Examination Survey (NHANES II) conducted in the United States between 1976 and 1980 showed that 4% of children between 6 months and 5 years of age had elevated lead blood levels. The prevalence of elevated blood levels was higher in Black children (12.2%) than whites (2%).

- The NHANES II Survey also showed:

  - There was a significant interaction between the degree of urbanization and race.

  - In central cities the percentage of children with elevated blood levels was significantly higher among Blacks (18.6%) than among Whites (4.5%).

  - Even in smaller urban and rural areas 10.2% of blacks had elevated blood levels as compared with fewer than 2% among Whites.

- New Jersey has defined its highest degree of urbanization as greater than 60,000 persons with greater than 5% of the population under 5 years of age being Black.

- The top six counties classified as high risk, based on the application of the NHANES methodology to 157 New Jersey municipalities are: Essex, Hudson, Passaic, Camden, Union and Mercer.

Injury

- In 1985-1987, 92% of all injury deaths classified as Non-White and 96% of the firearms deaths classified as Non-White were classified as Black.

- From 1979-1987 a steady decline in New Jersey gun deaths and gun homicides has occurred in the Non-White population in comparison to the White population where it has remained relatively constant.

- Based on the 3 year average ('85-'87), the percent of firearms used for homicide is higher for Non-Whites than for Whites, while the percent used for suicides is higher for Whites than for Non-Whites.

- Based on the 3 year average, Black males experienced the highest rate of injury deaths due to guns, unknown intention, drowning, homicide and fires.

Rape

- Fourteen counties reported that in 1987, 54% of all rape victims were White, 38% Black and 8% Hispanic. Sixty-seven percent of the Black victims were from Essex County, and treated by United Hospital, a provider where children who have been sexually abused are primarily served.

Program Description

Accident Prevention and Poison Control Program

- responsible for reducing deaths and injuries from accidents and to prevent serious impairment from lead toxicity through early identification and intervention in children with significant exposure to lead.

  Program efforts to control lead poisoning are directed to children living in areas identified as high risk with the State. A significant number of minority children were screened as a result of this focus.

  Additional activities including educational programs to prevent lead poisoning and home accidents.

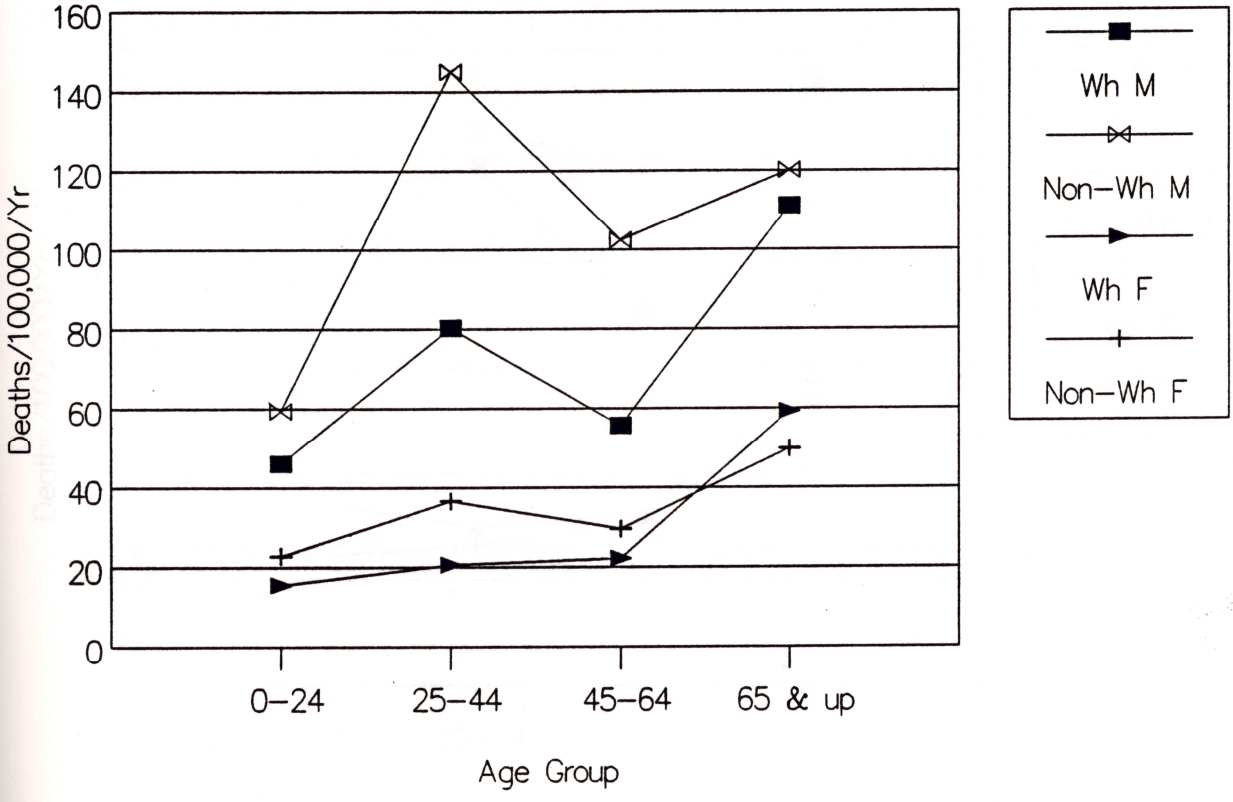
Rape

- responsible for administering contracts and providing technical assistance to agencies in 18 counties of the State for the provision of rape care services.

Injury

- Although no formal Injury program exists, efforts are underway to initiate such a program in the Division of Epidemiology within the Department of Health. Data is presently maintained by the Office of Research, Division of Research, Policy and Planning.

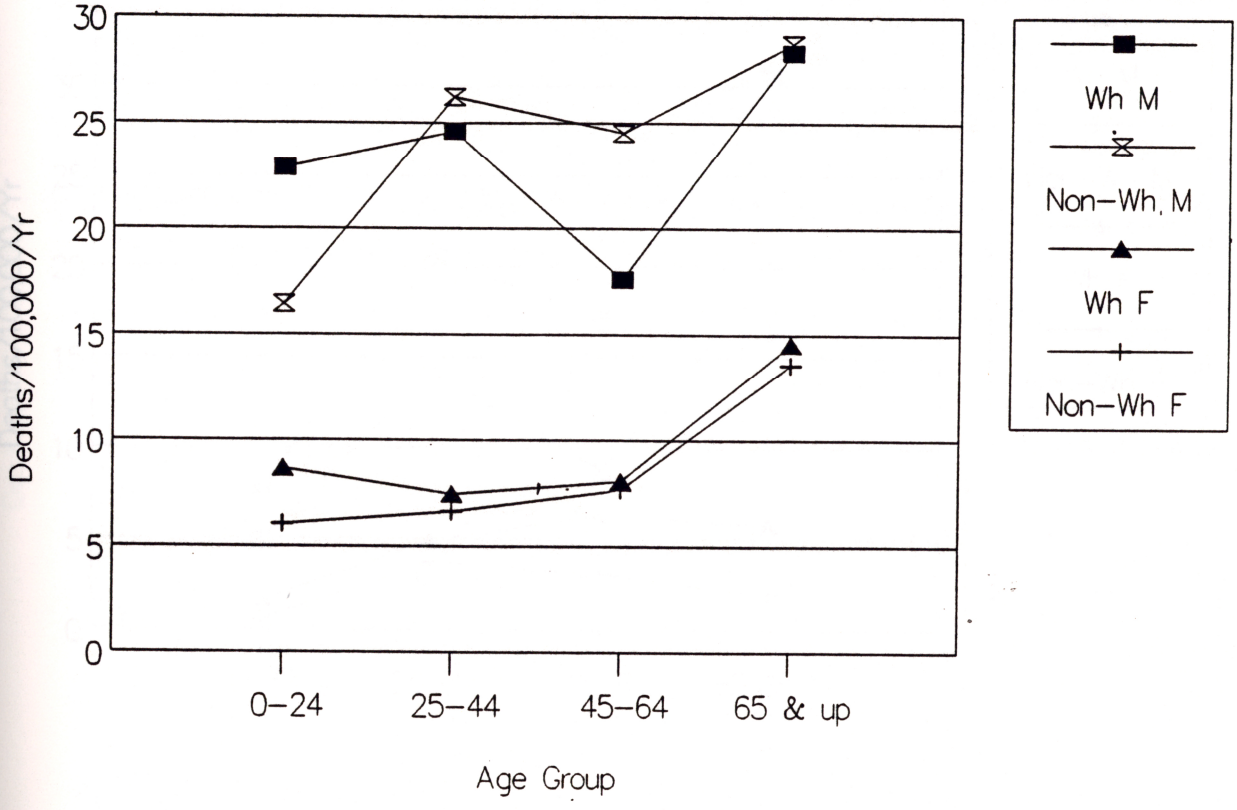
All Injuries Mortality by Age, Race, and Sex



Based on the three year average, Non-white males experienced the highest rate of mortality due to all injuries.

Non-white females experienced a higher rate due to all injuries in comparison to White females, except in the 65+ year age group.

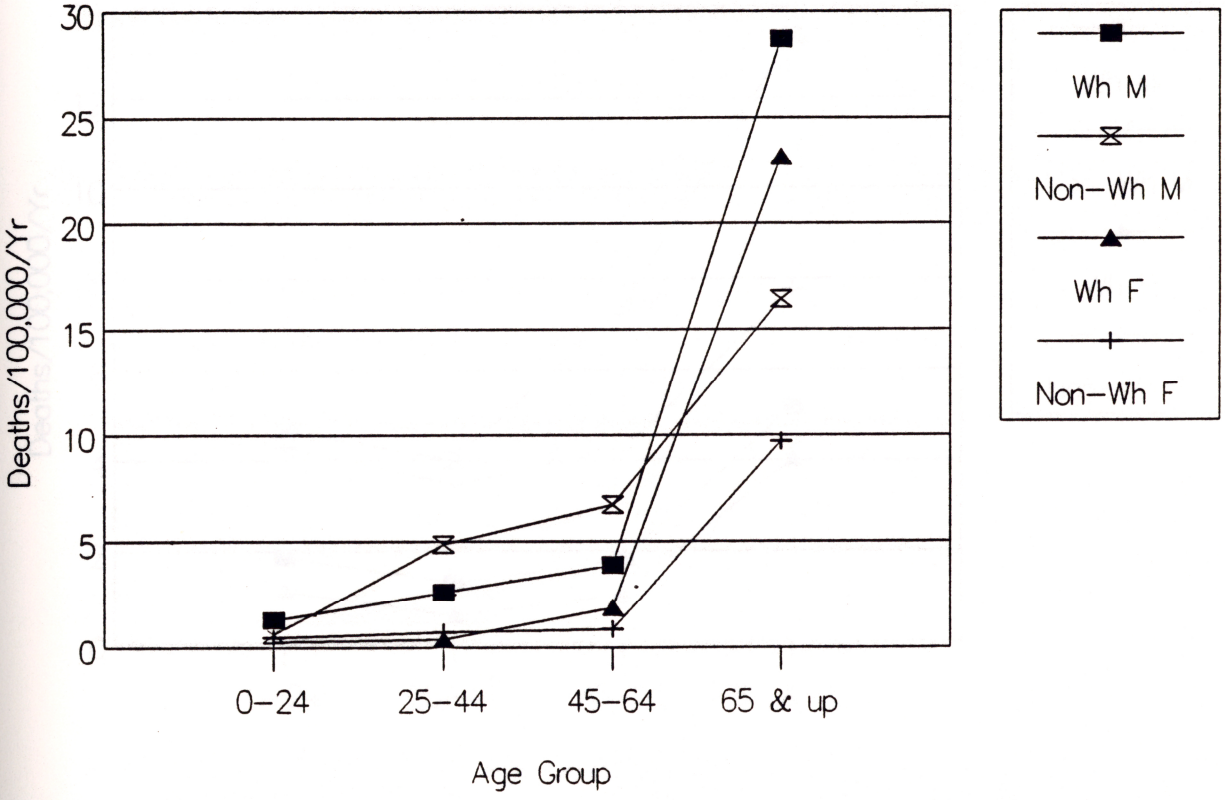
X*-Port Injury Mortality by Age, Race, and Sex



* Transportation

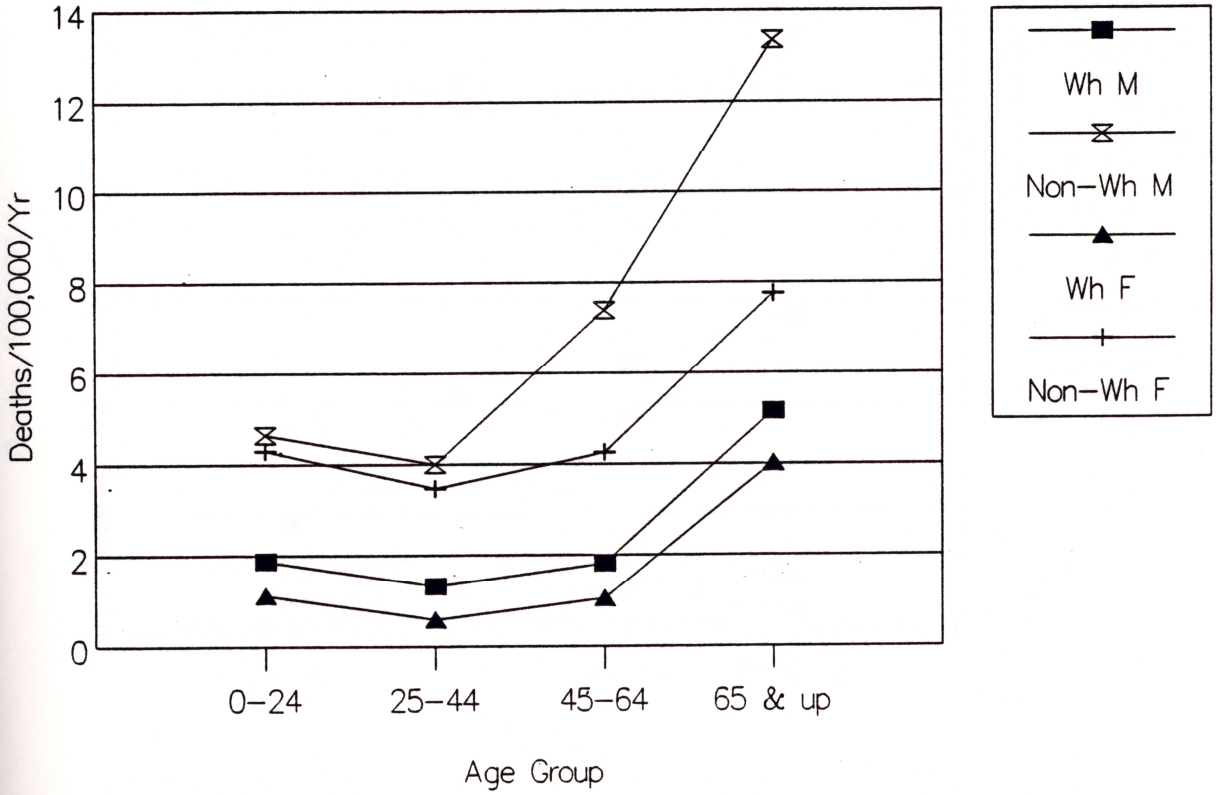
Based on the three year average, Non-white males (excluding 0-24 year age group) have the highest rate of mortality due to motor vehicle accident.

Fall Mortality by Age, Race, and Sex



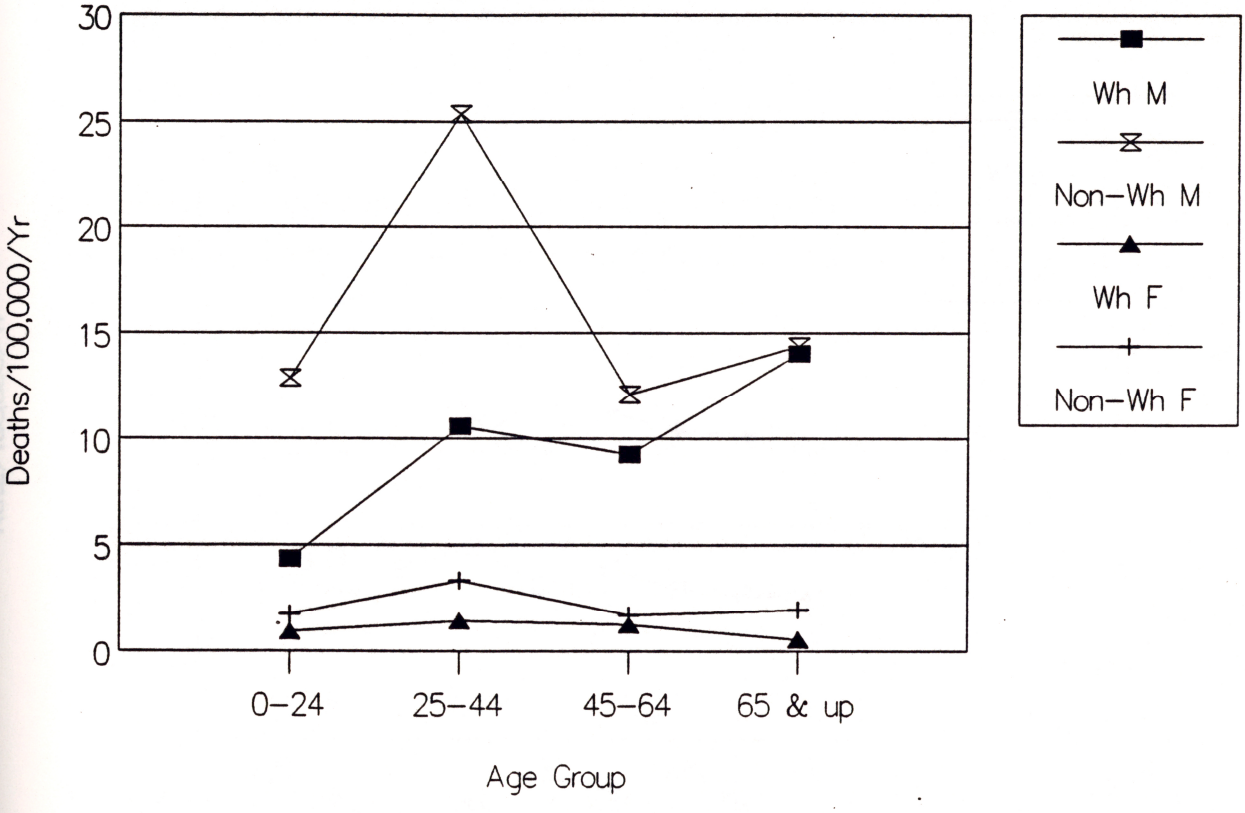
Based on the three year average, death due to fall is highest among Non-white males, ages 25-44 years and 45-64 years.

Fire Mortality by Age, Race, and Sex



Based on the three year average, death due to fire is highest among Non-white males, followed by Non-white females.

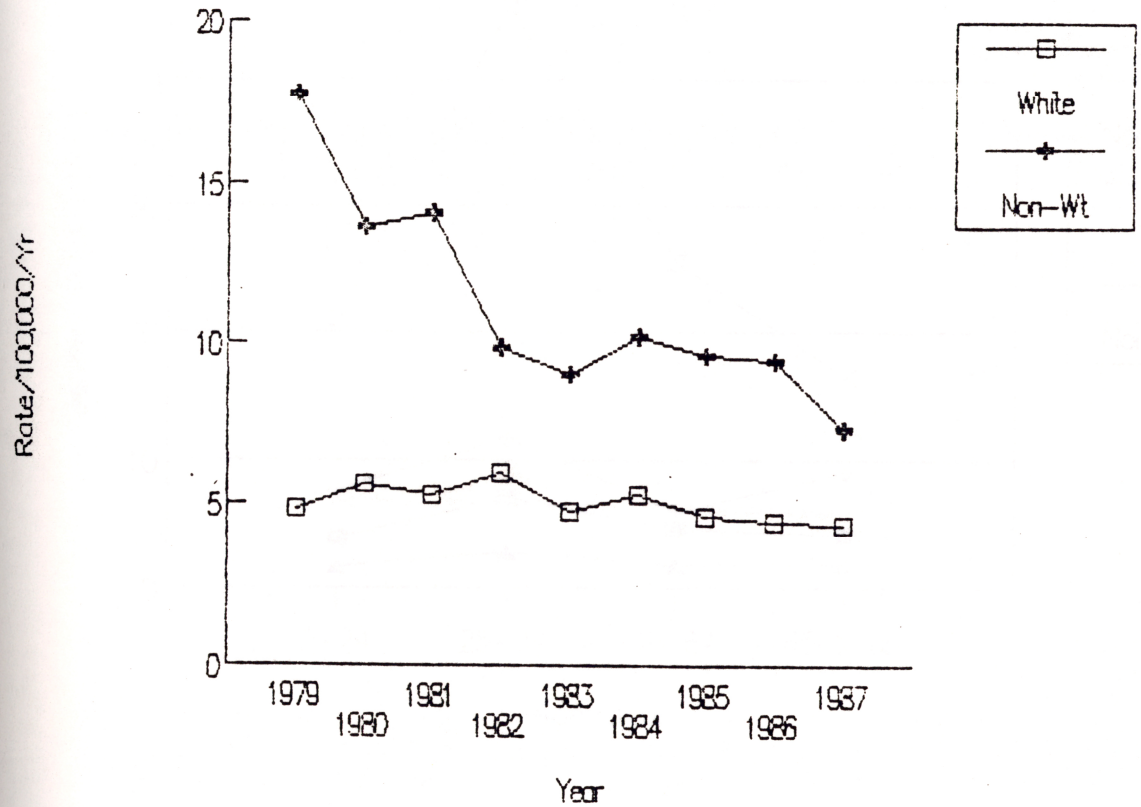
Guns Mortality by Age, Race, and Sex



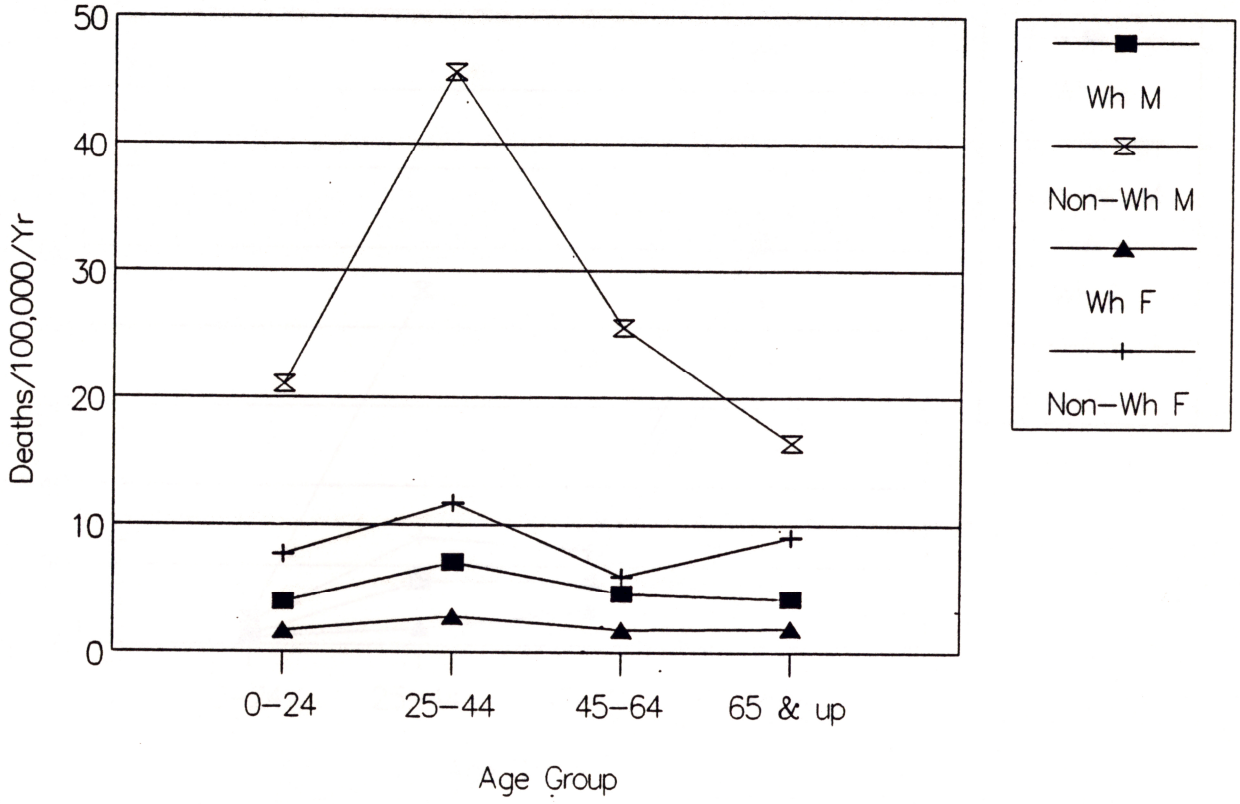
Based on the three year average, death due to gun is highest among Non-white males, except for ages 65+ years.

NJ Gun Death Rate 1979-87

By Race

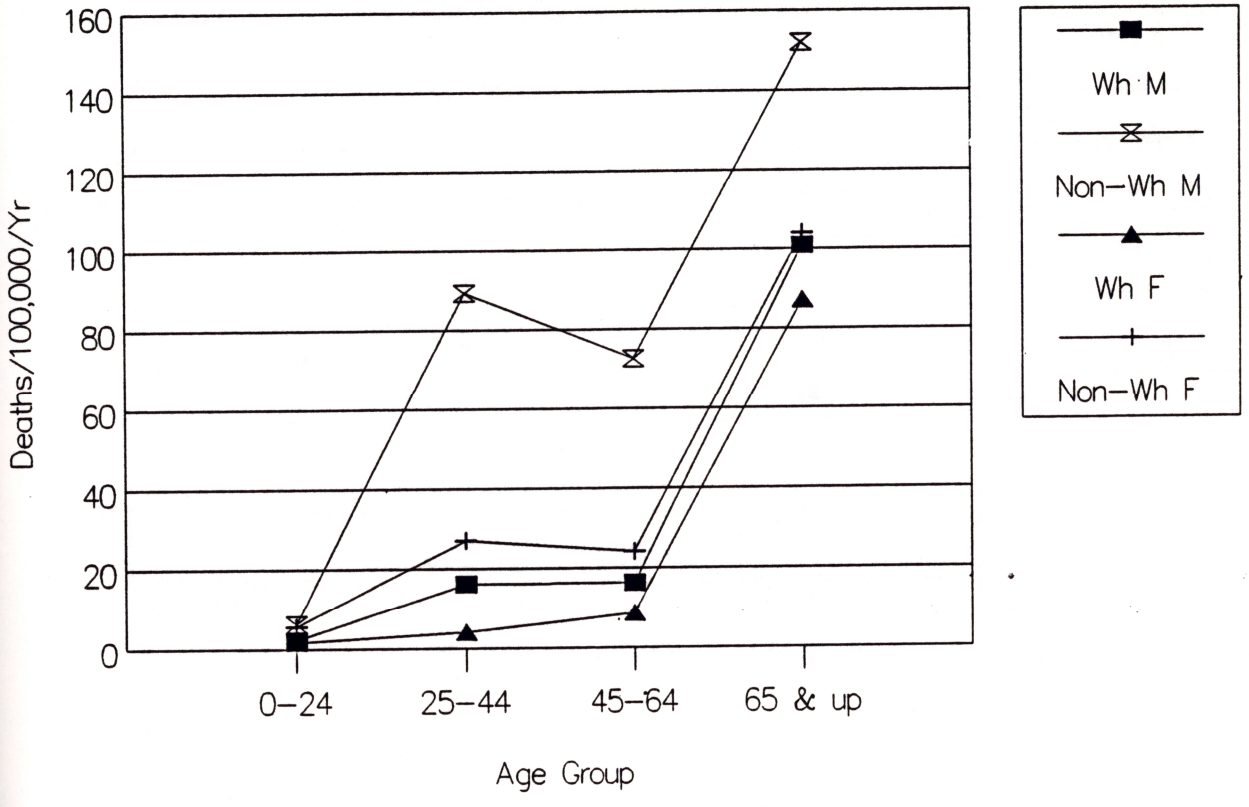


Homicide Mortality by Age, Race, and Sex



Based on the three year average, death due to homicide is highest among Non-white males, followed by Non-white females.

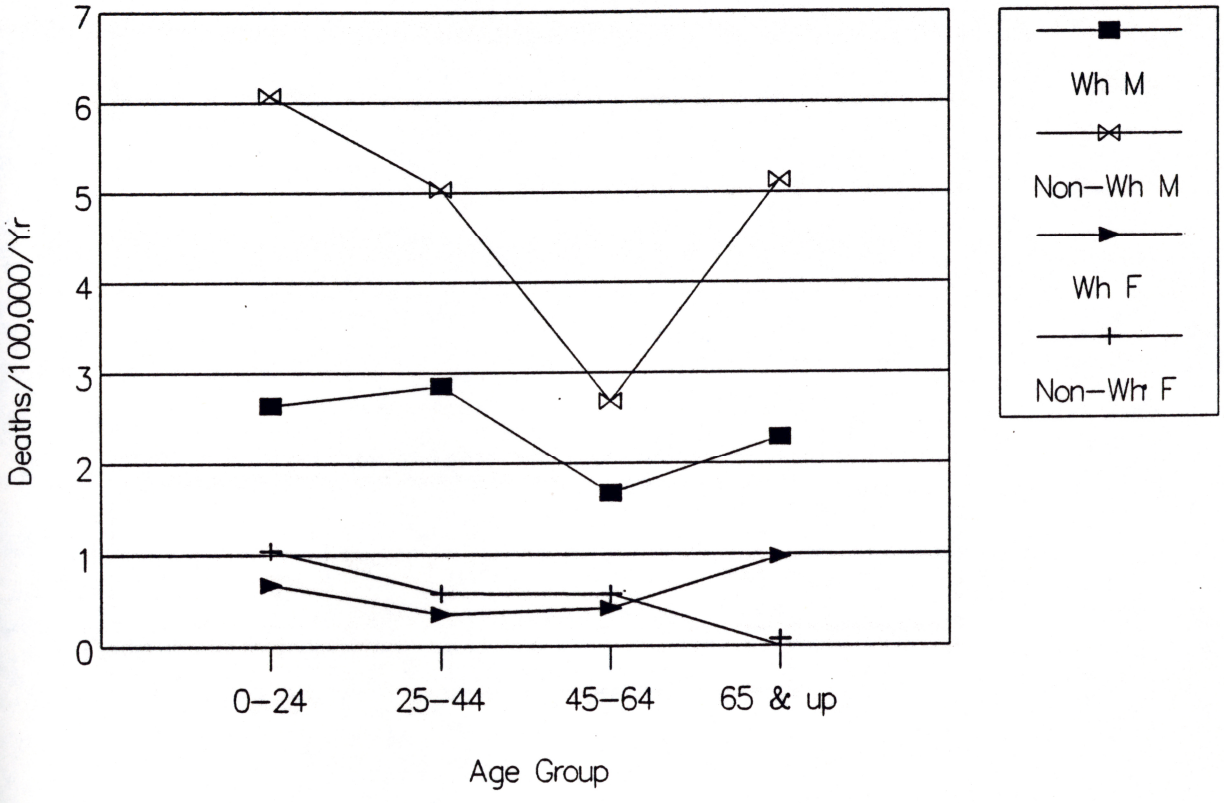
?* Intention Injury Mortality by Age, Race, and Sex



* Unknown

Based on the three year average, death due to unknown intention was highest among Non-white males followed by Non-white females.

Drown Mortality by Age, Race, and Sex



Based on the three year average, death due to drowning was highest among Non-white males.

Substance (Narcotics) Abuse

Background

- The sharp rise in admissions to drug treatment from 1979 to 1980 is attributed to the sharp rise in epidemic proportion of heroin use from several previous years.

- While all other race/sex groups admissions increased significantly from 1979 to 1980 the large admission increase for Black males appears to reflect a proportionally larger drug abuse epidemic for that group.

- In 1981, Federal funding was dramatically decreased for drug treatment and admissions fell; particularly for Black males.

- Black males and females were also negatively affected when client fees were established in order to offset Federal funding cuts.

- In 1987, a total of 15,644 clients were treated by New Jersey State Funded Treatment Centers. Racial breakdown was 49% White, 39% Black and 12% Hispanic.

- It is estimated that 154,000 drug abusers require treatment, and that on the average there are approximately 1,000 - 1,200 individuals (on a monthly basis) waiting treatment.

- White youth between the ages of 11-17 years enter treatment at a higher rate than Blacks and Hispanics.

- Hispanics between the ages of 21-30 enter treatment at a higher rate than Blacks and Whites.

- Blacks tend to seek treatment at the highest rate between the ages of 20-30.

- Hispanics and Blacks seek treatment later because of finances, insurance coverage and lack of family support systems.

- Two out of three Hispanic admissions are heroin users.

- Heroin admission among Blacks account for nearly 60% of all Blacks entering treatment.

- The percentage of Blacks entering treatment in 1987 for primary cocaine abuse was slightly lower than that of Whites and Hispanics. However the rate of Blacks entering treatment for crack use is more than three times that of any other group.

- Crack use, once considered an exclusive urban phenomenon has expanded to New Jersey's suburbs, but the rate continues to remain disproportionately high in New Jersey urban minority areas.

- Although minorities have a higher rate of heroin admissions than Whites, minorities are not admitted into methadone maintenance programs in comparative rates because of the cost involved in long term programs.

- Minorities choose the less expensive short term (detoxification) programs.

- Minorities have higher admission rates in drug-free residential programs.

- Research indicates that the criminal justice system plays an important role in providing treatment alternatives for minorities involved in criminal activities (Uniform Crime Report, State of New Jersey, 1987).

- Less than 30% of minorities admitted for treatment remain after the second week.

- Retention rates for minorities begin to decline at 1-2 months and continue through 4-6 months.

- Clinical studies reveal that treatment success is contingent upon the longevity in treatment. Therefore minorities leaving treatment to soon, minimize their chances of success.

Note: As information within this document is revised, it is the intent to also include data on mental health and illness, other forms of substance abuse, including adolescent use of "gate-way" drugs, and violence as a public health problem.

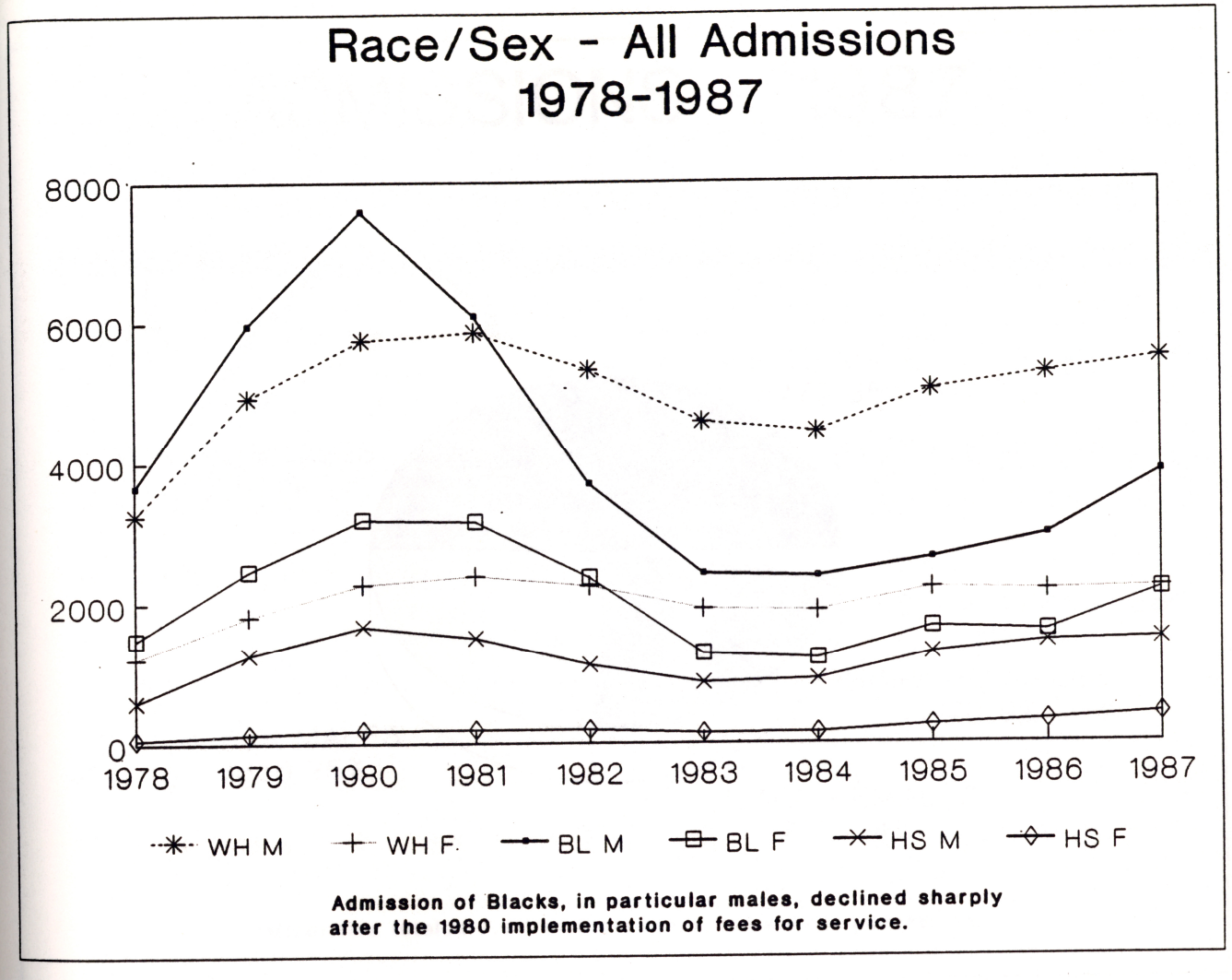
Program Description

The Division of Narcotics and Drug Abuse Control (DNDAC)

- Responsible for providing drug abuse treatment and prevention services in the State, and assuring services for all in need. As part of its effort, the Division has been directly responsible for and is now an indirect provider of funds to 71 treatment centers throughout the State. The majority of these programs are located in large, urban areas and service a large minority population.

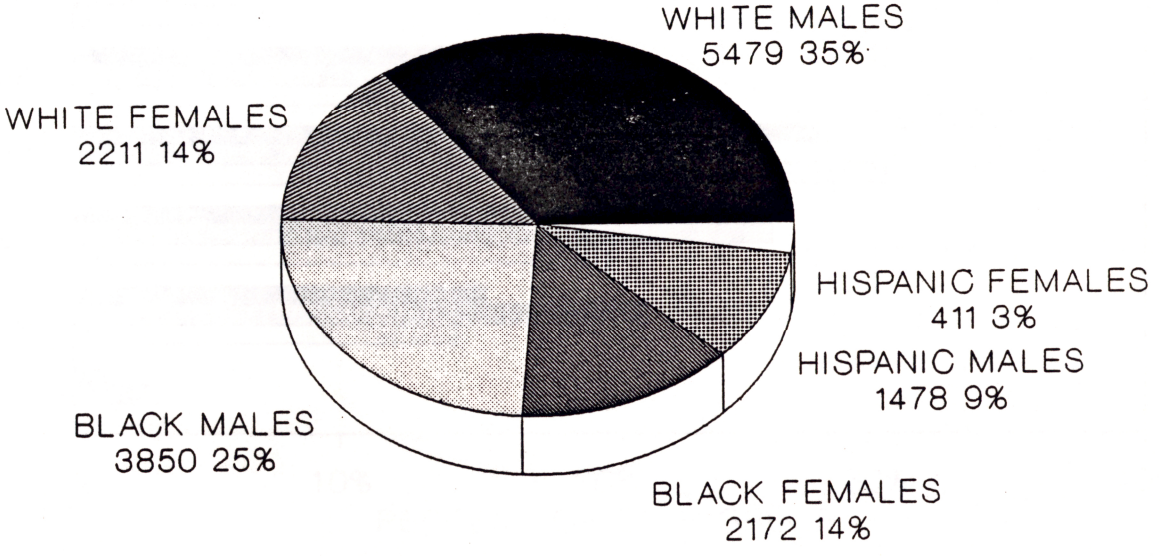
  The DNDAC Special Populations Unit is charged with paying particular attention to the needs of Blacks, Hispanics and other minorities as well as the special concerns of women who are involved with or affected by drug use. This activity is performed by attending to the inquiries of program clients, the organizing of conferences and educational sessions for program staff and community organization among Blacks and Hispanics toward eliminating or controlling drug use in particular areas or neighborhoods.

  Assessing client complaints and feeding back useful information to programs is a method of improving program attention to the legitimate needs of all clients. Of equal importance is the improvement of minority communities which have been organized to deal with health issues, including drug abuse.



Note: This chart reflects all admissions to State-funded programs. This does not reflect privately-funded agencies.

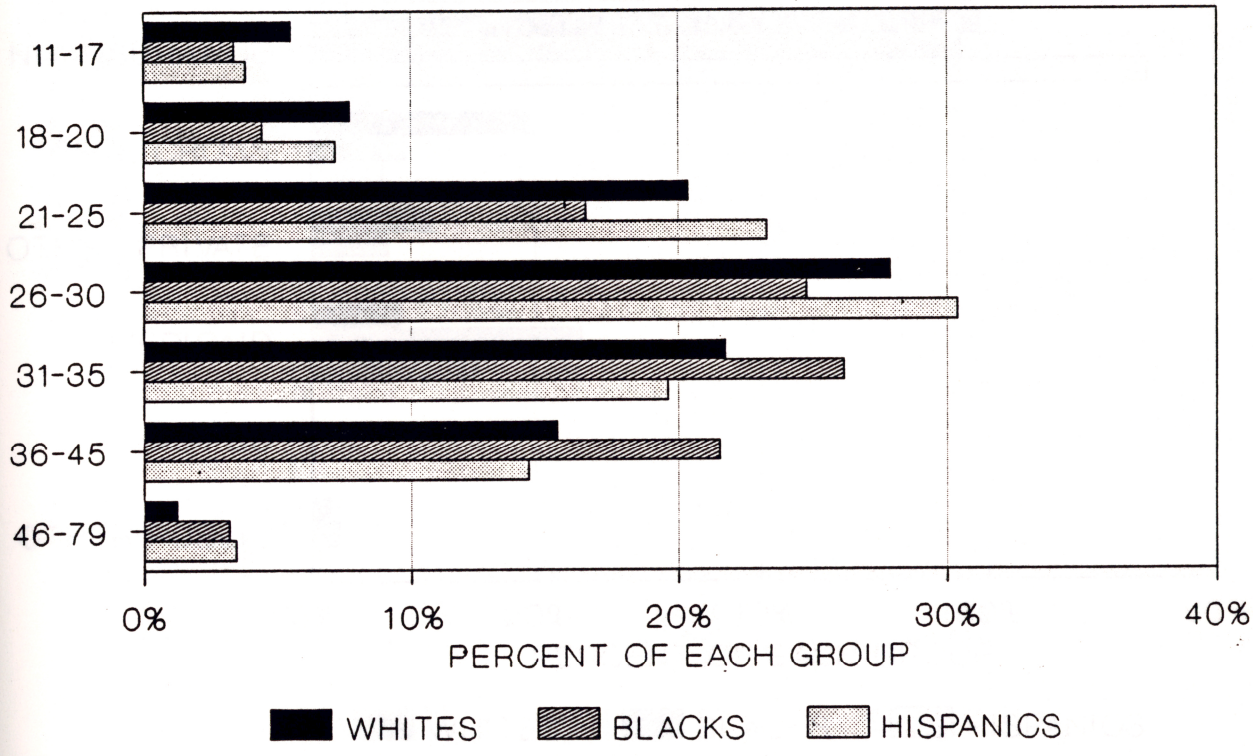
ADMISSIONS - 1987



Minorities totaled 7,911 of State funded treatment admissions.

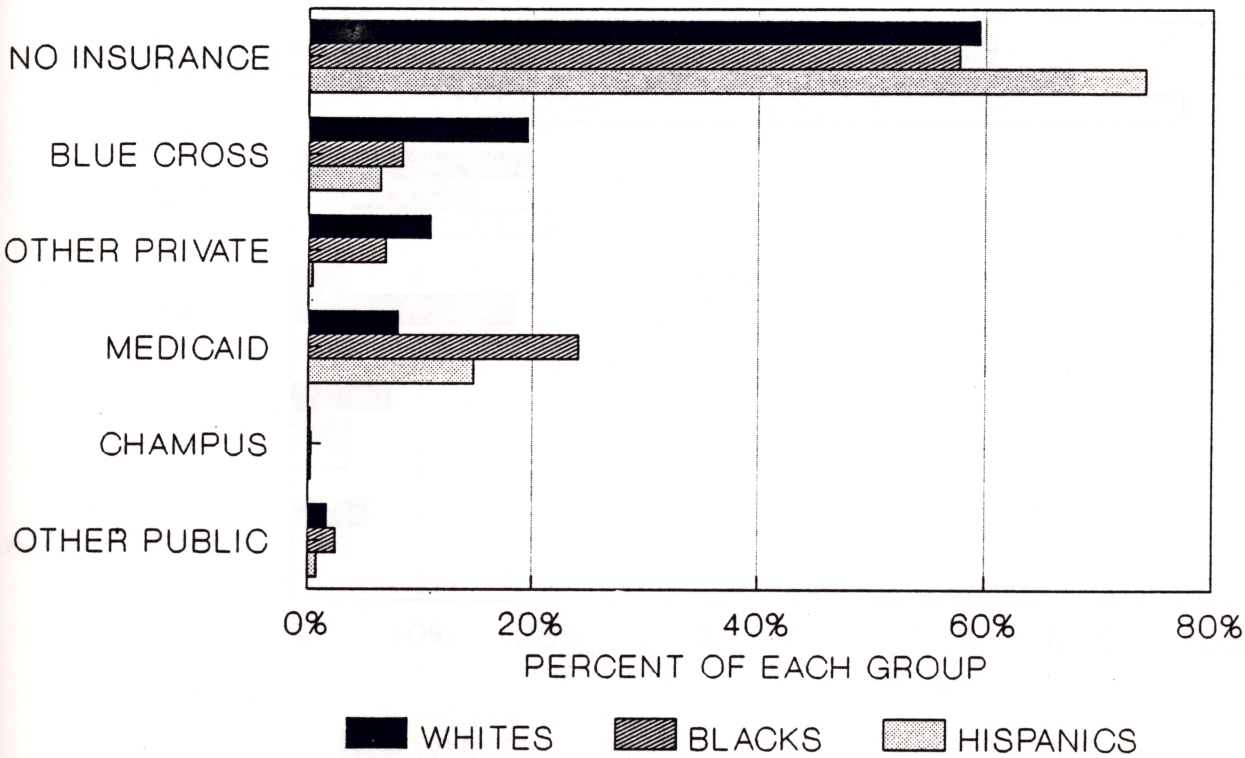
RACE-ETHNICITY BY AGE AT ADMISSION

1987 ADMISSIONS



Minority youths (ages 11 thru 17) are admitted to treatment at a lesser rate than that of Whites.

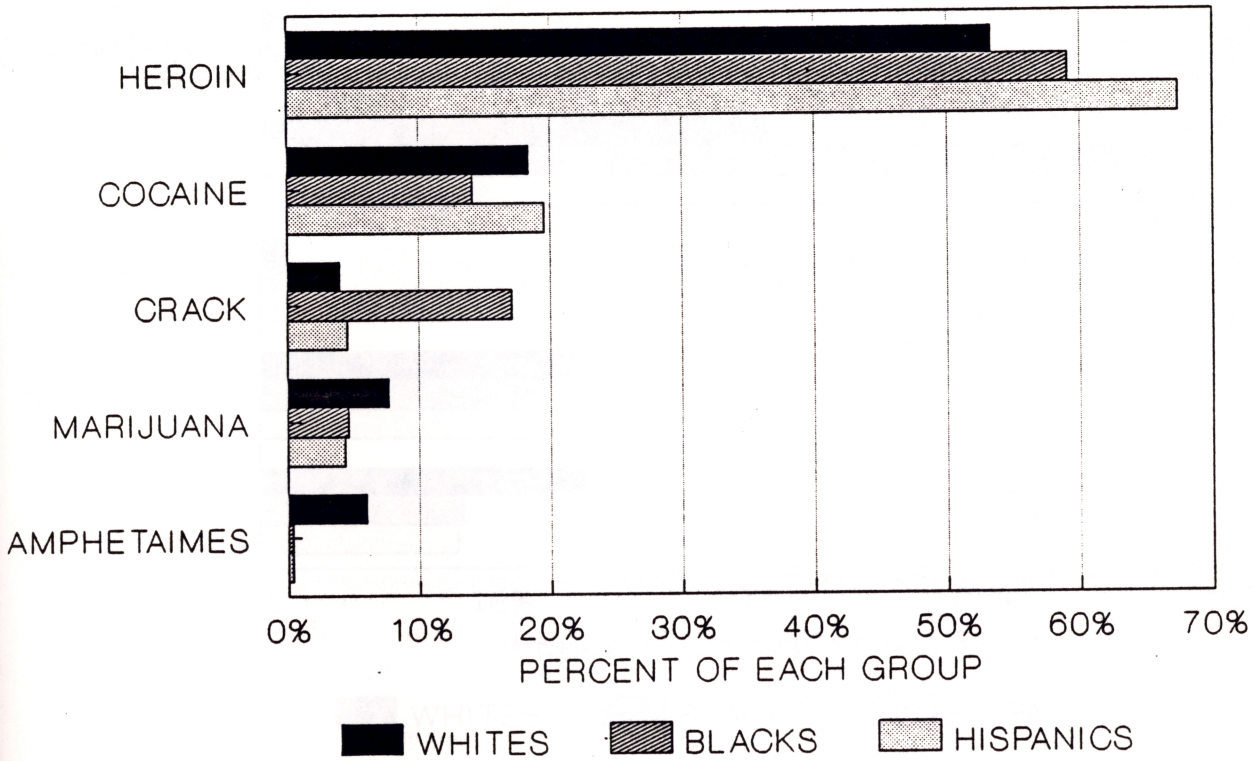
HEALTH INSURANCE STATUS
1987 ADMISSIONS



Minorities have higher rates of having no insurance and receiving public insurance such as Medicaid than Whites.

PRIMARY DRUG OF CHOICE

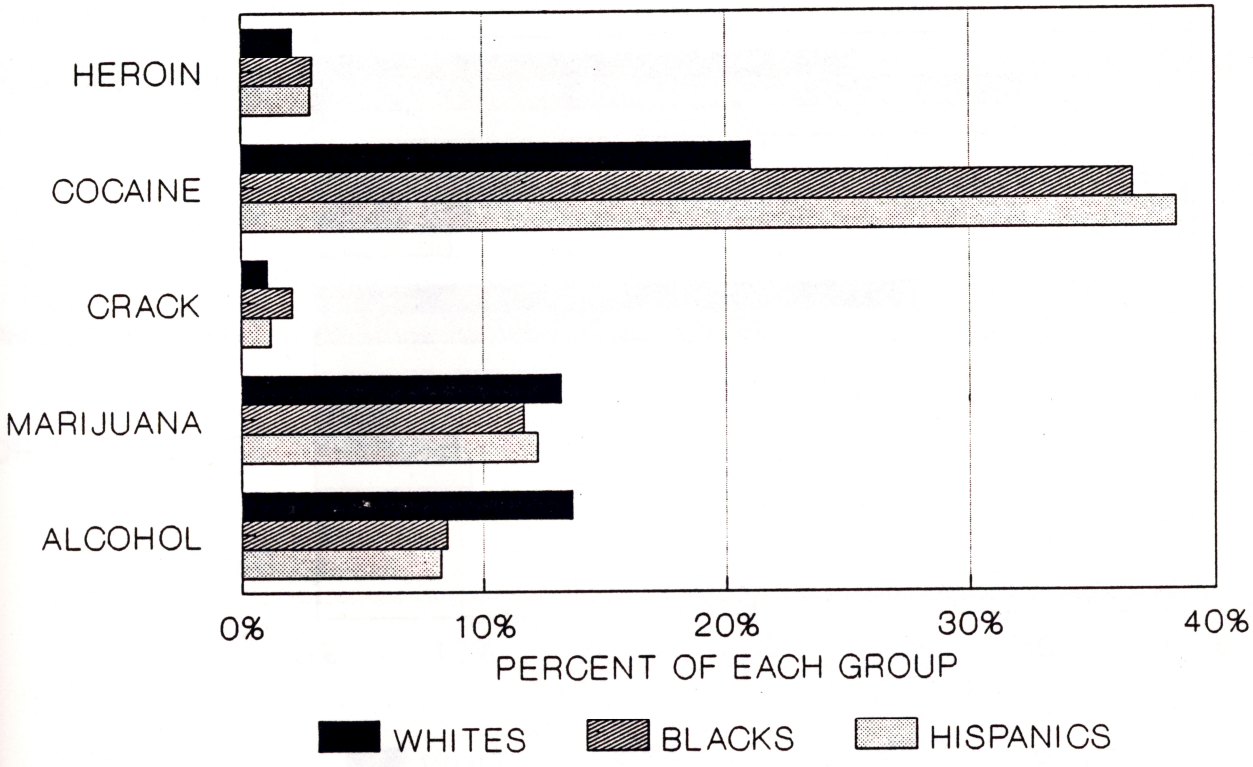
1987 ADMISSIONS - MAJOR DRUG TYPES



While heroin is the major primary drug of choice, minorities smoking cocaine in the highly addictive form of crack is particularly dramatic among Blacks.

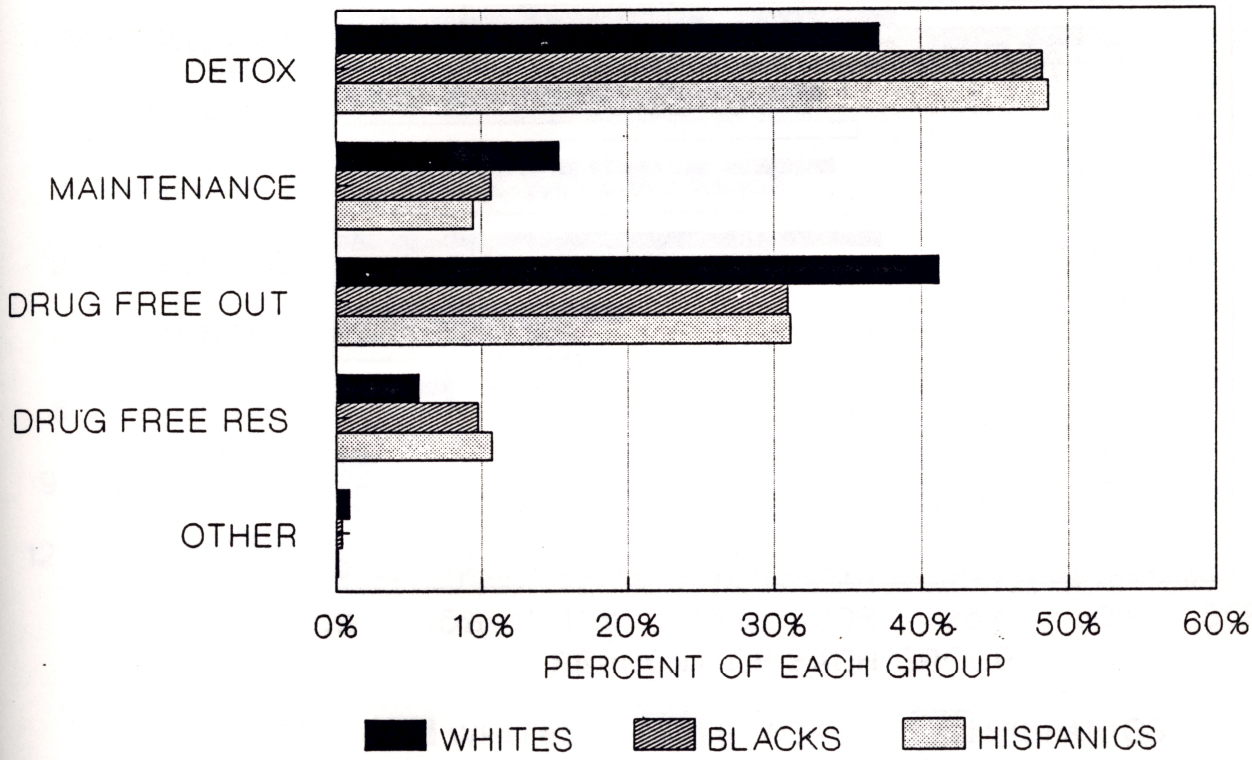
SECONDARY DRUG OF CHOICE

1987 ADMISSIONS - MAJOR DRUG TYPES



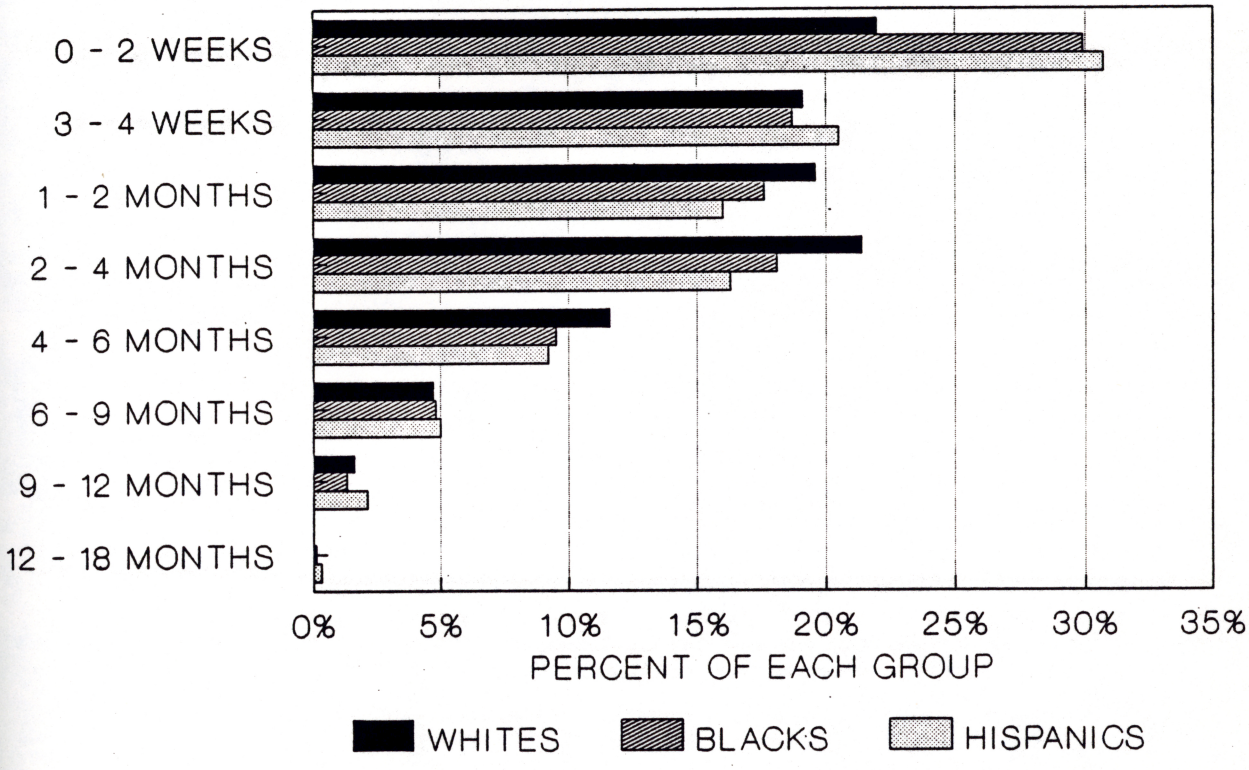
High rates of secondary cocaine use among minorities are of concern because of the drug's highly addictive nature.

MODALITY AT ADMISSION
1987 ADMISSIONS



Minorites choose the less expensive short-term program of detoxification.

TIME IN TREATMENT
1987 ADMISSIONS



A higher rate of minorities are discharged within the first two weeks of treatment than Whites.

Alcohol Abuse/Dependence

Background

- During 1987, admission rates of persons entering alcoholism treatment increased for all ethnic groups, however, proportionate increases for Blacks and Hispanics were greater.

- A total of 49,717 persons entered alcohol treatment programs in 1987, an increase of almost 10% over 1986 admissions. The racial breakdown was 66% White, 27% Black and 6% Hispanic.

- White admissions increased approximately 4%; however, both Black admissions increased by 23% and Hispanic admissions increased approximately 18%.

- It appears that Blacks and Hispanics tend to enter treatment at later ages (25-27 and 30-34) than Whites; suggesting that minorities have longer periods of problematic drinking before treatment intervention.

- Hispanic females compared to Whites and Blacks are in treatment in proportionately smaller numbers.

- Although male treatment admission tend to exceed Blacks and Hispanics almost 3 to 1, Blacks enter treatment older, more debilitated and with fewer resources.

- Black and Hispanic had more legal problems than Whites upon entering treatment, particularly probation and other pending legal actions.

- Unemployment was disproportionately high among Black and Hispanic admissions; almost 5-10% higher than Whites.

- Admission statistics show an overwhelming number of Black and Hispanic clients in treatment with no viable health insurance coverage.

- Information collected through varied sources on a small sample of admissions indicate that Black clients, especially come into the treatment system with additional varied health problems such as tuberculosis, carcinoma, anemia, delirium tremens, mixed drug dependence and major depression.

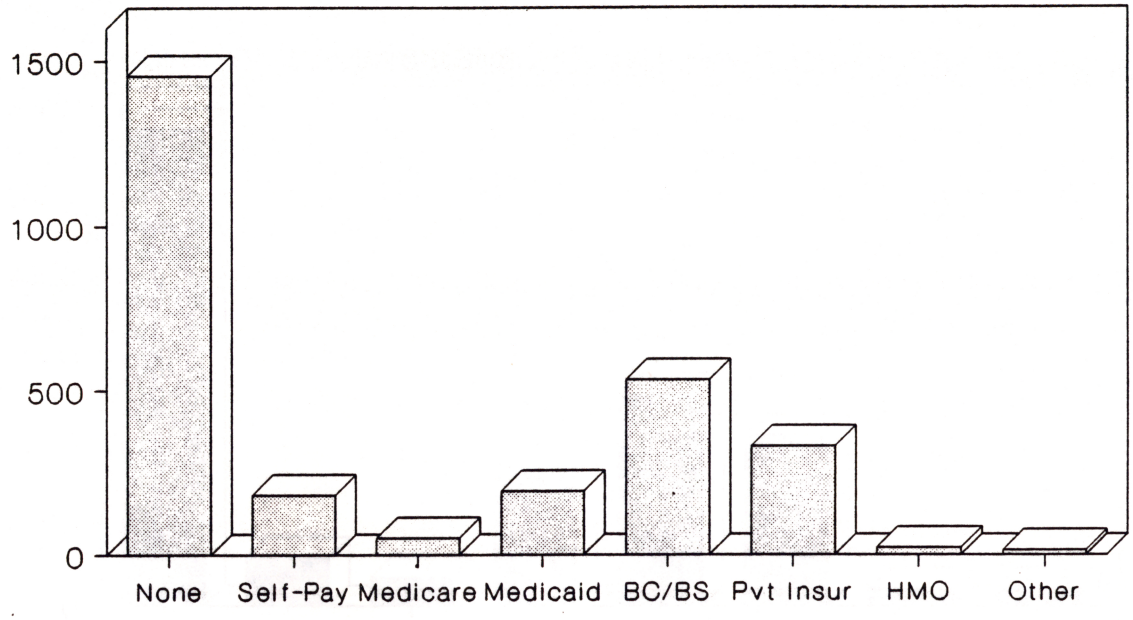
Note: As indicated in the Substance Abuse Section, future revisions to this document shall include data on mental health and illness, other forms of substance abuse, and violence as a public health problem.

Program Description

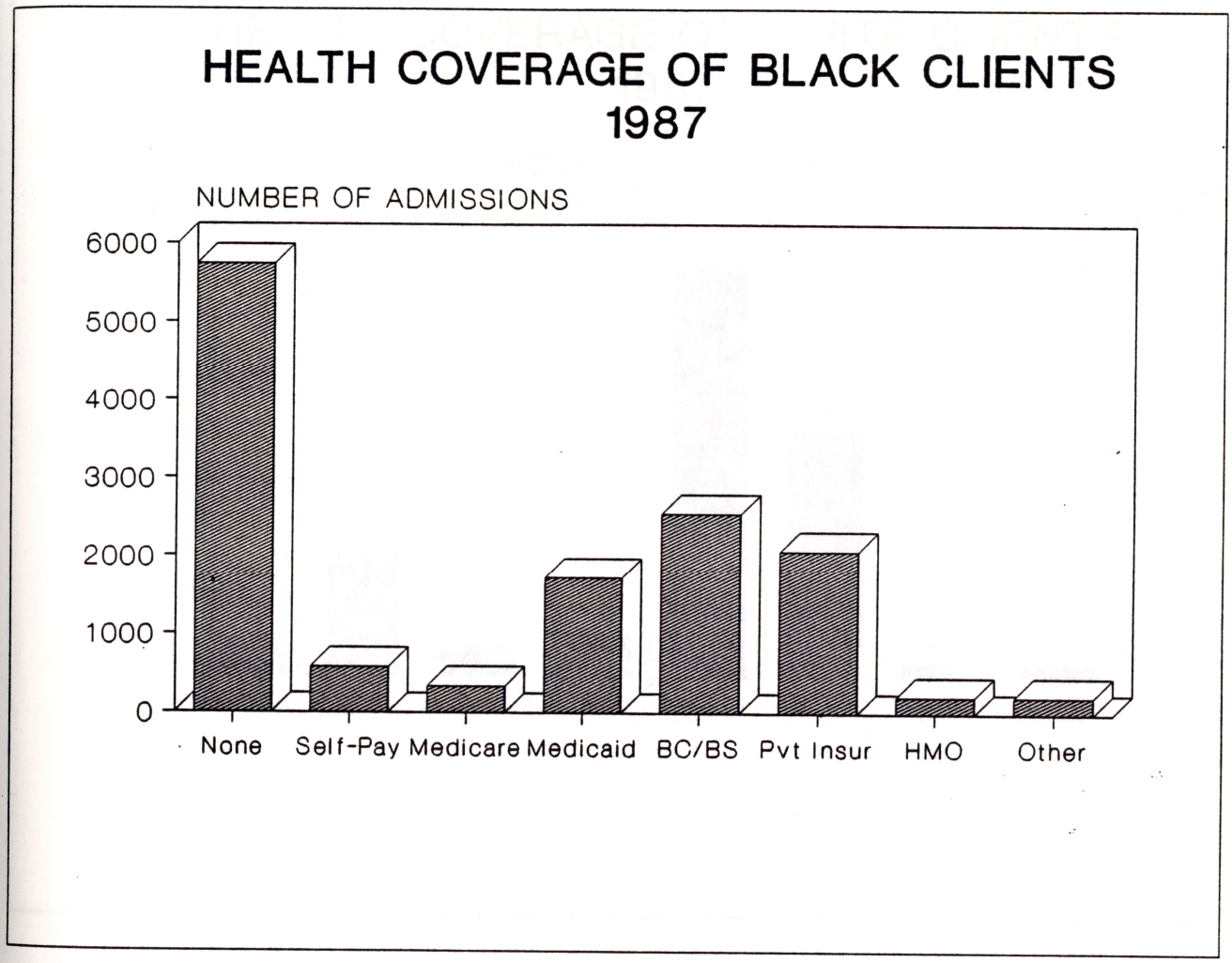
The New Jersey Division of Alcoholism (DOA)

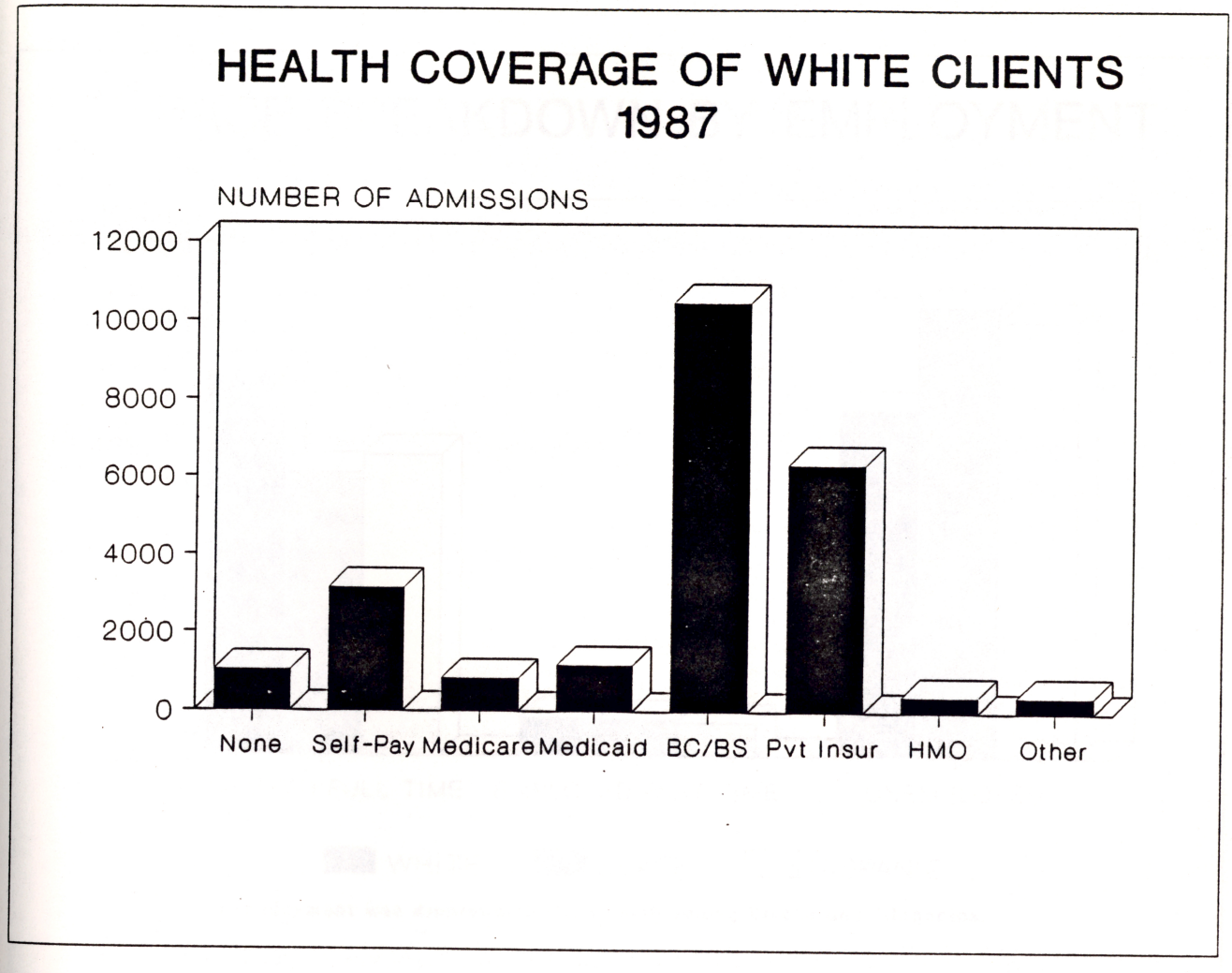
- Responsible to plan, develop and administer state funds for establishing alcoholism education and treatment services within the state's twenty-one (21) counties. As part of its planning process DOA places particular emphasis on trying to assess service needs of special populations which includes ethnic minorities (Blacks, Hispanics, American Indians, and Asians).

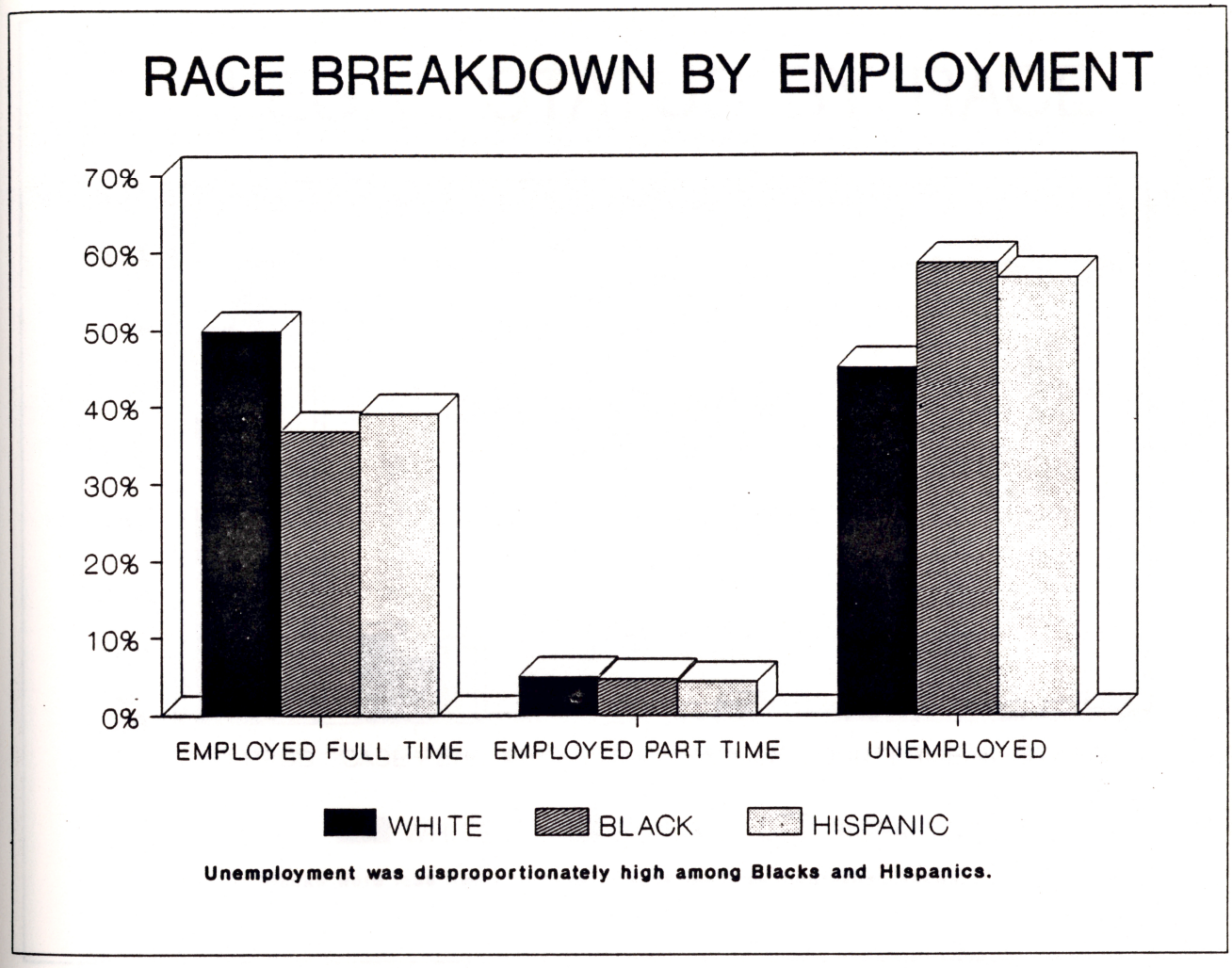
HEALTH COVERAGE OF HISPANIC CLIENTS
1987



Compared to Whites, Blacks and Hispanics are considerably more likely to have no health coverage.

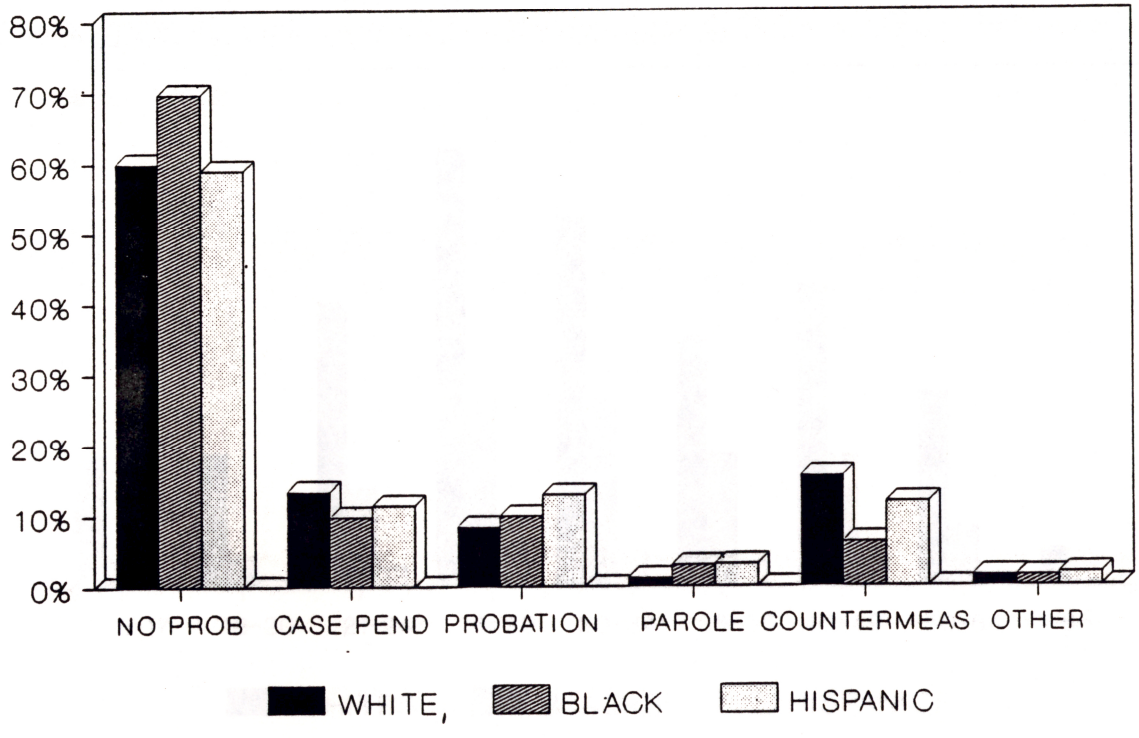

HEALTH COVERAGE OF BLACK CLIENTS
1987
NUMBER OF ADMISSIONS
6000
5000
4000
3000
2000
1000
0
None
Self-Pay
Medicare
Medicaid
BC/BS
Pvt Insur
HMO
Other


HEALTH COVERAGE OF WHITE CLIENTS
1987
NUMBER OF ADMISSIONS
12000
10000
8000
6000
4000
2000
0
None
Self-Pay
Medicare
Medicaid
BC/BS
Pvt Insur
HMO
Other



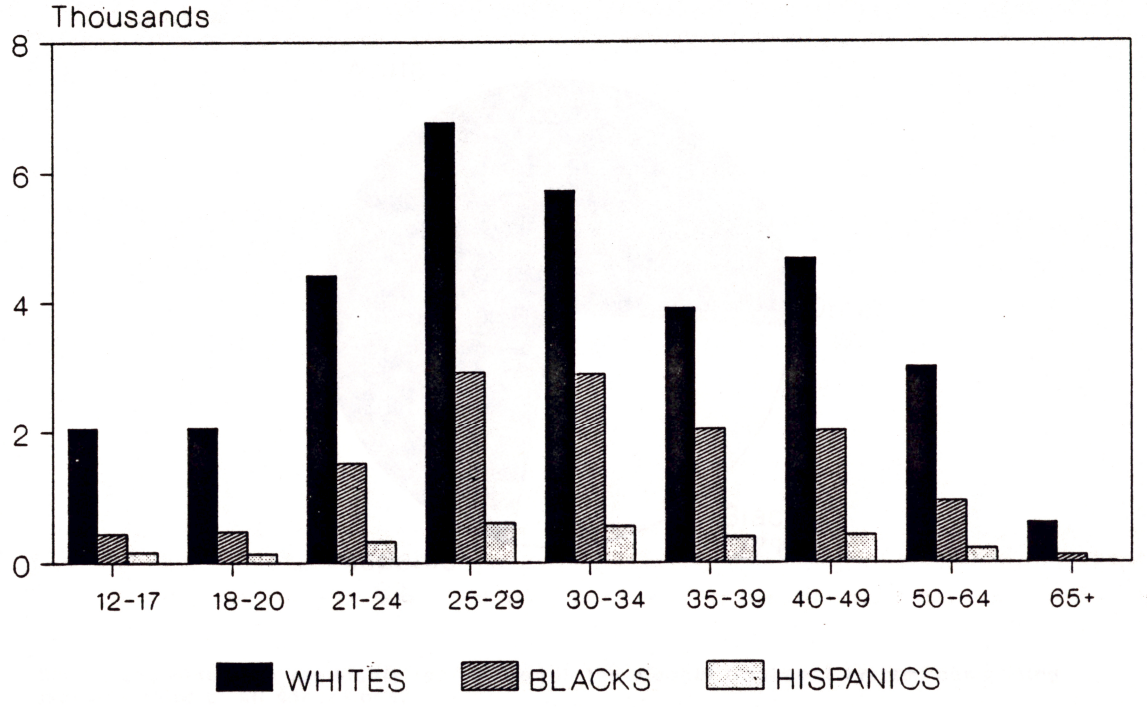
Unemployment was disproportionately high among Blacks and Hispanics.

LEGAL STATUS BY RACE



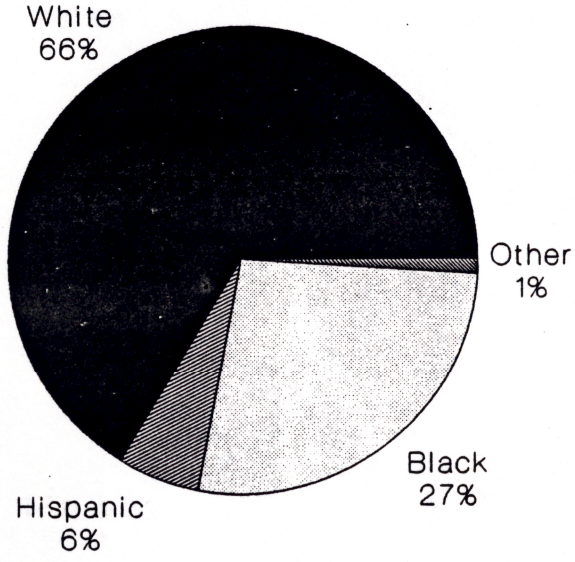
Blacks were less likely to have a legal problem than other races.

CLIENTS BY AGE/RACE ETHNICITY
1987



Blacks and Hispanics tend to enter treatment at later ages than Whites.

CLIENT RACE/ETHNICITY
1987



Blacks and Hispanics are highly represented in the alcohol treatment system, comprising over one-third of all admissions.

Access to Care: Minority Health

Background

Emergency Medical Services

- A 1985 New Jersey study of cardiac arrest survival rates showed a statistically significant difference in survival to admission for Blacks in comparison to Whites. For the sample of 2,124 cases, the survival rate to hospital admission was 19.7% for Whites and 11.4% for Blacks.

Long-Term Care

- In 1985 there were 32,136 occupied long term care beds. 92% of the beds were occupied by persons 65+ years. The racial breakdown for the occupants was 87% White, 7.6% Black, .06% Hispanic, and 5.34% Other/Unknown.

- For fiscal year ending 1987, a total of 5,577 recipients received Medicaid-funded services in skilled nursing facilities. 86.5% of those services were received by persons of all races, age 65 and over. The racial breakdown was 84% White, 11% Black, 0.06% Hispanic and 4.94% Other/Unknown.

- The percentage of Medicaid expenditures by race were 79% White, 14% Black, 1% Hispanic and 6% Other.

- Blacks in New Jersey appear to have access to and utilization of long term care services in proportion to their representation in the general population. Hispanics, however, are underrepresented in terms of both services and public expenditures.

- An informal survey is currently being completed with the assistance of the social work directors of five urban hospitals: UMDNJ, Newark Beth Israel, Our Lady of Lourdes, Robert Wood Johnson and Mercer Medical Center. The purpose of the survey is to obtain information on patients awaiting nursing home placement, by age, race, length of wait and insurance coverage. Data are being collected for the first quarter of 1989.

Emergency Department Utilization

- Conversations with numerous health care professionals highlight the following factors affecting access to care:

  - few primary physicians in inner city

  - problems in quality of care

  - inappropriate utilization of hospital emergency departments because they are accessible.

- A prospective study has been proposed to the N.J. Chapter of American College of Emergency Physicians. A draft survey and cover letter follows in the Appendix.

Minority Physician Education

- Minority graduates of UMDNJ Medical Schools and the School of Osteopathic Medicine represented 16% of the total graduates during 1983 to 1988.

- Minority graduates of the UMDNJ Dental School represented 19% of the total graduates during 1983 to 1988.

- Minority graduates of the UMDNJ Graduate School of Biomedical Sciences represented 18% of the total graduates during 1983 to 1988.

Program Description

Health Care Program for the Uninsured

- With the exception of the Organ Transplantation Program, the regulatory programs of the New Jersey Department of Health are not targeted to minority population, but to the population as a whole in addressing such issues, as access and availability of quality and affordable health care. Developing innovative strategies to providing coverage to the uninsured is given high priority consideration by the Department's Administration.

  The uninsured issue is important for minorities. Data on a national level show that the uninsured rate for minorities is substantially higher than for Whites. In 1987, 23.6% of the Black population was uninsured; 14.3% of the White population was uninsured and 20.1% of Other (including Hispanic) were uninsured. (Catherine Swartz, Ph.D., The Urban Institute, Personal Communication, January (1989).

  New Jersey's long-standing strategy for assuring and financing care for the uninsured is to include the cost of uncompensated care in hospital payment rates. This policy has been in effect since 1980 with important beneficial results. The poor, minorities, and those who lack health insurance have significantly better access to health care in New Jersey than do low income and uninsured persons in the nation as a whole, according to a recent nationwide study funded in part by the Robert Wood Johnson Foundation in Princeton and conducted by researchers at the University of California, Los Angeles, and the University of Illinois.

  For the past eight years, New Jersey's hospital payment system has permitted hospitals to add to the bills of their paying patients the cost for inpatient and outpatient care provided to uninsured poor persons. According to the State law which enacted New Jersey's all-payer hospital rate setting system, the cost of care provided to medically indigent persons (charity care) and the cost of bad debts may be included in each hospital's rates, which are then paid by all purchasers of hospital coverage in New Jersey.

  In January 1987, Governor Thomas H. Kean strengthened this system which pays for uncompensated care and made it more equitable when he signed a law creating the Uncompensated Care Trust Fund, through which the costs of indigent care are more equitably distributed to hospitals statewide. Though all hospitals were already guaranteed reimbursement for their uncompensated care under an already existing law (P.L. 1978, c.83) which is still in effect, the new law changed the collection and distribution of the funds. The more recent law does not change the source, amount, or use of uncompensated care funds.

  The primary objective of the legislation was to spread the cost of uncompensated care more evenly and more equitably across hospitals in the State. Before this legislation was passed, all uncompensated care reimbursement was hospital-specific. Each hospital collected through its own rates the funds to pay for its own uncompensated care. Uncompensated care add-ons ranged from a low of 1% to a high of 25%. Hospitals with a disproportionately high number of uninsured and low-income patients had to add higher-than-average uncompensated care charges to the bills of their paying patients, putting these hospitals at a competitive disadvantage compared to hospitals that had very low numbers of uninsured poor patients.

Under the new law, all hospitals use the same statewide uncompensated care add-on to the bills of their patients - the overwhelming majority of whom are insured. This uniform add-on (currently at 10.5%) replaces the 88 hospital-specific add-ons across the State. All 88 acute care hospitals in the State continue to be paid for the amount of uncompensated care which they provide, and all collect money through their rates via the statewide add-on. Approximately two-thirds of the State's hospitals provide a lower-than-average volume of uncompensated care and forward part of what they collect - their "excess" (the difference between the statewide add-on which they collect through their rates and their own approved uncompensated care expenses) - to the Trust Fund. The Trust Fund then redistributes this money to the remaining one-third of the State's hospitals that provide a higher-than-average volume of uncompensated care.

New Jersey's system works, in part, because it removes the financial disincentives hospital have historically faced in serving poor or uninsured persons. In addition, its success is due to sustained, strenuous, and cooperative efforts of hospital managers and boards of trustees, the major payers of hospital care, the Governor, and the legislature.

From an administrative point of view, the Trust Fund has been an unqualified success. Because all hospitals collect some funds for uncompensated care and all have a need for at least some of what they collect, the Trust Fund itself must handle (transfer) only about one-fifth of the total. This still comes to $7 million each month; however, all transactions are handled electronically, so administrative costs are minimal. The administrative cost of an expanded audit of hospitals' reported uncompensated care.

In addition to the Trust Fund, the Department of Health has pursued other initiatives related to uncompensated care. With the help and guidance of the Steering Committee on Health Care Services and Financing for the Uninsured, which began meeting in mid-1986, the Department has:

- Expanded and expedited the audit of hospital collection efforts and bad debt reporting practices;

- Initiated two demonstration projects aimed at reducing the cost of ambulatory care to the uninsured;

- Developed and adopted regulations setting new standards for cost-effective delivery of ambulatory services;

- Studied the uninsured population in New Jersey and the reasons people lack insurance; and

- Studied the range of options for expanding insurance coverage and for financing uncompensated care.

In addition to these efforts, the Department has convened and worked with the Trust Fund Advisory Committee. This group was created by the Trust Fund legislation and was charged in that statute with the responsibility of recommending to the Commissioner alternative methods of financing uncompensated care.

After careful examination by the Trust Fund Advisory Committee of numerous potential options and approaches to financing the care of the uninsured, only a limited number appear to be minimally feasible in New Jersey and no single solution is sufficient by itself. These options include:

Maintaining the Trust Fund; increasing the State's contribution by maximizing Medicaid coverage; expanding and intensifying cost containment efforts; maintaining/strengthening an "open enrollment" insurance product available to individuals and small groups; more appropriate pricing of ambulatory services to the uninsured; and subsidizing purchase of insurance by low-income individuals and employers of low-income individuals.

In accordance, with the law establishing the Uncompensated Care Trust Fund, P.L. 1986, c. 204, Commissioner of Health, Molly Joel Coye, M.D., M.P.H., issued a report in September 1988 on the cost and effectiveness of the Trust Fund, and proposed the following recommendations:

1. Continue the Trust Fund;

2. Develop a Pilot Program to Increase Private Insurance Coverage in New Jersey;

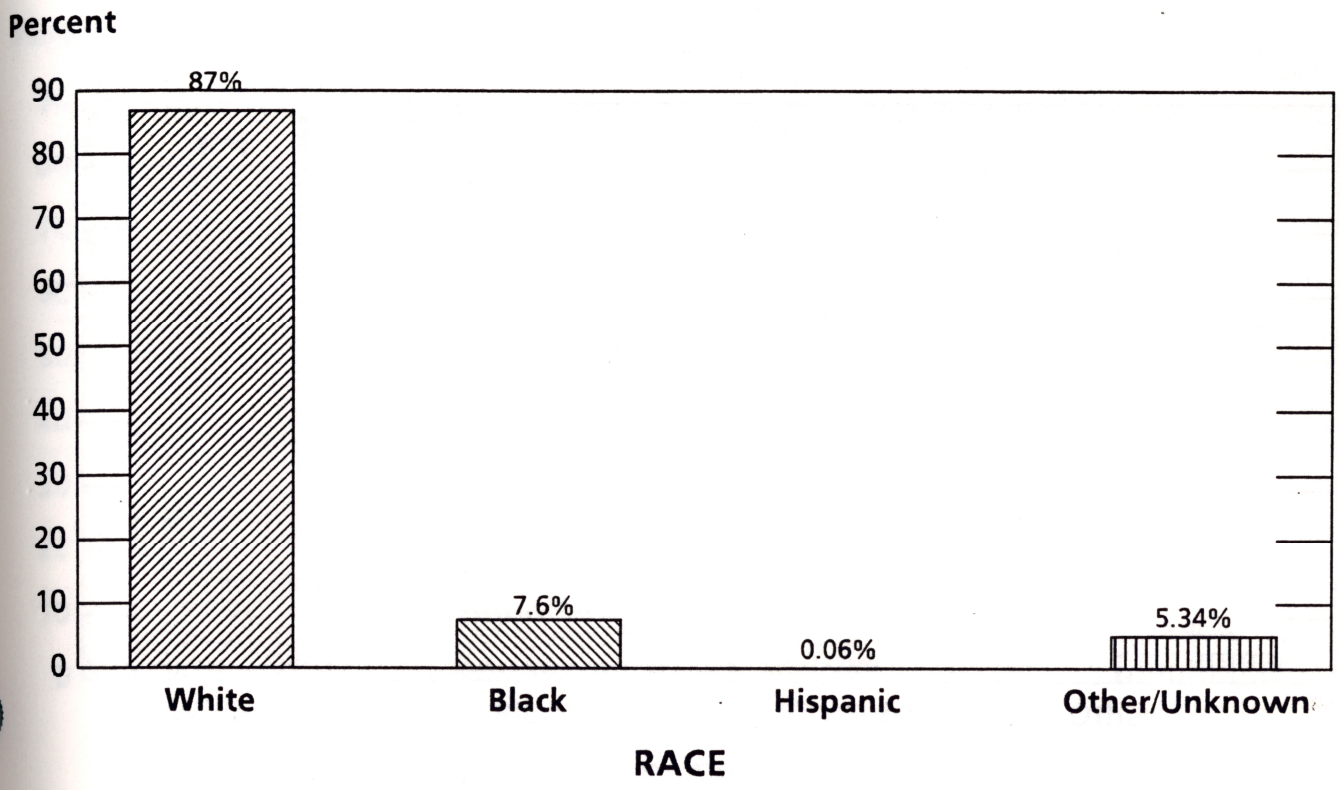
3. Establish Statutory Standards for Hospital Credit and Collection Policies;

4. Establish a Two-Tier Emergency Room Rate;

5. Require College Students to Obtain Health Insurance; and

6. Initiate an Employer Education Program on Health Insurance Premiums.

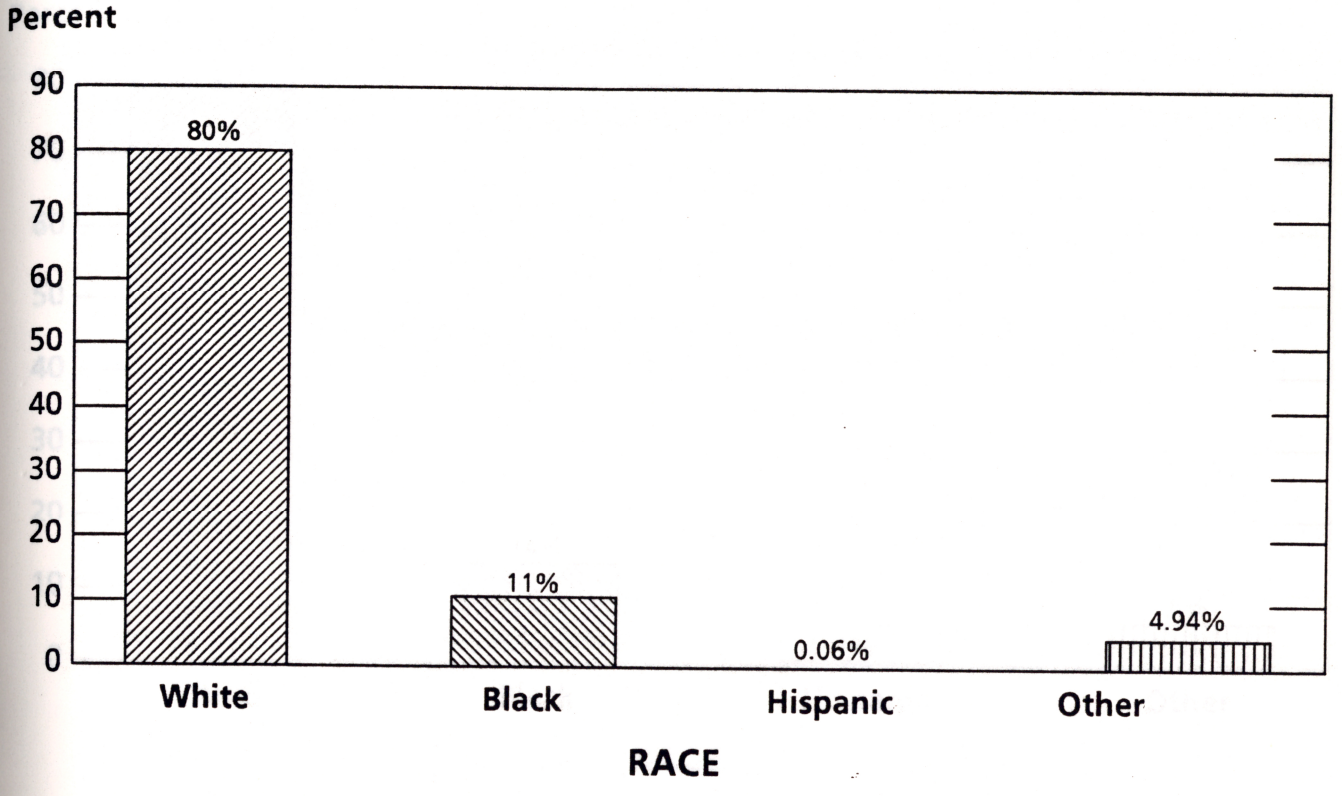
LONG TERM CARE
BED UTILIZATION 1985



η = 32,136 beds

The Black population appears to have access to and utilization of long term care services in proportion to their representation in the general population. Hispanics, however, are underrepresented in the utilization of services.

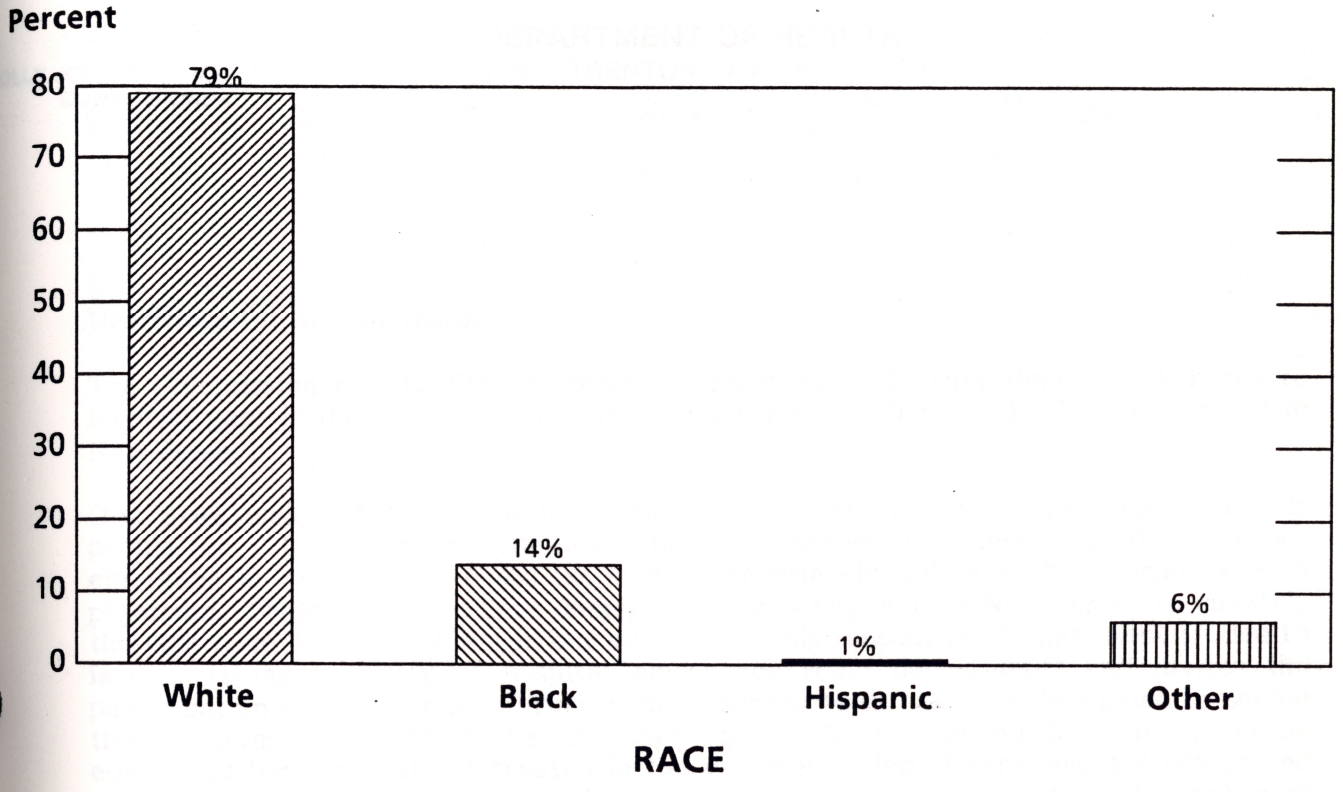
MEDICAID RECIPIENTS 1987



η = 5,577 recipients

There appears to be an underrepresentation of Hispanics who are Medicaid eligible recipients.

MEDICAID EXPENDITURES 1987



State of New Jersey

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

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

Dear Hospital Administrator:

The Commissioner of Health has recently appointed a Minority Health Task Force to identify gaps in the delivery of health care services to blacks and ethnic minorities in New Jersey.

One area under study is the utilization of emergency room departments by this population. In numerous instances, the care needed by these individuals is not emergent in nature, and could be more appropriately delivered by a primary care physician. Presently, there is no demographic data available in New Jersey to quantify the existence of this problem in our state. For this reason, the Department of Health is undertaking a survey of hospital emergency room departments and invites the participation of your facility. The enclosed survey form has been developed to enable the Department to obtain the necessary data. It is intended that this form be completed for each patient treated in the emergency department during a designated survey period, by either the attending physician or primary nurse. A staff member of the Department will be contacting your Emergency Department directly to discuss the study in more depth.

The Department hopes your institution will be interested in participating in this data collection effort. The information collected will be most useful in the next phase of the Commissioner's Minority Health initiative. Thank you.

Sincerely,

Neil Weisfeld
Director
Licensure Reform Project

Enc.

New Jersey Is An Equal Opportunity Employer

EMERGENCY DEPARTMENT UTILIZATION SURVEY

Registration Time (check one):

_____ 8 AM - 4 PM
_____ 4 PM - 9 PM
_____ 9 PM - 8 AM

Patient Age (check one):

_____ Under 6 years
_____ 6 to 17 years
_____ 18 to 44 years
_____ 45 to 64 years
_____ 65 years and older

Sex: _____ Male
_____ Female

County: _____

Payment (check one):

_____ Private Insurance/HMO
_____ Medicaid
_____ Medicare
_____ Uninsured

Race/Ethnicity (check one):

_____ White
_____ Black
_____ Hispanic
_____ Asian
_____ Other

Diagnosis or ICD-9-CM Discharge Code: _____

Patient's chief complaint (choose the main complaint):

_____ Abdominal pain
_____ Alcohol/drugs
_____ Anxiety/psych
_____ Assault/abuse (not rape)
_____ Blood pressure
_____ Chest pain
_____ Dermatologic condition
_____ EENT symptoms
_____ Headache
_____ Medication renewal
_____ Pregnancy
_____ Rape
_____ Seizure/syncope
_____ Shortness of breath
_____ Toothache
_____ Trauma related (general)
_____ Upper respiratory
_____ VD
_____ Other

Patient's ability to access medical care (choose one):

_____ Has private doctor
_____ Clinic patient
_____ No doctor or clinic

Disposition of case (choose one):

_____ Admitted to hospital
_____ Transferred to another facility
_____ Treated and referred
_____ Not treated and referred
_____ Not treated or referred

UMDNJ - NEW JERSEY MEDICAL SCHOOL

Minority Graduates

(1983 - 1988)

GRADUATION YEAR:	1983	1984	1985	1986	1987	1988	TOTALS
Total No. of Graduates:	161	157	159	152	147	165	941
Total No. Minority Graduates:	37	28	31	26	21	32	175
Number of Black Minorities:	23	14	16	18	10	17	98
% of Minority Graduates:	23%	18%	19%	17%	14%	19%	19%
% of Black Graduates:	14%	9%	10%	12%	7%	10%	10%

Source: UMDNJ, Department of Urban and Community Affairs

UMDNJ - ROBERT WOOD JOHNSON MEDICAL SCHOOL (CAMDEN)

Minority Graduates

(1983-1988)

GRADUATION YEAR:	1983	1984	1985	1986	1987	1988	TOTALS
Total No. of Graduates:	N/A	N/A	42	49	43	44	178
Total No. of Minority Graduates:	N/A	N/A	7	7	4	3	21
No. of Black Minorities:	N/A	N/A	3	2	0	0	5
% of Minority Graduates:	N/A	N/A	17%	14%	9%	7%	12%
% of Black Graduates:	N/A	N/A	7%	4%	0%	0%	3%

NOTE: **First graduating class was 1985**

Source: UMDNJ, Department of Urban and Community Affairs

UMDNJ - ROBERT WOOD JOHNSON MEDICAL SCHOOL (PISCATAWAY)

Minority Graduates

(1983-1988)

GRADUATION YEAR:	1983	1984	1985	1986	1987	1988	TOTALS
Total No. of Graduates:	104	97	104	103	92	102	602
Total No. of Minority Graduates:	14	14	14	24	20	18	104
No. of Black Minorities:	10	8	7	10	5	5	45
% of Minority Graduates:	13%	14%	13%	23%	22%	18%	17%
% of Black Graduates:	10%	8%	7%	10%	5%	5%	7%

Source: UMDNJ, Department of Urban and Community Affairs

UMDNJ - SCHOOL OF OSTEOPATHIC MEDICINE

Minority Graduates

(1983-1988)

GRADUATION YEAR:	1983	1984	1985	1986	1987	1988	TOTALS
Total No. of Graduates:	28	35	43	58	53	45	262
Total No. of Minority Graduates:	1	2	4	3	6	7	23
No. of Black Minorities:	0	0	0	0	1	0	1
% of Minority Graduates:	4%	6%	9%	5%	11%	16%	9%
% of Black Graduates:	0%	0%	0%	0%	0%	0%	0%

Source: UMDNJ, Department of Urban and Community Affairs

UMDNJ NEW JERSEY DENTAL SCHOOL

Minority Graduates

(1983-1988)

GRADUATION YEAR:	1983	1984	1985	1986	1987	1988	TOTALS
Total No. of Graduates:	83	73	71	86	83	72	468
Total No. of Minority Graduates:	15	18	10	22	14	8	87
No. of Black Minorities:	4	4	3	2	3	2	18
% of Minority Graduates:	18%	25%	14%	26%	17%	11%	19%
%of Black Graduates:	5%	5%	4%	2%	4%	3%	4%

Source: UMDNJ, Department of Urban and Community Affairs

UMDNJ - GRADUATE SCHOOL OF BIOMEDICAL SCIENCES

Minority Graduates

(1983-1988)

GRADUATION YEAR:	1983	1984	1985	1986	1987	1988	TOTALS
Total No. of Graduates:	10	13	11	9	5	18	66
Total No. of Minority Graduates:	1	2	2	0	1	6	12
No. of Black Minorities:	1	0	0	0	0	0	1
% of Minority Graduates:	10%	15%	18%	0%	20%	33%	18%
% of Black Graduates:	10%	0%	0%	0%	0%	0%	2%

Source: UMDNJ, Department of Urban and Community Affairs

AIDS

New Jersey State Department of Health (NJSDOH)

Definition of Race

White: White, non-Hispanic
Black: Black, non-Hispanic
Hispanic: White and Black persons whose cultural background is Hispanic
Other/Unknown: Native American, Asian/Pacific Islander, etc.

Population Denominator:

The population of each racial/ethnic group was that reported by the Bureau of the Census for 1980. The ideal population used to calculate the risk of infection should be all those engaged in the particular risk behavior, (e.g., all IV drug users or homosexuals). Since the size of the population engaging in the particular behavior is unknown for the various age, gender, and racial/ethnic categories, the total population in the age, gender and racial/ethnic categories was used in calculating incidence rates by behavioral group.

Other Definitions:

Cumulative Incidence - the number of AIDS cases reported in a group since the onset of the epidemic per million population of the same group. We used AIDS cases gathered by the Centers for Disease Control for a national comparison to the AIDS cases gathered by the New Jersey State Department of Health's AIDS Registry. Case reports from 1981 to November 30, 1988 were included in the analysis.

Reference Group - The group whose incidence rate of a disease or condition serves as the baseline rate or the norm to which other groups are compared. In the analysis on AIDS, the White population of men, women, or children in the United States and New Jersey serves as the reference group to which other populations of men, women, and children in the United States and New Jersey are compared.

Relative Risk - The relative risk in a given group is the ratio of the cumulative incidence in that group to the cumulative incidence in reference group. For one analysis presented on AIDS, the reference group is non-Hispanic, Whites. For example, the risk of AIDS for New Jersey Hispanic children whose mothers are IVDUs would be the cumulative incidence rate in United States non-Hispanic White children whose mothers were IVDUs, (e.g., 150.7/1.7 = 88.6). The relative risk of AIDS for New Jersey Hispanic children whose mothers are intravenous drug users is 88.6 times the risk of corresponding United States White children.

The major intravenous drug abuse (IVDU) risk groups are:

Intravenous Drug Abuse (IVDU) Risk Groups:

Homo/Bi IVDU	Homosexual/Bisexual men who are IVDUs.
Men, Hetero IVDU	Heterosexual men who are IVDUs.
Women, Hetero IVDU	Heterosexual women who are IVDUs.
Men, Partner IVDU	Men whose sex partner is an IVDU woman.
Women, Partner IVDU	Women whose sex partner is an IVDU man.
Child, Mom IVDU	Child whose mother is an IVDU.
Child, Mom Part. IVDU	Child whose mother's sex partner is an IVDU.

Glossary

Maternal and Child Health

Definition of Races:

Varies, refer to illustrations in Section 3.

Population Denominator:

1960, 1970 and/or 1980 census.

Other Definitions

Infant - persons under one year of age

Low Birth Weight - 1500 - 2500 grams at birth

Very Low Birth Weight - less than 1500 grams at birth

Infant Mortality Rate: $\frac{\text{\# White or non-White infant deaths}}{\text{Total White or non-White births}} \times 1{,}000$

Relative risk (Infant mortality) - ratio of the mortality in a given group to the mortality in the reference group. For infant mortality, the reference group is the White population. The White population includes a significant portion of Hispanics. A relative risk = 1 means that non-Whites are at an equal risk, less than 1 means lesser risk by the determined factor and more than 1 means greater risk by the determined factor.

Chronic and Communicable Diseases

Cancer

Definition of Races:

Black: Black, non-Hispanic
White: White, non-Hispanic
Other Non-White: American Indian/Alaskan, Chinese, Japanese, Filipino, Hawaiian

Hispanic: based primarily on the use of the Generally Useful Ethnic Search System (GUESS) Program, as well as additional information that takes into account patient surnames and other demographic data.

Population Denominator:

1980 census and projection through 1985 based on standard linear progression.

Other Definitions:

Corpus - uterus

Unadjusted rates - data do not account or adjust for age differences in the population.

Age-adjusted - a method used to make valid statistical comparisons by assuming the same age distribution among different groups being compared.

Diabetes

Definition of Races

White: White and White Hispanic
Non-White: Black, Black Hispanic and all other minorities

Population Denominator

1980 census

Dialysis

Definition of Races

White: White and White Hispanic
Black: Black and Black Hispanic
Other/Unknown: All other minorities

Chronic and Communicable Diseases (cont.)

Transplantation

Definition of Races

White: White and White Hispanic
Black: Black and Black Hispanic

Newly Diagnosed Hypertension

Definition of Races

Minority: Black, Hispanic (also included in White) and other minorities

Sexually Transmitted Diseases

White: White, Hispanic and other minorities
Non-White: Black

Population Denominator

1980 census

Glossary

Injury

Definition of Races:

White: White, White/Hispanic and Hispanic
Non-White: Black, Black/Hispanic, Asian, American Indian, etc.

Population Denominator:

1986 unofficial population estimate.

Other Definitions:

Mortality rate: Based on a three year average for 1985, 1986 and 1987.

Resident injury deaths were tabulated from the single cause of death tape.

Substance Abuse (Narcotics and Alcohol)

Definition of Races:

White: White, non-Hispanic
Black: Black, non-Hispanic

Glossary

Access to Care

Long Term Care

Definition of Races

White: White, European origin
Black: Black, Negro, Jamaican, Black, Puerto Rican, West Indian, Haitian or Nigerian
Hispanic Origin: Puerto Rican, Mexican, Cuban, Spanish origin (Spain or Central or South America

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