

Healthy
New Jersey
2020

New Jersey STATE HEALTH ASSESSMENT 2018



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See end of report for a list of contributors and collaborating organizations.



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August 2018

Dear Public Health Partner,

The 2018 New Jersey State Health Assessment (SHA) is a comprehensive report compiled with input from our outstanding partners across the state. The findings will be used to best direct resources and facilitate collaborative efforts focused on improving the health of New Jersey residents.

This SHA report recaps information gathered from numerous state and local stakeholders, sister state agencies, and the Healthy New Jersey Advisory Council. It provides a summary of the health status of New Jerseyans and offers a high-level analysis of social determinants of health, quality of life, state assets, and causes of state health challenges that impact the health of the population. These data and information were collected and analyzed from a variety of sources, and informed a framework used to identify population health priorities, which will guide the next phase of the Healthy New Jersey initiative –the State Health Improvement Plan (SHIP).

We appreciate the participation received from every region of the state. Without this involvement, the assessment could not have been accomplished. We will use the SHA as a roadmap for defining next steps and organizing to improve specific priority health outcomes.

Your continued engagement is needed as we work to achieve the Department’s mission to ***improve health through leadership and innovation***. We hope you will use this report as a foundation for the development of population health improvement initiatives and activities statewide.

Shereef Elnahal, MD, MBA
Commissioner, New Jersey Department of Health

Population health focuses on keeping healthy New Jerseyans well, preventing those at risk from getting sick, and keeping those with chronic conditions from getting sicker. Population health promotes prevention, wellness, and equity in all environments, resulting in a healthy New Jersey.

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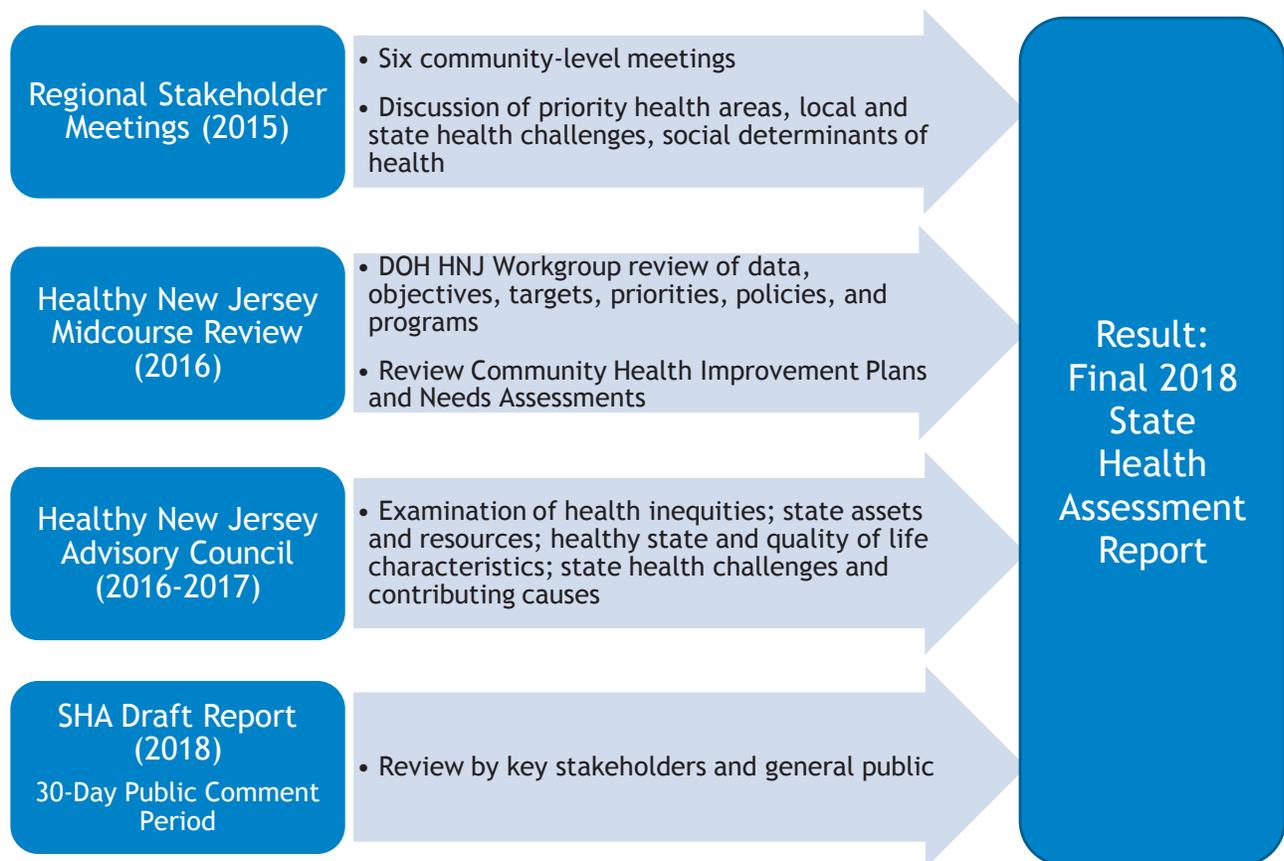
PURPOSE

A state health assessment (SHA) is a foundational and collaborative approach to examining the health of a population. Developing the SHA involves a comprehensive review and analysis of statewide health data, interpretation of results, and distribution of findings.¹ In New Jersey, the SHA and the subsequent State Health Improvement Plan (SHIP), are coordinated by the New Jersey Department of Health (DOH), and lead to the shared implementation of comprehensive strategies for community health improvement. The SHA and SHIP together are collective, systematic undertakings of the Healthy New Jersey (HNJ) initiative.

PROCESS

The New Jersey SHA included collaboration of DOH staff, community-based organizations, public and private agencies, the healthcare system, and the Healthy New Jersey Advisory Council to evaluate the overall quality of life and health status of New Jersey's population, and examine health inequities, policies, and resources which impact health outcomes (Figure 1).

2018 State Health Assessment Framework

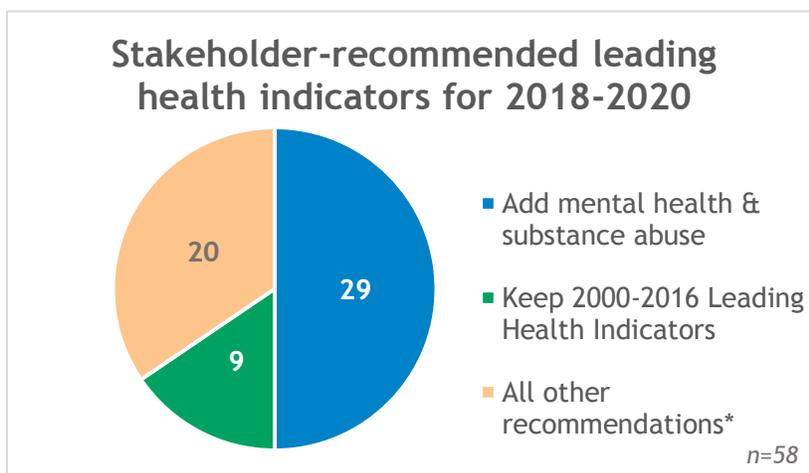


¹ Retrieved from: <http://slideplayer.com/slide/2309606/>. Cibula, D. Assessing Community Health: Measures of Community Health Status and Sources of Population-Based Health Data.

REGIONAL STAKEHOLDER MEETINGS

The implementation of the 2015 Healthy New Jersey 2020 (HNJ2020) Regional Meeting Series, funded by the NJ State Innovation Model grant, initiated the SHA development process. In partnership with the Rutgers Center for State Health Policy, DOH organized six public meetings to assess the impact, value, and success of health improvement activities taking place statewide, and collect stakeholder feedback on emerging public health issues as well as recommendations for advancing HNJ2020's health objectives. Overall, there were 170 attendees at the Regional Meetings (Asbury Park, Camden, Newark, Paterson, Trenton, Vineland) from a diverse group of community stakeholders from health care, social service, education, government, and others serving a wide variety of populations in New Jersey and representing approximately 90 organizations.

The HNJ2020 Regional Meeting Series allowed attendees to promote and exchange local and state-level health improvement strategies for improving health outcomes, and prioritize New Jersey's leading health indicators for the next five years. As shown in the graphic below, a majority of stakeholders selected **Mental Health and Substance Abuse** as a state leading health indicator.



**Other recommendations each had 6 or fewer votes*

Source: 2015 Healthy NJ 2020 Regional Meetings

HEALTHY NEW JERSEY MIDCOURSE REVIEW

HNJ Workgroup

To strengthen the SHA collaborative process, the Department conducted a two-phase HNJ2020 Midcourse Review beginning with the DOH HNJ Workgroup in the summer and fall of 2016. Comprised of approximately 30 members who provide data analysis and specialized public health expertise for tracking and updating the HNJ2020 objectives, the DOH HNJ Workgroup evaluated data trends, primary and secondary data sources, program strategies, policies, partnerships, and health disparities associated with all 100+ HNJ objectives. Workgroup members also identified state assets and resources for achieving targeted health improvement goals, as well as statewide challenges which impact results. A summary of this review is provided in Section 3 of this report.

County and Regional Health Priorities

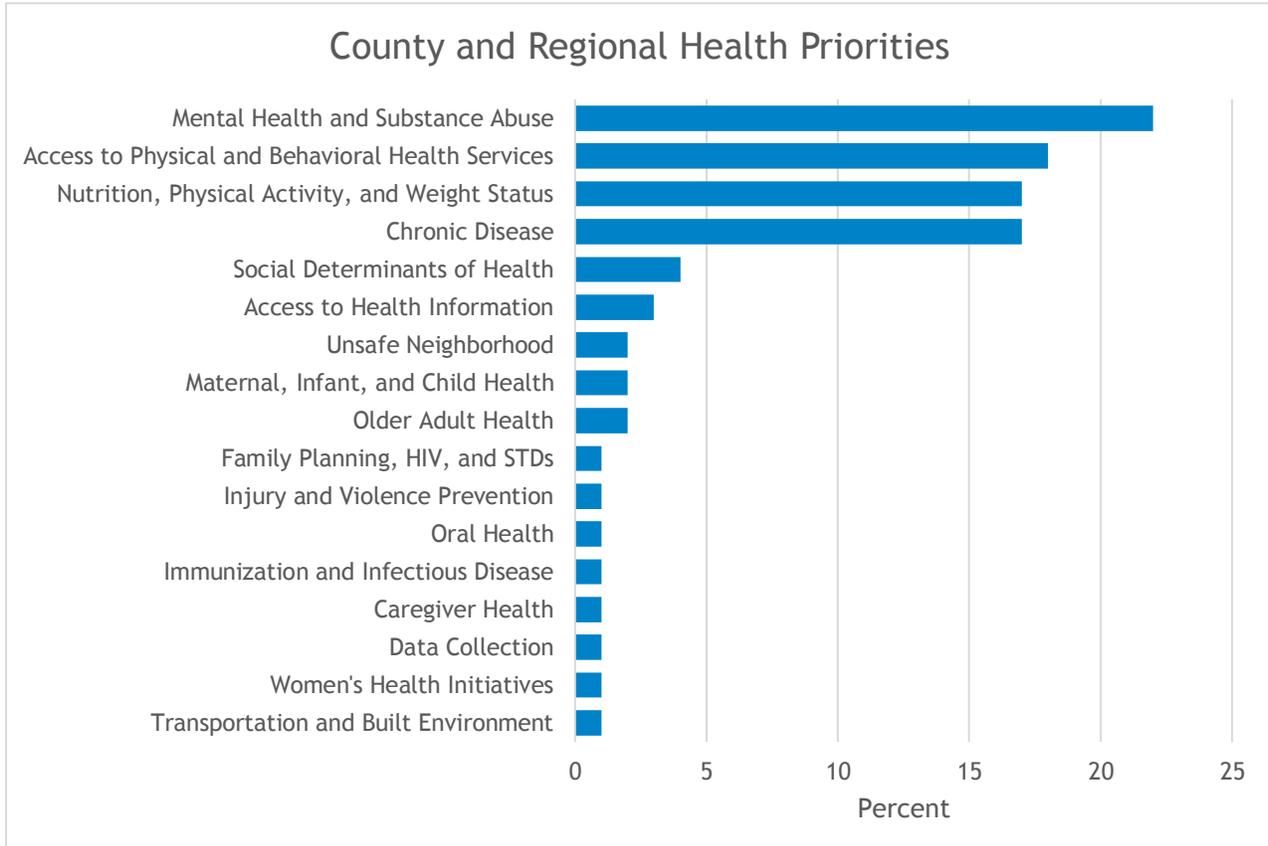
The second phase of the Midcourse Review included the analysis of local health priorities identified in approximately 30 Community Health (Needs) Assessments (CHA or CHNA) and Community Health Improvement Plans (CHIPs) for each of New Jersey’s 21 counties. CHAs were produced by local health departments while CHNAs were compiled by a local hospital or a joint effort between the two. Priority health needs identified by local public health departments and healthcare system partners across the state were ranked and compared.

Local-level health priorities were tallied across all CHAs, CHNAs, or CHIPs and ranked as shown in the bar graph below.

The leading county and/or regional health priorities cited were as follows:

1. **Mental Health and Substance Abuse** All but one county included Mental Health and/or Substance Abuse as a top priority.
2. **Access to Health Services (Both physical and behavioral)**
3. **Nutrition, Physical Activity, and Weight Status** (Focused on the importance of addressing the obesity epidemic and healthy behaviors)
4. **Chronic Disease** (Includes diabetes, cancer, heart disease, and stroke)

This analysis revealed consistency with results of the regional meeting health priority selection across the state.



ADVISORY COUNCIL

The Healthy New Jersey Advisory Council (HNJAC) was established in 2016 to solicit input from multi-disciplinary experts across the state about the State Health Assessment development, findings, and activities. Comprised of representatives of community-based organizations, consumer associations, healthcare systems, and other diverse partners, HNJAC members provided perspectives on statewide quality of life, health disparities, social determinants of health, and the assets and resources that exist to address current public health challenges. See Appendix 5 for a list of HNJAC members.

PUBLIC COMMENT PERIOD

A public comment period was held from January 10, 2018 to February 10, 2018. Over seven hundred partners were contacted via email and were asked to share the information with their contacts. This outreach was conducted with the Healthy NJ Advisory Council, the 2017 Population Health Summit mailing list, recipients of the DOH Office of Local Public Health's "News You Can Use" newsletter, and the NJ Local Information Network Communication System (LINCS) Health Alert Network (HAN) email distribution list which includes LINCS Coordinators and Backups, Health Planners, IT Specialists, Partnership Coordinators, Regional Health Planners, and Team Members; Local Health Officers and Assistants, Communicable Disease Investigators, Health Educators, Public Health Nurses, Registered Environmental Health Specialists, Epidemiologists, and other Local Public Health staff; academic leaders; animal health organizations; blood banks; business and industry leaders; DOH staff; EMS Council; food safety organizations; healthcare organizations; hospitals; occupational health organizations; public health associations; Public Health Council; and state and federal government leaders. A notification was also posted on the DOH internet and intranet sites. Links to the comment form were posted on multiple pages throughout the DOH's website.

The Healthy NJ website had 2,719 unique visitors during the comment period and received 40 responses through the comment form. Of the 40, six were duplicates or abandoned, so the following results are based on 34 responses. A complete list of the public comment form questions is in Appendix 6.

Respondents were asked to rate the report on a scale of 1 to 5 for the following questions:

- Was the information in this State Health Assessment easy to understand? (1 = No, not at all | 5 = Yes, very clear)
- After reading this report, do you have a better understanding of the health concerns that might affect you or your community's health? (1 = No, not at all | 5 = Yes, much better)

The report received an average of 4.1 on both measures.

Respondents' affiliations were:

AFFILIATION	NUMBER OF RESPONDENTS
Community / Non-profit / Faith-based Organization	9
DOH Staff	6
College / University faculty or staff	4
NJ Resident	3
Hospital / Healthcare Provider	2
Regional Public Health Coalition / Organization	1
Other health professional	3
Other	3
(blank)	3
Total	34

Health data not identified in this report that respondents felt was important included Human Papilloma Virus (HPV) vaccination rates, domestic violence and rape incidence, more social determinants of health data, premature death rate, substance use and mental health, oral health, gender identity with respect to HIV statistics, sources of health insurance, more exercise/physical activity data, pedestrian and bicycle injury, urgent care facilities, and data on specific populations such as South Asians and zip code-level data.

SHA results that surprised some respondents included the extent of health disparities, black teen birth rates, and the percentage of Asians without a primary care physician.

Respondents expressed that their reason for interest in the SHA and for providing comments was due to their professional roles relative to public health. Other reasons mentioned included wanting a better understanding of the overall health of NJ residents and wanting to see what progress had been made since the beginning of the HNJ 2010 initiative.

Comments on specific sections of the report were focused primarily on what was not included in the report, such as sepsis, HPV, the opioid epidemic, strategies for reducing elective c-sections, the Safe Routes to Parks initiative, the Mayors' Wellness Campaign, other initiatives and organizations, and more linkage between topics like tobacco use effects on chronic diseases.

PRIORITIES 2018-2020

Based on the regional stakeholder meeting communications, local community health assessment and improvement plan analyses, and the Healthy New Jersey Advisory Council feedback described above, the Leading Health Indicators are:

- 1 Improve Access to Health Services
- 2 Improve Birth Outcomes
- 3 Increase Childhood Immunization Rates
- 4 Reduce Heart Disease and Stroke
- 5 Reduce Obesity
- 6 Improve Mental Health & Substance Abuse Outcomes (NEW)

MENTAL HEALTH & SUBSTANCE ABUSE

The data below summarize some mental health and substance abuse outcomes for NJ residents which will be considered in the development of the 2018-2020 State Health Improvement Plan (SHIP).

MENTAL HEALTH

Mental illness, specifically depressive disorders, are associated with increased prevalence of chronic diseases, including diabetes, obesity², and cardiac disease³, as well as a decreased ability to manage them. One in ten NJ residents suffer from a mental health issue.

The federal Healthy People 2020 tracks suicide rates and major depressive episodes among youth and adults. The table below provides a comparison of US and NJ rates for these objectives. While the NJ suicide rates are lower (8.3 per 100,000 population) compared to the US (13.3), major depressive episodes occur at about the same rate in NJ compared to the US.

HP2020 Objective	Data Year and Source	NJ Value	US Value	NJ Compared to US
MHMD-1: Suicide rate	2015 Death certificates	8.3 per 100,000 population, age-adjusted	13.3 per 100,000 population, age-adjusted	
MDMH-4.1: Major depressive episodes (age 12-17)	2014-2015 National Survey on Drug Use and Health (NSDUH)	10.3%	11.9%	
MDMH-4.2: Major depressive episodes (age 18+)	2014-2015 NSDUH	6.5%	6.6%	



New Jersey is performing BETTER than the U.S., and the difference is statistically significant.



The New Jersey value is the same or ABOUT THE SAME as the U.S. Differences are not statistically significant.

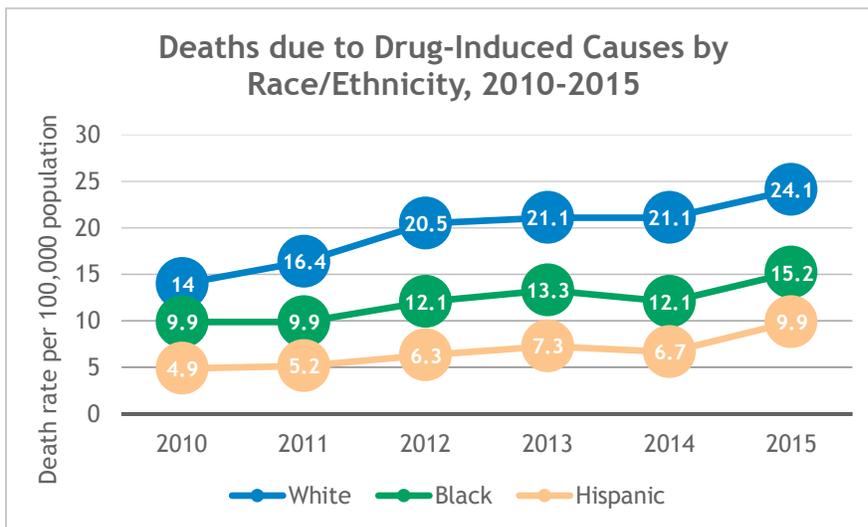
² Luppino FS, de Wit LM, Bouvy PF, et al. [Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies](#). *Archives of General Psychiatry*. 2010;67:220-9.

³ Huffman, Jeff C., Celano, C. M., Beach, S.R., Motiwala, S.R., and Januzzi, J.L.. (2013). [Depression and cardiac disease: epidemiology, mechanisms, and diagnosis](#). *Cardiovascular Psychiatry and Neurology* 2013:695925.

SUBSTANCE ABUSE

Substance abuse, as defined in the DSM-IV-TR⁴, is a “maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.”⁵ Individuals who abuse substances may experience harmful consequences. Overdose and/or fatality from substance abuse is a major potential consequence that has created a public health emergency nationally, as well as in New Jersey.

Overdose fatalities from substance abuse has increased significantly nationally and in NJ since 2010. This public health crisis has further mobilized NJ’s government and health systems to take a population health approach to addressing the impact of mental health and addictions on the overall health and wellness of New Jerseyans.



Other summary statistics specific to the opioid crisis statewide, support the overwhelming call to prioritize it as a leading health indicator:

- There were 1,901 overdose deaths involving prescription opioids in New Jersey in 2016 –a 321.5% increase since 2006 (451).⁶
- Naloxone, an over-the-counter medicine that is used to reverse an opioid overdose was administered thousands of times. During 2014-2016, Camden County had the most Naloxone administrations (2,777), followed by Essex County (1,499), and Middlesex County (1,120).⁷
- According to the New Jersey Office of the Regional Operations & Intelligence Center (ROIC), other opioids such as fentanyl have had the greatest impact on drug overdoses statewide. Fentanyl is found in approximately 30% of the overdoses in NJ.⁸

⁴ Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision

⁵ American Psychiatric Association [APA], 2000, p.198

⁶ Data from the Office of Emergency Medical Services (OEMS), PHILEP, NJ Department of Health program files

⁷ Data reported voluntarily and exclusively by Advanced Life Support and Basic Life Support Agencies through the State Electronic Patient Care Report (ePCR) data collection system

⁸ New Jersey State Police data

- Substance abuse treatment admissions for heroin and other opioids increased 15% in New Jersey between 2016 (38,334)⁹ and 2015 (32,529).¹⁰

Furthermore, research demonstrates that people who suffer from addiction tend to also have one or more co-occurring health issues -- chronic diseases, such as cardiovascular disease and cancer; infectious diseases; or mental health disorders. Understanding this correlation between physical and mental health is key for improving health outcomes for these New Jerseyans.

OTHER ESSENTIAL PUBLIC HEALTH ISSUES

While developing the SHA, other essential public health issues that are impacting New Jersey residents were identified, but are not addressed among the topic area findings shown in Section 4 of this report. These important issues, which can impact a wide range of health outcomes of New Jerseyans, are summarized below.

ANTIBIOTIC RESISTANCE

- According to the CDC, antibiotic resistance causes more than two million illnesses and 23,000 deaths every year in the U.S.¹¹
- An increasing proportion of tuberculosis infections in New Jersey are due to multiple drug resistant (MDR) strains that increase the length of time for treatment and require more expensive second line medications.
- In New Jersey, reported cases of gonorrhea, which is becoming increasingly difficult to treat due to antibiotic resistance, according to the World Health Organization, increased 9% between 2014-2015.

CLIMATE CHANGE

- New Jersey Department of Environmental Protection reported a statistically significant rise in average statewide temperature over the last 100+ years, with both winters and summers becoming warmer in New Jersey during this time period.¹²
- Rutgers University New Jersey Climate Adaptation Alliance sorts the impacts of climate change on human health into four broad categories: 1) heat-related illnesses; 2) air quality conditions; 3) storm-related injuries and stresses; and 4) infectious diseases.¹³

⁹ New Jersey Department of Human Services, Division of Mental Health and Addiction Services. (June 2017). *Substance Abuse Overview 2016 Statewide Report*

¹⁰ New Jersey Department of Human Services, Division of Mental Health and Addiction Services. (June 2016). *Substance Abuse Overview 2015 Statewide Report*

¹¹ CDC. Antibiotic Use in the United States, 2017: Progress and Opportunities. Atlanta, GA: US Department of Health and Human Services, CDC; 2017.

¹² New Jersey Department of Environmental Protection. (June 2013; updated Aug 2017). [Climate change in New Jersey: Temperature, precipitation, extreme events and sea level.](#)

¹³ Rutgers, the State University of New Jersey. NJ Climate Adaptation Alliance. (March 2014). [A Summary of Climate Change Impacts and Preparedness Opportunities for the Public Health Sector in New Jersey.](#)

- The State of New Jersey 2014 Hazard Mitigation Plan identified several State Hazards of Concern, including coastal erosion and sea-level rise, dam/levee failure, drought, earthquakes, and floods.

POST-DISASTER RECOVERY AND VULNERABILITY

- The NJ Chapter of the American Planning Association estimates that long-term disaster recovery (and resiliency) can take up to 5-10 years, if not more.¹⁴
- According to the Sandy Child and Family Health Study, which was published in 2015 by Rutgers University and New York University, among those New Jersey residents whose homes suffered significant structural damage from Superstorm Sandy in 2012, 27 percent were experiencing moderate or severe mental health distress and 14 percent reported the signs and symptoms of PTSD even two and a half years after the storm.¹⁵

SEPSIS (SEPTICEMIA)

- Sepsis is the body's extreme response to an infection. It is life-threatening, and without the timely treatment, sepsis can rapidly cause tissue damage, organ failure, and death.¹⁶
- Septicemia is one of only two leading cause of death for which New Jersey's rate is higher than that of the United States. Kidney disease is the other leading cause.
- In 2015, age-adjusted septicemia mortality in NJ was 17.9 per 100,000 persons, compared to 11.0 per 100,000 persons in the U.S.
- In 2015, Blacks (28.0) exhibited higher overall sepsis mortality per 100,000 population (age-adjusted) than Whites (17.1), Hispanics (16.0), and Asians (10.0).¹⁷

NEXT STEPS

The 2018 State Health Assessment (SHA) represents the first step in a two-part process to identify and address the population health needs of the state. The SHA provides foundational data and information needed for the second phase - developing the State Health Improvement Plan. Drawing from the SHA, stakeholders will implement strategies to drive population-wide health improvements in the six Leading Health Indicators.

The following pages summarize the findings of this collaborative process of collecting and analyzing state demographic and public health data and information to assess and ultimately improve the health of New Jersey residents.

¹⁴ American Planning Association New Jersey Chapter. (March 5, 2014). [APA-NJ Comments on CDBG-DR Action Plan](#).

¹⁵ Rutgers, the State University of New Jersey. Rutgers TODAY. (July 29, 2015). [Superstorm Sandy Child and Family Health Study Finds Lingering Effects of Mental Health Distress, PTSD and Depression](#).

¹⁶ CDC. [What is Sepsis?](#) Page last updated: August 25, 2017

¹⁷ New Jersey Department of Health. New Jersey State Health Assessment Data (NJSHAD). [Complete Health Indicator Report of Deaths due to Septicemia \(Sepsis\)](#)



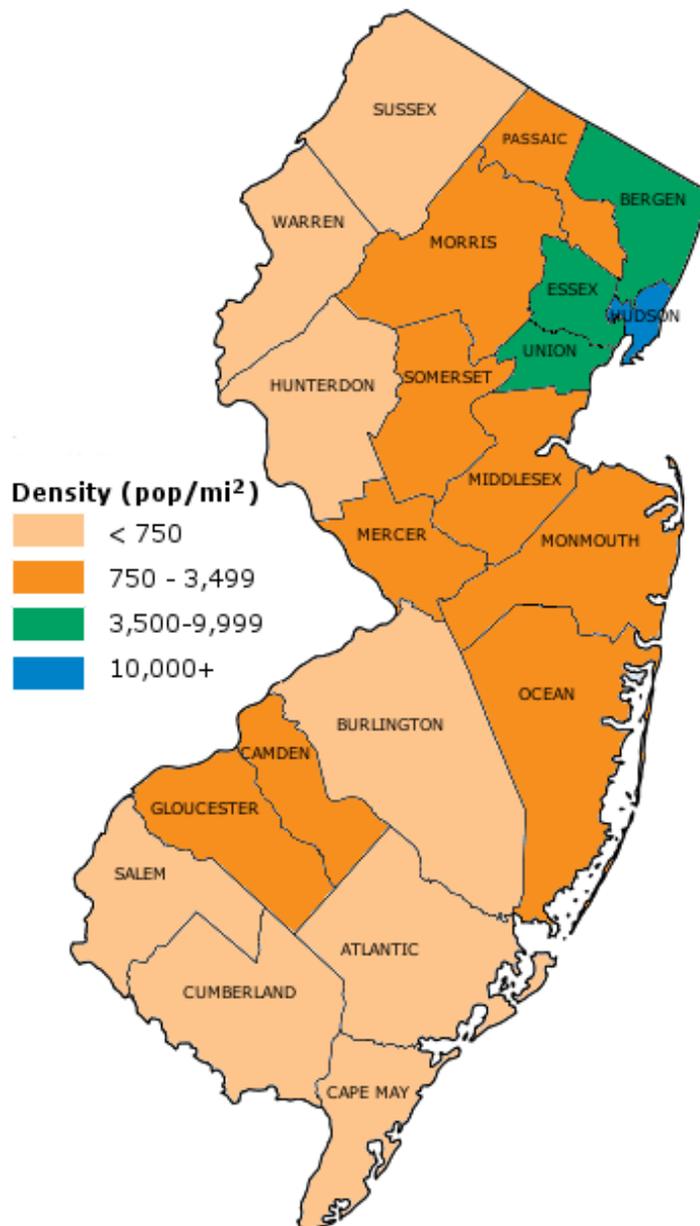
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New Jersey Resident Profile

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DEMOGRAPHIC & SOCIOECONOMIC CHARACTERISTICS

This demographic profile of New Jersey residents provides a description of the state population. It includes population density, age, race/ethnicity, nativity, language spoken, disability status, education, poverty and unemployment, income, and travel time to work data which provide insight to the diverse health needs and impacts statewide. Much of the data shown contains estimates from the US Census Bureau's 2015 American Community Survey. Racial/ethnic groups presented throughout the report are mutually exclusive. In other words, data for White, Black, and Asian do not include Hispanics. Hispanic ethnicity includes persons of any race.

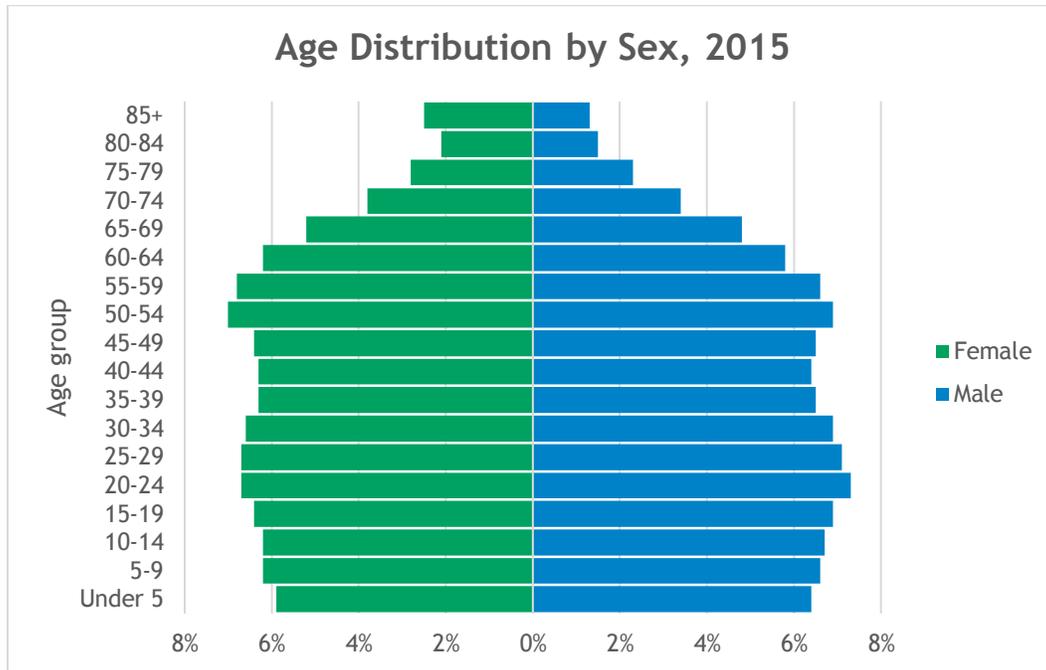


New Jersey has nearly 9 million residents and is the 11th most populous state, despite being the fifth smallest state geographically.

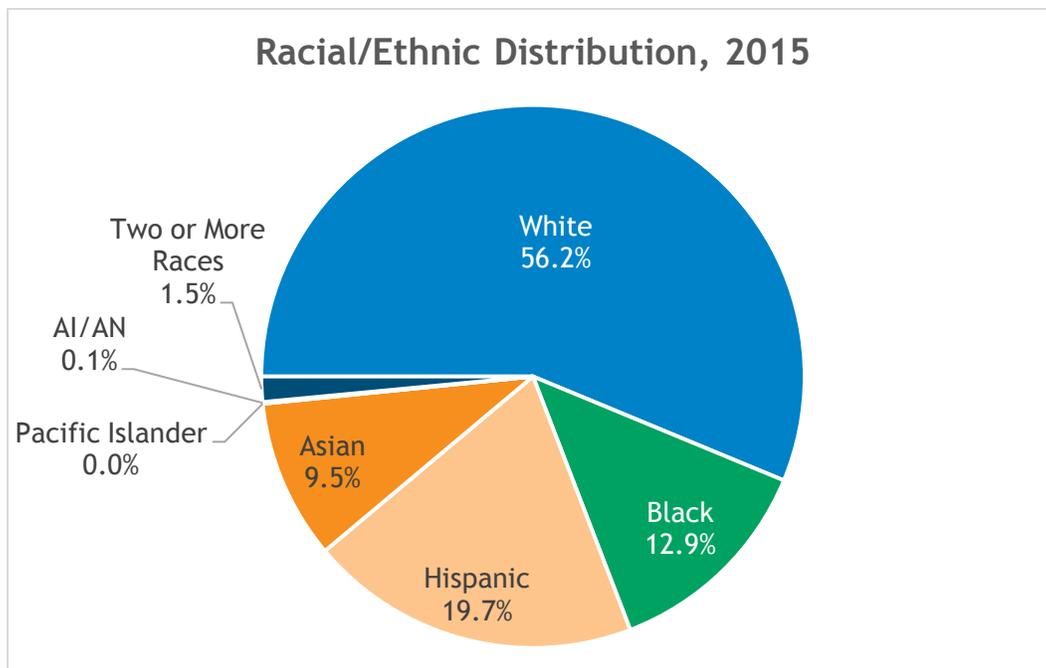
We have the **highest population density of any state** with 1,218 persons per square mile. The most densely populated town, Guttenberg, contains nearly 12,000 residents in its 0.2 square miles (59,615 persons per square mile). Jersey City is the most densely populated large city at 17,865 persons per square mile, and both municipalities are in the most densely populated county (Hudson County, 14,610 persons per square mile). This contrasts with Walpack Township with its sparse 0.6 persons per square mile in rural Sussex County (276.8 persons per square mile).

Thirty-seven of New Jersey's 565 municipalities (7%) have more than 10,000 persons per square mile, while 184 have less than 1,000 per square mile (33%).

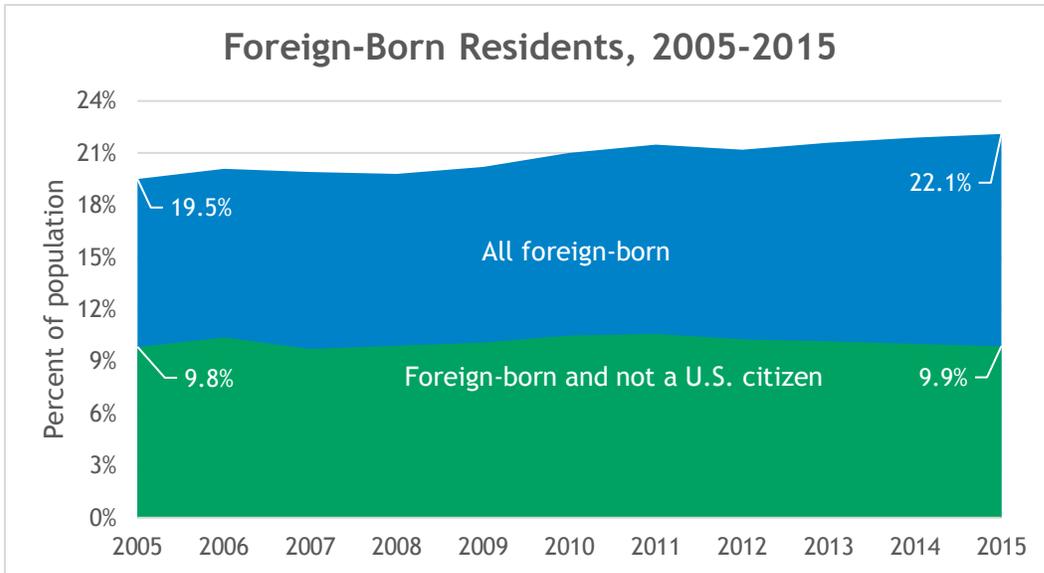
New Jersey's age distribution indicates slow and sustained population growth with the birth rate exceeding the death rate, but not by a great margin. Females ages 75 years and older have a longer life expectancy compared to males in the same age group.



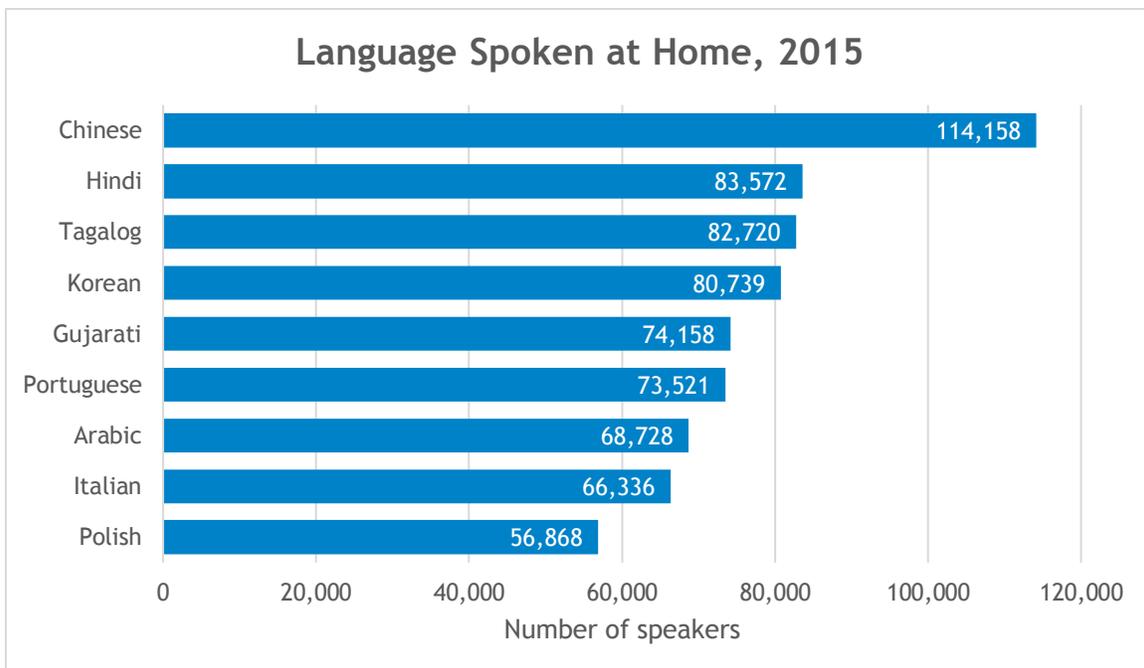
More than half of New Jersey's residents are White and one-fifth are Hispanic. Blacks comprise 13 percent of the population and Asians are nearly 10 percent. The remaining 1.7% of the population consists of American Indians/Alaska Natives (AI/AN), Pacific Islanders, and persons who identify as two or more races.



The proportion of the New Jersey resident population that is foreign-born increased 13.3% between 2005 and 2015. However, the share of residents who are not U.S. citizens remained constant around 10%.

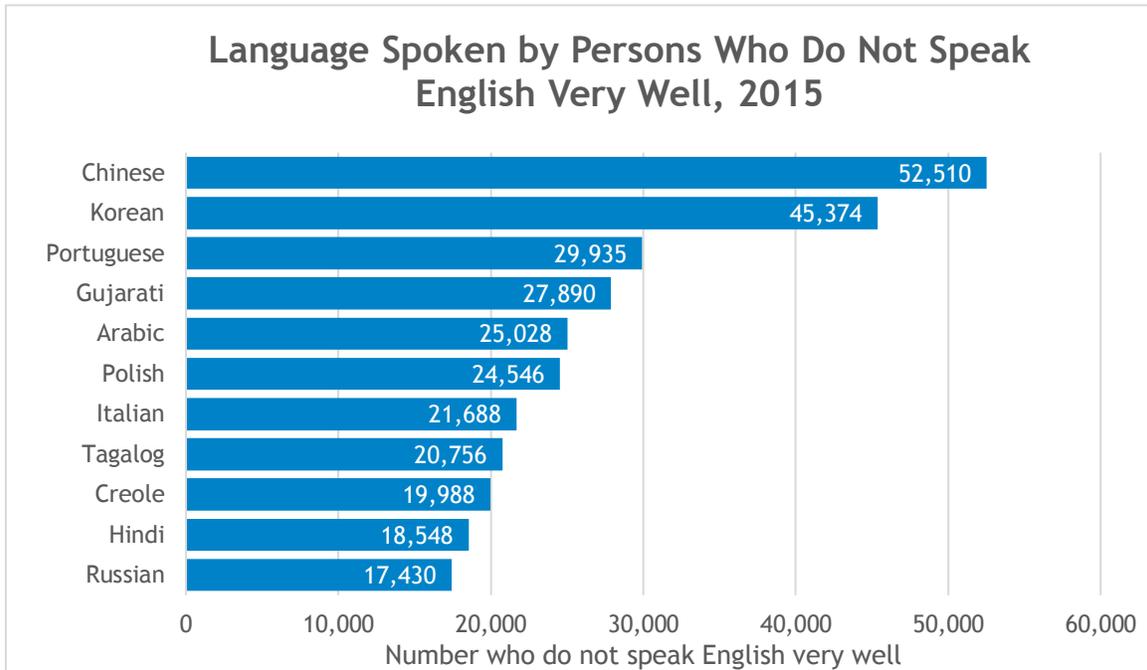


Among New Jersey residents over 5 years of age, 2.6 million (31%) speak a language other than English at home. Of those, half speak Spanish (1.3 million). Other languages with more than 50,000 speakers in New Jersey are shown in the graph below.

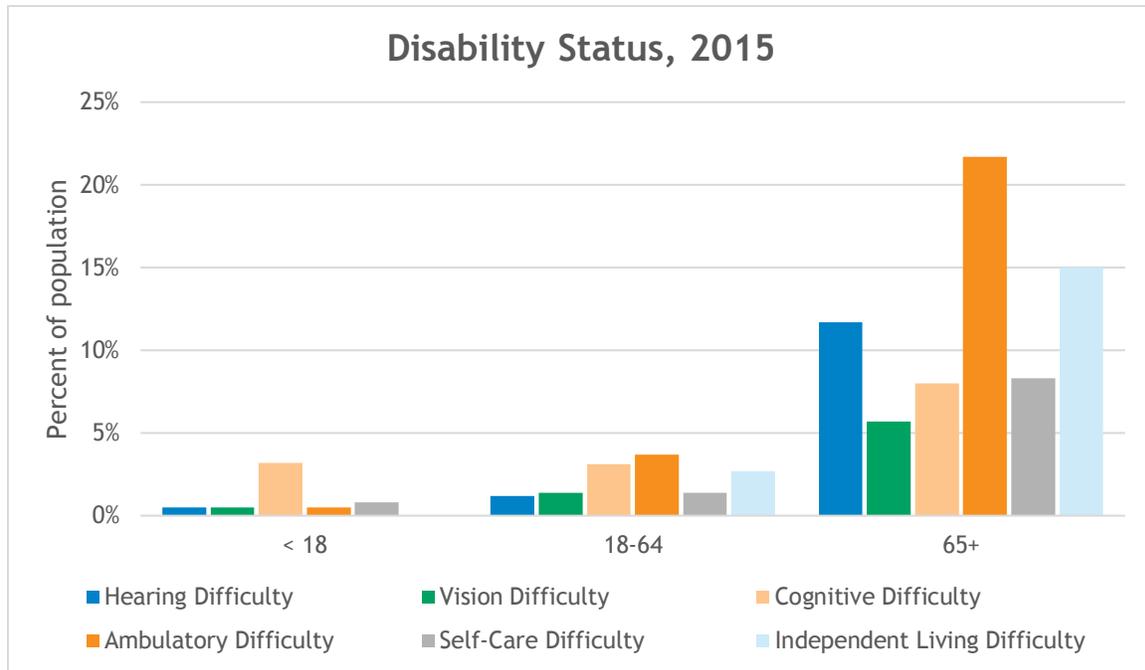


Limited English proficiency can be a barrier to accessing health care. Of the 2.6 million who speak another language at home, one million report that they speak English less than “very well” and therefore are at risk of negative health outcomes solely because of a language barrier.

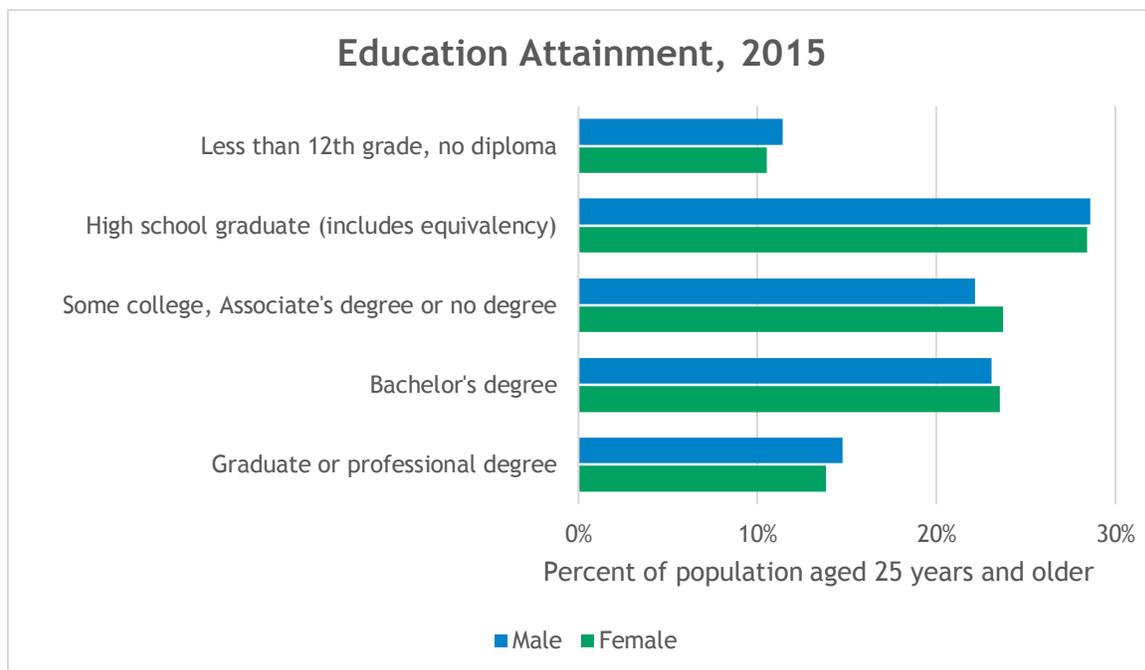
There are nearly 600,000 Spanish-speaking NJ residents over the age of five who do not speak English very well. Other languages with more than 15,000 persons who do not speak English very well are shown in the graph below. These are the languages most in need of translation services.



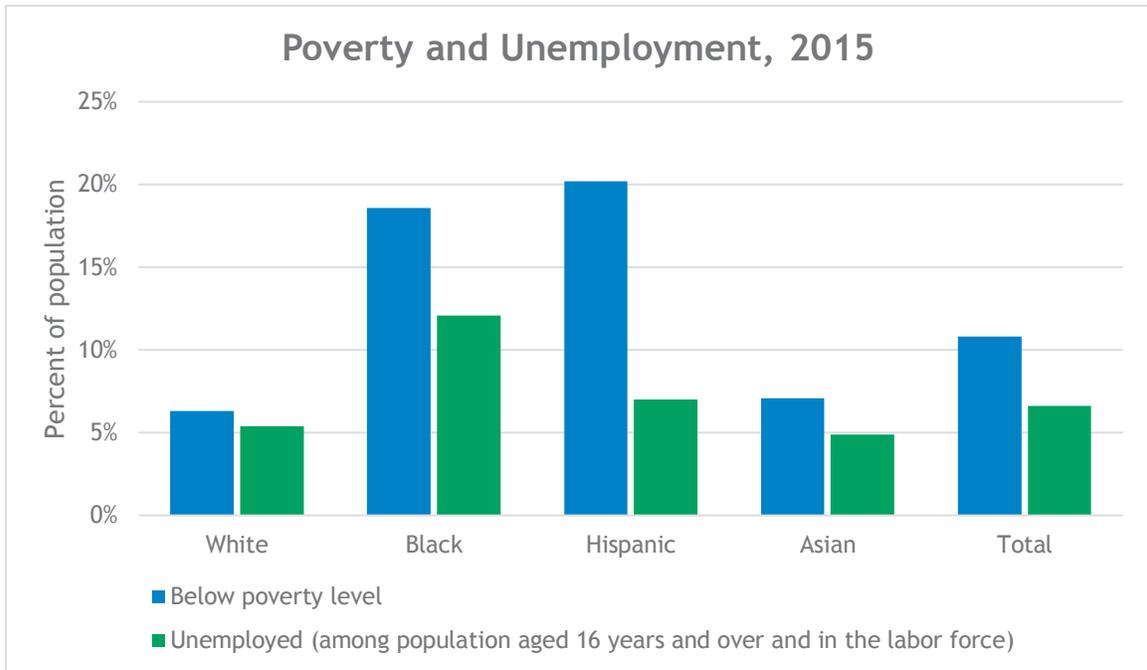
Ten percent of New Jersey’s civilian non-institutionalized population has some type of disability. As expected, with increased age comes increased difficulty with vision, hearing, walking, and other aspects of daily living.



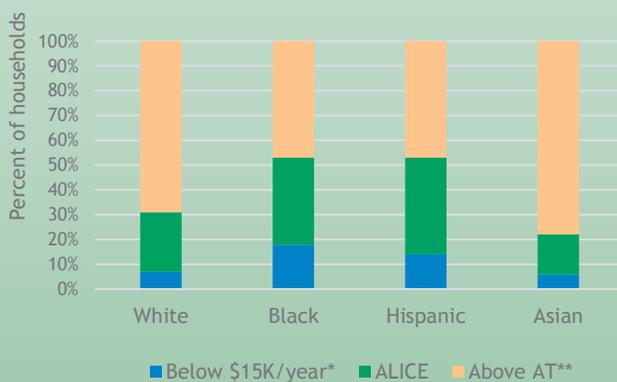
Eleven percent of New Jersey’s residents aged 25 years and over do not have a high school diploma or equivalency. The rate is 12.8% nationally.



Nearly 11% of New Jersey residents live below the Federal Poverty Level (FPL). The unemployment rate is 6.6% among residents aged 16 years and over. National rates are 14.7% and 6.3%, respectively. Hispanics are most likely to have incomes below poverty level and Blacks have the highest rate of unemployment.



Households by Race/Ethnicity and Income, 2014



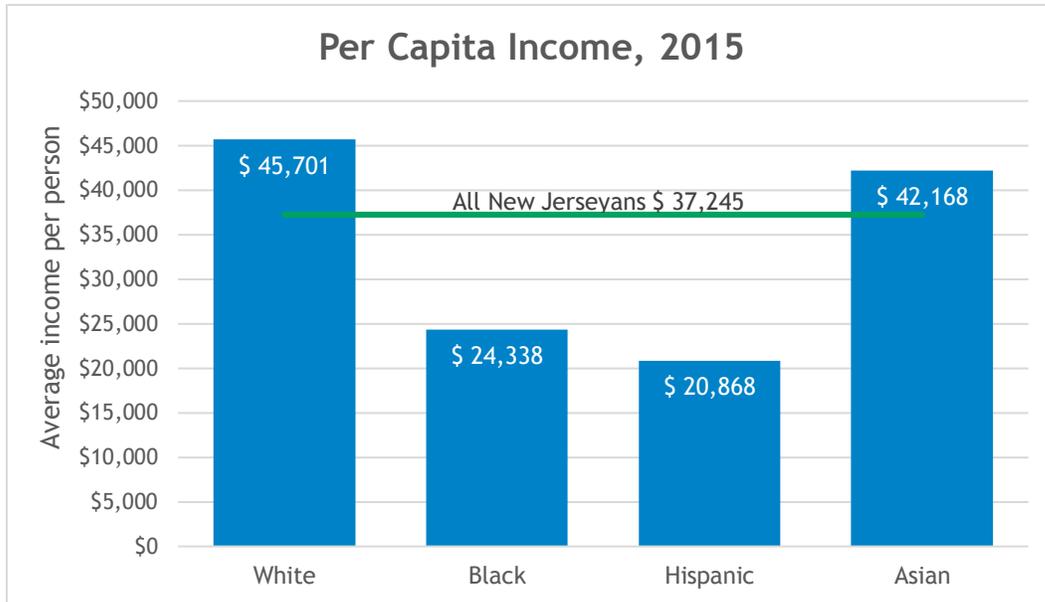
* NOTE: ALICE uses income below \$15,000 as a proxy for poverty, because household poverty data is not available for the American Community Survey's Race/Ethnicity categories.

** AT (ALICE Threshold) - households that earn more than the Federal Poverty Level (FPL), but less than the basic cost of living for the state

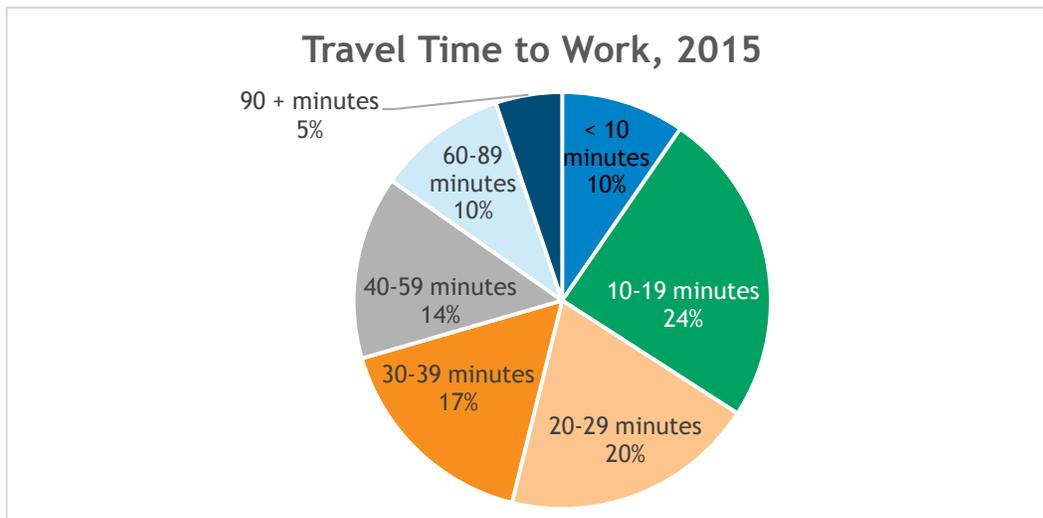
The ALICE Project

In 2006, the United Way began a research project called ALICE--Asset Limited, Income Constrained, Employed--which represents households that earn more than the Federal Poverty Level (FPL), but less than the basic cost of living for the state (the ALICE Threshold or AT). The ALICE Project provides a framework, language, and tools to measure and understand the struggles of the growing number of households that do not earn enough to afford the basic expenses of housing, child care, food, transportation, and health care. As of 2016, 15 states, including New Jersey, participate in the study to better understand the struggles of the ALICE population.

New Jersey has a higher cost of living than the national average. Housing, groceries, health care, transportation, and other services are more expensive in New Jersey than nationally. However, per capita annual income in New Jersey is \$37,245, compared to \$29,979 nationally.



Time spent commuting to work is a quality of life issue and determinant of health status.^{18,19} Nearly half of New Jersey residents spend more than half an hour traveling to work each day compared to 37.5% nationally.



Unless otherwise noted, the source for all the preceding demographic data is the U.S. Census Bureau, 2015 American Community Survey 1-Year Estimates.

¹⁸ Association for Psychological Science. 2015. [Lengthy Commutes Take a Mental Toll.](#)

¹⁹ UK Office for National Statistics. 2014. [Measuring National Well-being, Commuting and Personal Well-being, 2014.](#)

A summary of the above statistics which illustrate the social and economic characteristics of the population by county is presented below.

SOCIAL DETERMINANTS OF HEALTH, STATISTICS BY COUNTY, 2015

County	Population	Percent (%)							
		Age 65+	Non-White	Foreign born	Language	College	Disability	Not in labor force	Poverty
Atlantic	274,219	16	44	17	27	25	9	34	42
Bergen	938,506	16	42	30	39	47	5	34	29
Burlington	450,226	16	32	9	13	36	7	33	34
Camden	510,923	15	42	11	20	30	10	34	44
Cape May	94,727	25	15	6	10	30	9	41	40
Cumberland	155,854	14	53	10	26	15	11	43	59
Essex	797,434	13	68	26	34	33	9	34	44
Gloucester	291,479	15	21	5	9	29	9	33	33
Hudson	674,836	11	71	42	59	38	6	31	40
Hunterdon	125,488	16	14	9	10	49	5	32	24
Mercer	371,398	14	49	22	29	40	7	34	39
Middlesex	840,900	14	56	32	42	41	5	35	34
Monmouth	628,715	16	25	13	17	43	6	34	31
Morris	499,509	16	28	19	25	51	4	31	25
Ocean	588,721	22	15	8	13	27	8	41	40
Passaic	510,916	13	58	28	48	26	6	37	48
Salem	64,180	18	25	5	8	20	11	38	46
Somerset	333,654	14	42	24	31	53	4	31	26
Sussex	143,673	15	13	8	10	34	6	30	33
Union	555,786	13	58	30	43	33	6	31	36
Warren	106,869	17	17	9	12	30	7	33	29
New Jersey	8,958,013	15	44	22	31	37	7	34	26
United States		15	38	13	21	30	9	37	N/A

Sources: US Census Bureau Quick Facts, except Poverty: United Way ALICE Report, New Jersey, 2016 Update

Population: Estimate as of 7/1/15.

Age 65+: Persons 65 years and over, 7/1/15.

Non-White: Persons not "white alone, not Hispanic or Latino," 7/1/15.

Foreign born: Foreign born persons, 2011-2015.

Language: Language other than English spoken at home among persons age 5 years+, 2011-2015.

College: Bachelor's degree or higher among persons age 25 years+, 2011-2015.

Disability: With a disability, under age 65 years, 2011-2015.

Not in labor force: Not in civilian labor force, population age 16 years+, 2011-2015.

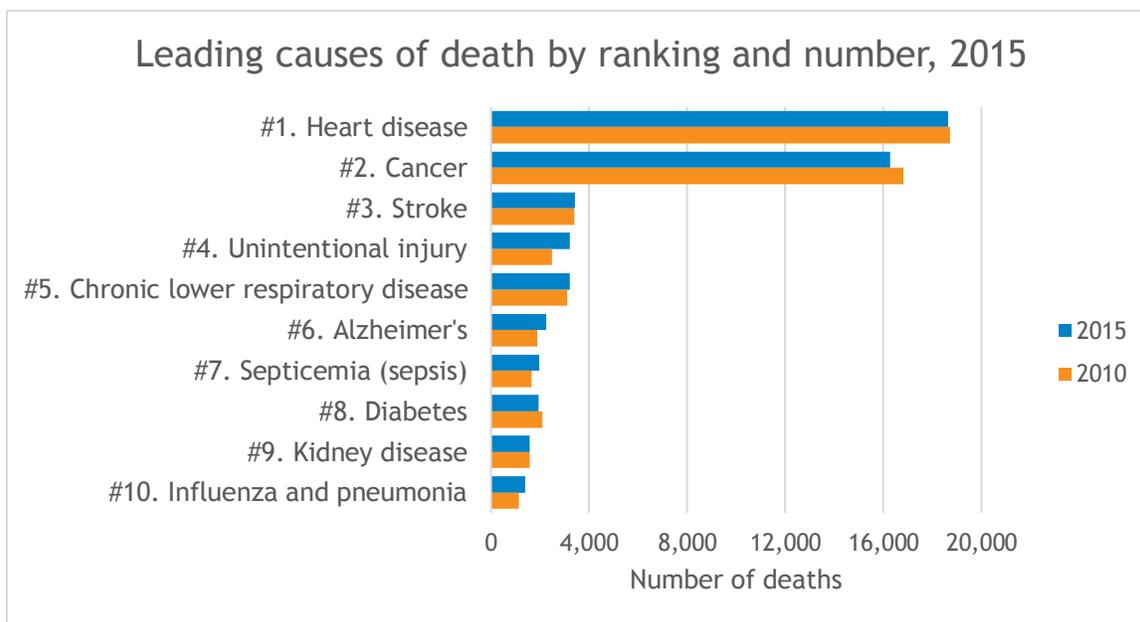
Poverty: Households below federal poverty level (FPL) plus households below Asset Limited, Income Constrained, Employed (ALICE) threshold, 2014 (ALICE = households with income above the FPL but below the basic cost of living).

LEADING CAUSES OF DEATH

A look at the leading causes of death statewide provides insight about the health issues which have the greatest impact on population health. The ten leading causes of death (LCODs) have been the same for many years, however, in 2015, the order within the top ten causes changed for the first time since 2010. An increase in unintentional injury (UI) deaths, primarily those due to poisonings which includes overdose deaths due to opioids, caused UI to become the fourth leading cause of death, while chronic lower respiratory disease (CLRD) dropped to fifth. Deaths due to diabetes are on the decline. Deaths due to Alzheimer’s disease and septicemia (sepsis) are rising. As a result, diabetes dropped from the sixth LCOD to eighth while Alzheimer’s disease and septicemia LCOD rankings rose to sixth and seventh, respectively.

The ten leading causes of death together account for about 75% of New Jersey resident deaths. Heart disease and cancer are the cause of nearly half the deaths in New Jersey. The same is true for the U.S. as a whole. The age-adjusted death rates for New Jersey’s ten leading causes of death are lower than that of the U.S. for each cause except septicemia and kidney disease.

Reducing heart disease and stroke is one of New Jersey’s Leading Health Indicators (LHI). Another LHI, obesity, is a major risk factor in heart disease, cancer, stroke, diabetes, and kidney disease. Access to health services, also a LHI, is a major risk factor in many diseases that contribute to the leading causes of death.



Source: NJ Death Certificate Database, New Jersey Department of Health

HEALTH DISPARITIES

Health disparities are population-specific differences in the presence of disease, health outcomes, or access to health care.²⁰ Disparities are not solely based on racial, ethnic, and cultural differences within the population. Age, sexual orientation, lack of access to health services, geographic location, transportation, and personal, socio-economic, and environmental characteristics also impact health.²¹

Significant disparities exist across the health topic areas examined for the New Jersey State Health Assessment. A comparison of birth and death rates, prevalence of chronic and acute disease, or access indicators across racial and ethnic groups identifies vulnerable populations.

Even though NJ does better in many health indicators compared to the U.S., health disparities persist, and are often greater than other states' disparity rates. For example, NJ's infant mortality rates are second lowest in the country. However Black-White disparity rates are significantly greater than states with worse overall outcomes in this area.

As summarized in the following table, Blacks and Hispanics in New Jersey experience the highest proportion of health disparities compared to Asians and Whites.

²⁰ The Henry J Kaiser Family Foundation. 2016. [Disparities in Health and Health Care: Five Key Questions and Answers](#).

²¹ Riley, W.J. 2012. [Health Disparities: Gaps in Access, Quality and Affordability of Medical Care](#), Transactions of the American Clinical and Climatological Association. 2012; 123: 167-174.

Summary of Major Racial/Ethnic Disparities by Health Topic				
HEALTH TOPIC	BLACK	HISPANIC	ASIAN	WHITE
Uninsured/lack of primary care provider		●	●	
Asthma	●	●		
Cancer deaths	●			
ESRD incidence and deaths	●			
Diabetes deaths	●			
HIV transmission and deaths	●	●		
Homicide	●	●		
Firearm injury deaths	●			
Suicide *		●		●
Unintentional poisoning deaths				●
Infant mortality	●			
Very low birth weight	●			
Teen births (15-17)	●	●		
Obesity among teens	●	●		
Hip fracture/fall deaths (65+)				●
STD incidence and transmission	●			
Smoking among teens		●		●
TB incidence	●	●	●	

● Group's rate is more than double that of at least one other group.

* Hispanic teens have a high rate of suicide attempts. Whites have a high rate of suicide death.

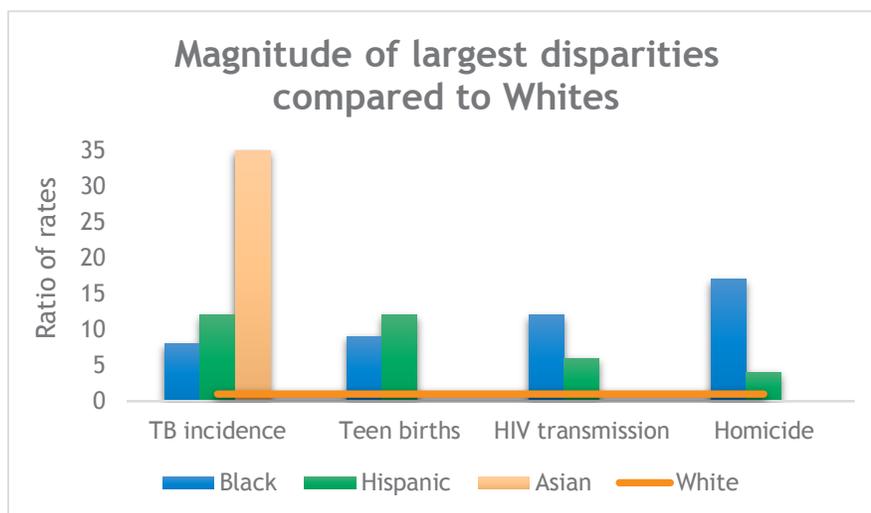
Data sources:

All death data: 2014 NJ Death Certificate Database
 Primary care provider: 2015 NJ Behavioral Risk Factor Survey
 Asthma ED visits: 2015 Hospital Discharge Data Collection System
 ESRD incidence: 2014 Quality Insights Renal Network 3 data
 HIV transmission: 2014 Enhanced HIV/AIDS Reporting System
 Suicide attempts: 2013 NJ Student Health Survey of High School Students
 Infant mortality: 2015 NJ Linked Infant Death-Birth Certificate Database

Very low birth weight: 2015 NJ Birth Certificate Database
 Teen birth rate: 2015 NJ Birth Certificate Database and 2015 Census population estimates
 Obesity: 2013 NJ Student Health Survey of High School Students
 Hip fractures: 2015 Hospital Discharge Data Collection System
 STDs: 2015 NJDOH STD Program data
 Smoking: 2014 NJ Youth Tobacco Survey
 Tuberculosis: 2015 Tuberculosis Information Management System

Disparities lead to excess morbidity and disease burden for certain racial/ethnic groups. The following ratios show how large health disparities are for Blacks, Hispanics, and Asians compared to Whites in New Jersey:

- HIV transmission rates are 10 times higher among Blacks, and deaths from homicide are more than 15 times higher.
- Births to teenage Hispanic mothers are 10 times higher.
- Asian tuberculosis infection rates are nearly 35 times higher.



Data sources are listed above.

Other significant health disparities are highlighted by racial/ethnic group below.

BLACKS

- **Asthma** death, hospitalization, and emergency department (ED) visit rates among Blacks are three to six times the rates among Whites.
- The cervical **cancer** death rate among Black women is double that of White women and the prostate cancer death rate among Black men is 2.5 times that of White men, despite higher screening rates among Blacks for both types of cancer.
- The incidence of **end-stage renal disease** (ESRD) among Blacks is double that of Whites and the death rate is nearly triple.
- The **diabetes** death rate for Blacks is double that of Whites.
- **HIV** transmission among Blacks is 12 times that of Whites and the death rate among Blacks is 17 times that of Whites.
- The Black **homicide** rate is 17 times the White homicide rate and the rate among Blacks aged 20-34 years is 41 times the White rate for the same age group.
- The Black death rate due to **firearm-related injuries** is more than five times White and Hispanic rates.

- The Black **infant mortality** rate is 3.2 times the White rate and 2.1 times the Hispanic rate.
- The percentage of Black infants weighing less than 1,500 grams (**very low birth weight**) is three times that of Whites.
- The **birth rate** among Black females aged 15-17 years is nine times the White rate.
- The percentage of positive **chlamydia** tests among Blacks aged 15-24 years old at family planning and STD clinics is 1.6 times that of Whites, down from triple in 2010.
- The primary and secondary **syphilis** sustained domestic transmission rate among Blacks is triple that of Whites and double that of Hispanics, down from six times the White rate in 2010.
- **Tuberculosis** incidence among Blacks is 8 times the rate among Whites.

HISPANICS

- The percentage of Hispanics who are **uninsured** or who don't have a primary care physician is three times the percentage among Whites.
- **Asthma** hospitalization and ED visit rates among Hispanics aged 65 years and over are 2.5 and 4 times the rates among Whites aged 65 years and older, respectively.
- **HIV** transmission among Hispanics is six times that of Whites and the death rate among Hispanics is three times that of Whites.
- The Hispanic **homicide** rate is four times the White homicide rate and the rate among Hispanics aged 20-34 years is 6.6 times the White rate for the same age group.
- The percentage of Hispanic high school students who report **attempting suicide** is double the percent of White students.
- The Hispanic **infant mortality** rate is 1.5 times the White rate.
- The **birth rate** among Hispanic females aged 15-17 years is twelve times the White rate.
- The percentage of Hispanic high school students who are **obese** is double the White percentage and the percentage who drink one or more sodas per day is nearly double.
- **Tuberculosis** incidence among Hispanics is 12 times the rate among Whites.

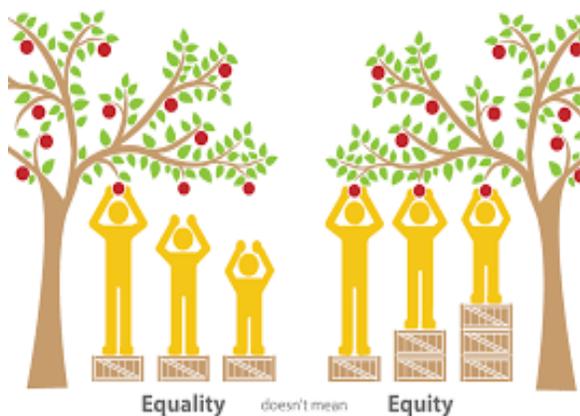
ASIANS

- The percentage of Asians **without a primary care physician** is double that of Whites.
- **Tuberculosis** incidence among Asians is nearly triple the rate among Hispanics, more than four times the rate among Blacks, and 35 times the rate among Whites.

WHITES

- The **suicide** rate among Whites is more than double that of all other racial/ethnic groups.
- The **unintentional poisoning** death rate among Whites is 2.7 times that of Hispanics and 1.7 times that of Blacks, and the gaps are widening. This is predominantly drug overdoses, but does include other poisons consumed unintentionally.
- The **hip fracture** rate among White women aged 65 years and older is 3.5 times the Black rate, 2.7 times the Hispanic rate, and 3.7 times the Asian rate.
- The hip fracture rate among White men aged 65 years and older is 2.6 times the Black rate, 2.8 times the Hispanic rate, and 3.8 times the Asian rate.
- The **fall-related death** rate among Whites aged 65 years and older is 2.5 times the Black and Asian rates and double the Hispanic rate.
- The percentage of White high school students who are current **smokers** is 2.5 times that of Black students.

EXAMINING HEALTH EQUITY & DISPARITIES



Besides race and ethnicity, the social, cultural, environmental, and economic factors that contribute to poorer health outcomes must be considered. As defined by the American Association of Medical Professionals Health Equity Research Center, **health equity** is a state where everyone has the opportunity to attain his or her full health potential and no one is disadvantaged because of their social position or socially derived circumstance. To improve population health, multidisciplinary, multi-sector collaborations must exist to evaluate

systems, policies, and make changes that facilitate opportunities to achieve optimal health.

As illustrated in the graphic above, **equality does not mean equity**. Though individuals within the community may appear to have equal access to healthier choices, they may remain out of their reach due to systemic barriers beyond their control. To achieve equity, appropriate supports must be in place via policies as well as practice to ensure equitable access is achieved. Potential policy and socioeconomic barriers may not be readily recognizable, so evaluation of systems and policies is essential for population health improvement to occur. Data-driven action, fostering strong community-based partnerships, and promoting health in all policies are also key to eliminating health disparities.

During the 2017 meeting series with the Healthy New Jersey Advisory Council—an external steering committee comprised of healthcare, non-profit, and academic organizations—members classified some potential strategies for identifying health inequities at organizational, state, and local levels. These are summarized in the table below.

Stakeholder Discussion: What can be done to identify and improve health disparities?	
ORGANIZATIONAL LEVEL	STATE/LOCAL LEVEL
<ul style="list-style-type: none"> • Study hospital utilization patterns • Understand staff-client demographics • Evaluate insurance coverage versus health care utilization • Institutionalize cultural competency supports for health care providers • Conduct focus groups, forums, and/or surveys to understand consumer issues • Provision of consumer-friendly transportation and scheduling options to improve access • Know employment status, stressors, and other factors that may impact health of clients 	<ul style="list-style-type: none"> • Implement and promote health in all policies • Analysis of county health indicators and social determinants of health statewide • Awareness of barriers to care, beyond insurance, e.g. transportation, employment, childcare, etc. • Evaluation of health improvement program outcome and participation rates (e.g. chronic diseases self-management program) • Comparison of health outcomes data by socio- economic and demographic characteristics • Understand and support regional- and local- specific health disparity reduction • Investment in rural health areas

New Jersey’s health assets available to reduce disparities are summarized below.

- Regional health collaboratives, which engage health care providers, local authorities, and community-based representatives in region-specific health improvement initiatives and health information exchanges
- Statewide grant programs supporting evidence-based interventions targeting vulnerable populations and coordinated and integrated health care models that address social needs
- NJ-211 website and phone number to communicate community resources 24 hours a day, 365 days a year
- The national Healthy Corner Store Initiative, which increases healthy food access by linking community partners with corner store owners to help them profitably stock,

market, and sell nutritious, affordable foods in communities that are underserved by supermarkets

- Medicaid expansion and Federally Qualified Health Centers (FQHCs)
- Health data availability and research, such as the New Jersey State Health Assessment Data web portal and Rutgers Center for State Health Policy's Integrated Population Health Data Initiative
- Healthy community networks which promote systems-level changes that make healthier choices easier
- Patient and consumer advocacy groups and multi-generational homes that provide family-based support networks
- Investments in children and families, such as subsidized meal programs operating in schools, trauma-informed care to children, youth, and families grounded in the CDC's Adverse Childhood Experiences (ACE), early childhood/school-based healthy lifestyle learning, Supplemental Nutrition Assistance Program (SNAP).



3

Quality of Life

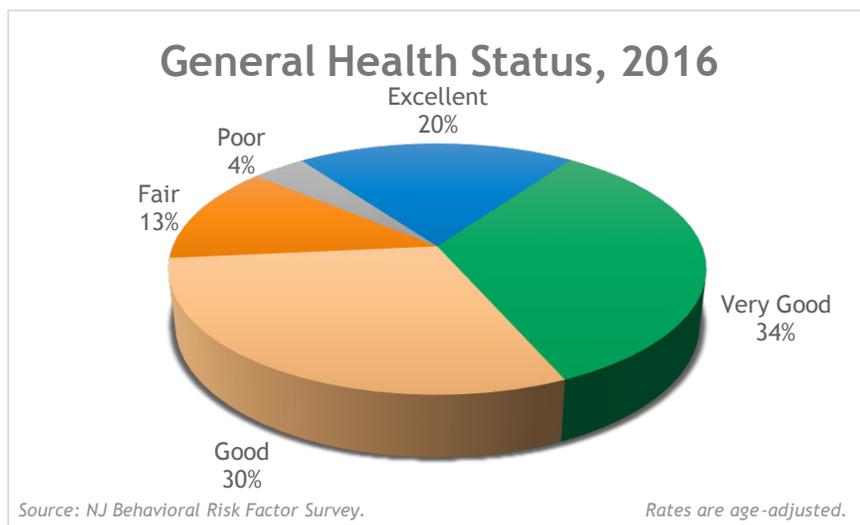
Quality of Life in New Jersey	30
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State Assets and Challenges	32
Limitations	35

QUALITY OF LIFE IN NEW JERSEY

According to Healthy People 2020, “health-related quality of life (HRQOL) is a multi-dimensional concept that includes domains related to physical, mental, emotional, and social functioning.”²² The New Jersey SHA process gathered data and information on New Jersey quality of life and well-being from the following quantitative and qualitative sources.

NEW JERSEY BEHAVIORAL RISK FACTOR SURVEY (NJBRFS)

A cross-sectional telephone survey of non-institutionalized adults aged 18 years old or older in the state, NJBRFS measures HRQOL with four core questions about general health status and number of unhealthy days.



New Jersey county age-adjusted rates for good, very good, and excellent general health status range from 94.0% in Morris to 74.3% in Cumberland. Nationally, 2016 Behavioral Risk Factor Surveillance System results for self-described general health status ranked New Jersey 18th among the 50 states and D.C. in the age-adjusted percentage of residents with excellent general health status (19.8%). When good, very good, and excellent are combined, New Jersey ranked 29th (83.6%).

Other quality of life measures from the New Jersey Behavioral Risk Factor Survey showed that:

- 11.3% of New Jersey residents reported that their physical health was not good 14 or more days in the previous month
- 16.1% had their activities limited due to physical, mental, or emotional problems
- 18.0% have a disability (defined as activity limitation or use of special equipment)
- 10.9% have frequent mental distress (i.e., 14 or more of the past 30 days were not good)

²² [Health-Related Quality of Life & Well-Being](#). Washington, DC: US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020 [Online].

2016 NEW JERSEY HEALTH AND WELL BEING POLL

The quality of life in residential environments can also affect an individual's health. According to the research report, *Wide Differences in Perceptions of Well-Being in New Jersey Communities*,²³ which is the first in a series of briefs from the 2016 New Jersey Health and Well Being Poll, researchers at the Rutgers Center for State Health Policy (CSHP) gained new insight about health and well-being in New Jersey, especially in disadvantaged communities.

Findings from Rutgers CSHP's initial Poll Brief included:

- Higher satisfaction was experienced by those with higher income, White or Asian race/ethnicity, US citizenship, excellent or very good health status, private health insurance, families consisting of 2 or more adults and no children, college graduates, and retired persons.
- “Across all three neighborhood dimensions - as a place to live, buy healthy food, and walk or exercise - people in low income families, or who are black, Hispanic, or non-citizens, or report being less healthy or without health insurance give much lower ratings. For example, compared to the state average, about 1.5 to 2 times as many low-income respondents rate their neighborhoods as a fair or poor place to live (43%), buy healthy food (46%), and walk or exercise (41%).”

HEALTHY NEW JERSEY ADVISORY COUNCIL (HNJAC)

Highlights from discussions with HNJAC community partners about important issues that must be addressed to improve health-related quality of life in the state of New Jersey were:

- The state's high economic pressure, (i.e., expensive cost of living and high-income inequality), was recognized as having the strongest influence on individual and household quality of life.
- A lack of personal transportation or transit options negatively impacts quality of life. This is especially true in rural Cumberland County—which is perennially the worst performing county in the state in terms of health outcomes and health factors²⁴—where transportation barriers affect access to food, healthcare, and employment.
- Another contributing transportation factor is long commuting times. In 2016, New Jersey had the second largest proportion of residents with commute times longer than 60 minutes (15.7%) behind New York (18.0%).²⁵
- Other factors that impact New Jerseyans' quality of life include, risks to physical safety, such as violence and crime, as well as subjective perception of threats and the ensuing feelings of anxiety.

²³ Rutgers Center for State Health Policy. May 2017. [New Jersey Health & Well-Being Poll: Wide Differences in Perceptions of Well-Being in New Jersey Communities](#). 2016 Poll Brief No. 1.

²⁴ [2017 County Health Rankings: New Jersey](#). University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, County Health Rankings & Roadmaps.

²⁵ U.S. Census Bureau; [2016 American Community Survey 1-Year Supplemental Estimates, Travel Time to Work, Table K200802](#); generated by New Jersey Dept of Health; using American FactFinder. <https://factfinder.census.gov>

CHARACTERISTICS OF A HEALTHY STATE

At all geographic levels, several frameworks exist to define what makes a place healthy. The National Center for Health Statistics' report *Health, United States, 2016*²⁶ uses the following indicators to monitor nationwide health status: health status and determinants; health care utilization; health care resources; and health care expenditures. At the local level, various approaches and models have been developed for identifying the key elements of Healthy Settings and Healthy Cities,²⁷ counties,²⁸ municipalities,²⁹ and communities.³⁰

When the Healthy New Jersey Advisory Council (HNJAC) was asked to identify the most important characteristics of a healthy state, a list of six attributes were divided among three categories: 1) health determinants, 2) access to health care and coverage, and 3) health resources:

Characteristics of a Healthy State, 2017		
HEALTH DETERMINANTS	ACCESS TO CARE	HEALTH RESOURCES
Reduction or elimination of health disparities	Access to health insurance and quality health care	Specialty care and behavioral health services
Equal opportunity to achieve economic success	Proficient health literacy skills	Involvement of those that support healthy behaviors outside the traditional health care system

STATE ASSETS AND CHALLENGES

Numerous state, local, public, and private partners contribute to public health initiatives in New Jersey. Community stakeholders, public health professionals, and partners of the Healthy New Jersey Advisory Council (HNJAC) identified statewide assets and resources, which have been summarized below.

ASSETS AND RESOURCES

State assets and resources that can be mobilized to improve population health were identified as part of the SHA development process. Overall, NJ's public health system benefits from the following:

²⁶ National Center for Health Statistics. [Health, United States, 2016: With Chartbook on Long-term Trends in Health](#). Hyattsville, MD. 2017.

²⁷ [Healthy Settings](#). Geneva, Switzerland: World Health Organization.

²⁸ [Community Health Status Indicators \(CHSI\) 2015](#). Atlanta, GA: US Department of Health & Human Services, Centers for Disease Control and Prevention.

²⁹ [About Healthy Municipalities](#). Washington, DC: World Health Organization, Pan American Health Organization, Regional Office for the Americas of the World Health Organization.

³⁰ [Healthy Communities](#). Princeton, NJ: Robert Wood Johnson Foundation.

- A growing commitment to data mining and transparency to support evidence-based interventions
- The transition of health systems from an episodic system of care to one that routinely considers a population health approach
- The move toward applying integrated health models so that mental health, substance use disorder, and physical health care services may be provided in one setting
- An increasingly engaged private sector beginning to understand the importance of population health
- Medicaid expansion allowed for more New Jersey residents who meet financial eligibility standards to receive coverage for many of their health care expenses. Residents who do not qualify for Medicaid may be eligible for free or low-cost health insurance coverage through NJ FamilyCare.

In 2016, the Commissioner of Health convened the Population Health Action Team which represents several state agencies that are working collaboratively by combining their respective assets and resources to improve health outcomes. To provide a few examples:

- The Department of Agriculture promotes child nutrition by driving programs that provide free or subsidized school breakfasts and lunches.
- The Department of Education assists state and local education and health agencies in monitoring and assessing practices related to characteristics of bullying prevention and mental health; nutrition; physical education and physical activity; health-related professional development; school health education; school organization to guide health policy; sexual health; tobacco prevention; and other health topics.
- The Department of Environmental Protection proactively addresses environmental hazards that disproportionately impact NJ residents.
- The Department of Human Service’s provides services that cater to the physically and developmentally disabled.
- The Division of Mental Health and Addiction Services, within the Department of Health as of 2017, assists people who struggle with addictions and mental illnesses.
- The Department of Children and Families provides resources for victims of domestic violence and for LGBTQI adolescents and young adults.
- The Department of Transportation drives local initiatives to support children walking or biking to school to increase hours of physical activity throughout the day.
- The Department of Community Affairs ensures safe and livable housing is available.

More than 90 of New Jersey’s county and local health departments provide essential public health and safety services. The services include but are not limited to the following:

- | | |
|--|---|
| • Animal Bites & Rabies Control | • Inspections (Animal facilities, Potable Wells, and Drinking Safety) |
| • Body Art, Tattoo, And Permanent Cosmetics Safety | • Inquiries, Issues, and Complaint Investigations |
| • Childhood Lead Exposure Prevention | • Recreational Bathing Facilities |
| • Communicable Disease Control | • Retail Food Establishment Safety |

- Emergency Preparedness & Response
- Health Education & Promotion
- School Immunization Record Audits

Other NJ assets identified which can be mobilized statewide to improve health are dedicated community & faith based organizations, regional coalitions, public libraries, non-profit organizations, academic institutions, and private businesses, funders, and foundations.

CHALLENGES

Upon review of some of the poorer performing Healthy New Jersey objectives, partners were asked to discuss these health challenges and their contributing causes. Several overarching issues included socioeconomic factors and overall access to health care services including but not limited to insurance rates:

Socioeconomic Factors

- New Jersey has been cited by national data sources for its high-income inequality³¹, slow job and economic growth³², and high cost of living.³³
- According to *America's Health Rankings*, New Jersey is ranked 36th within the U.S. in terms of health disparity by education and ranked 33rd for air pollution.³⁴
- Within New Jersey, *County Health Rankings* reports social and economic factors³⁵ are worst in the state's most southern counties (Atlantic, Cape May, and Cumberland).

Access to Health Services

- New Jersey's uninsured rate is higher (9.8%) than that of surrounding Mid-Atlantic states, including New York (7.9%), Pennsylvania (7.5%), and Delaware (6.9%).³⁶
- Despite notable strengths of New Jersey's medical assistance programs to help New Jersey residents with access to care, several barriers such as the state's pending acute shortage of specialized health care providers prevent individuals from accessing needed health care services. (Association of American Medical Colleges)

UNDERLYING CAUSES OF STATE HEALTH CHALLENGES

Factors stakeholders cited as contributing to state health challenges:

- Poverty, health literacy levels, and safety and crime levels in neighborhoods, among other socioeconomic and environmental factors, present barriers to accessing needed care which are not well-documented or addressed systematically.

³¹ Posey, K.G. (Sep 2016) [Household Income: 2015](#). U.S. Census Bureau, American Community Survey Briefs.

³² US Bureau of Labor Statistics (Aug 22 2014). [Employment increased in 49 states, decreased in Alaska, from July 2013 to July 2104](#). TED: The Economics Daily.

³³ Cohn, Scott (Jul 11 2017) [America's 10 most expensive states to live in 2017](#). CNBC.com.

³⁴ United Health Foundation. America's Health Rankings 2016 Annual Report: State summary: [New Jersey](#).

³⁵ Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. County Health Rankings and Roadmaps (2017) [New Jersey Rankings: Social & Economic Factors <map>](#).

³⁶ United Health Foundation. America's Health Rankings 2016 Annual Report: State summary: [New Jersey](#).

- Complex health systems coupled with low population health literacy levels.
- Inadequate integration of affordable prevention efforts with population-specific interventions.
- Robert Wood Johnson Foundation’s data showing that ZIP code is a predictor of excess mortality, and differences in life expectancy by race/ethnicity.
- The demand for substance abuse and mental health resources is greater than what is currently available.
- Limited or no public transportation in some areas of the state impacts healthcare access for many.
- Language barriers and limited translation services impact access to quality services among New Jerseyans who speak a language other than English at home.

LIMITATIONS

While this report attempts to provide a comprehensive review of the overall health status of New Jersey residents, there are some noteworthy limitations.

The most recently available data sources were used, but for some of the indicators, this data is several years old.

Data limitations also prevent an extensive analysis of disparities due to sexual orientation, disabilities, or other socio-economic and environmental characteristics which also impact health.³⁷ However, we know they exist. For example, people with disabilities suffer higher prevalence of chronic disease compared to the general population. Improving data collection and analysis is required to better serve these populations.

Stakeholder opportunities for qualitative feedback were vast, but were conducted in multiple forums. Participation rates varied, and several community voices may have been lost, if they did not have representation at the meetings or as members of the Healthy New Jersey Advisory Council. An opportunity to capture their feedback exists during the public comment period of this draft report.

Gaps in the state health assessment data presented in Section 4 occur for a variety of reasons including but not limited to:

- Data source was retired or discontinued during the surveillance period;
- Data collection methodology was changed since baseline measures were developed; or
- New definitions or updated testing/treatment recommendations were implemented.

³⁷ Riley WJ. [Health Disparities: Gaps in Access, Quality and Affordability of Medical Care](#). Transactions of the American Clinical and Climatological Association. 2012;123:167-174.



4

State Health Assessment Data

**2020 Health Improvement Objective
Progress Assessment**

37

Progress Assessment by Topic Area

38

2020 HEALTH IMPROVEMENT OBJECTIVE PROGRESS

A mid-decade review of the Healthy New Jersey 2020 (HNJ2020) initiative was conducted to assess the status of its 100+ health objectives in 20 focus areas. Baseline values were established for each objective beginning in 2010, and specific targets were set to be achieved by the year 2020. The midcourse review provided an opportunity to assess the progress that has been made during the first half of the decade.

CONDITION	STATUS	
The target was met or surpassed	MET	<p>Status of the HNJ2020 objectives toward achieving health improvement goals are classified into 5 categories as defined to the left. For each health improvement objective, the percentage change from baseline (2010 or other specified year) to the most recent data year was analyzed. At a glance, readers can assess population level progress in achieving the objectives thus far.</p> <p>In addition, for each of the 20 HNJ topic areas, qualitative and quantitative data and information gathered from the HNJ Workgroup are organized into the following subheadings as described below:</p>
The change was steady and in the desired direction but the target has not yet been met	IMPROVING	
The change was in the wrong direction	WORSENING	
The change was minimal (< 10% of the proposed improvement) and/or the trend was too unstable to determine its overall direction	NO CHANGE	
There were not enough data points to assess a trend	INSUFFICIENT DATA	

HEALTH DISPARITIES

Significant racial/ethnic, geographic, gender, or socioeconomic differences in health outcomes

POLICIES

Policies which support DOH-sponsored health improvement initiatives as of 2016 to address the health topic area are listed.

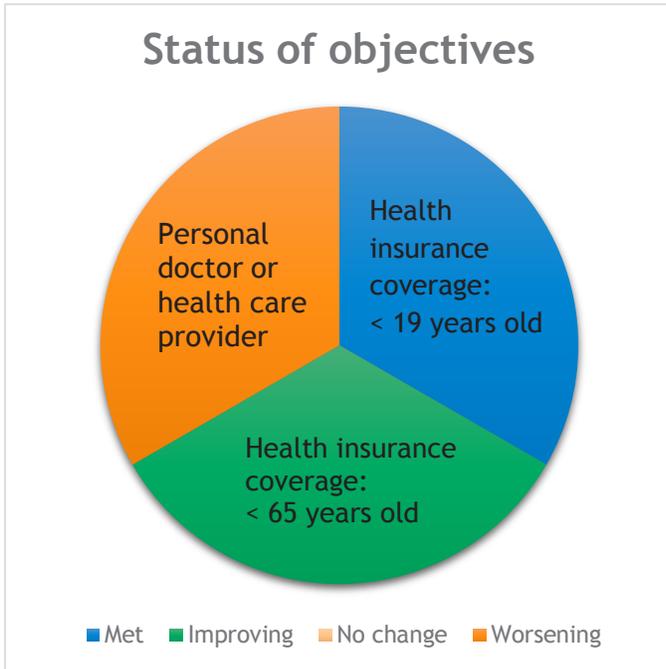
CHALLENGES

Specific challenges cited as underlying or/and contributing to the stated health problems

STATE ASSETS & RESOURCES

State assets and resources that exist and can be mobilized to addresses these health issues

This information is to educate stakeholders as well as to stimulate dialogue and action to reverse poor trends and achieve the set health improvement goals by 2020.

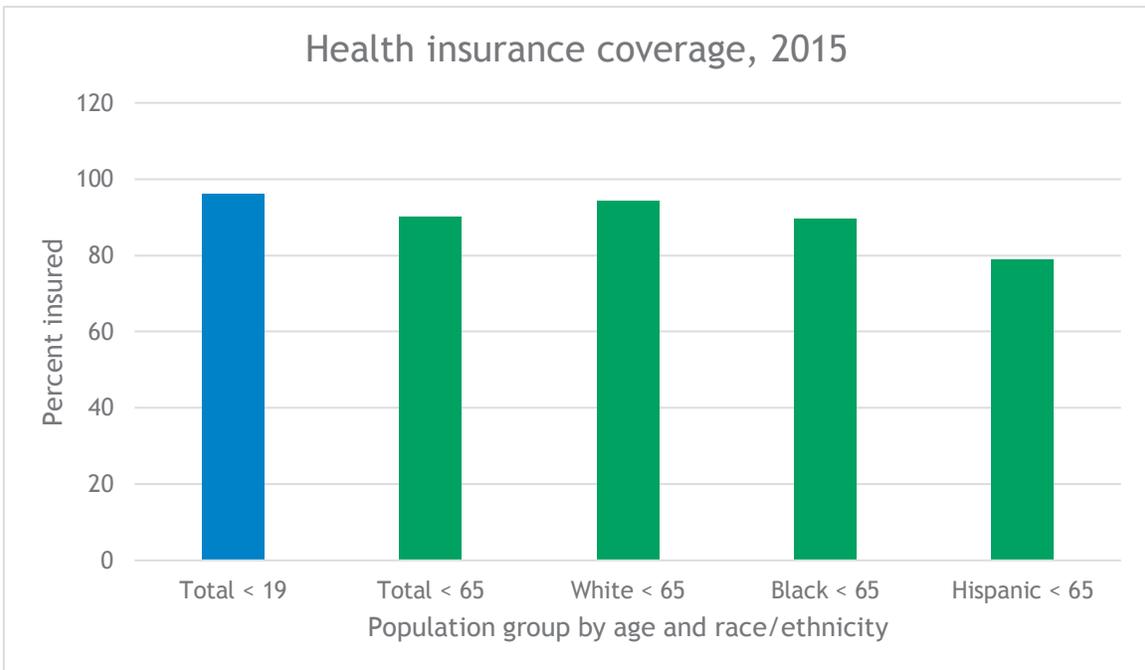


BY THE NUMBERS

90.0 % insured among persons < 65 years of age¹

96.1 % insured among persons < 19 years of age¹

82.0 % of adults with a personal doctor or health care provider²



Sources: ¹Small Area Health Insurance Estimates, US Census Bureau, 2015 data
²NJ Behavioral Risk Factor Survey, New Jersey Department of Health, 2015 data

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

AHS-1a	Health insurance coverage (age < 65)	■
AHS-1b	Health insurance coverage (age < 19)	■
AHS-2	Have primary care provider (age 18+)	■

DISPARITIES

- Black and Hispanic mothers are less likely than White or Asian mothers to receive prenatal care in the first trimester

POLICIES

- The New Jersey Office for Health Information Technology (HIT) promotes the widespread adoption of electronic sharing of clinical data among hospitals, physicians, and other health care stakeholders.
- The Delivery System Reform Incentive Payment (DSRIP) Program is one component of New Jersey's Comprehensive Medicaid Waiver as approved by the Centers for Medicare & Medicaid Services (CMS). DSRIP is a demonstration program designed to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower costs by transitioning hospital funding to a model where payment is contingent on achieving health improvement goals.

CHALLENGES

- The demand for substance abuse and mental health resources is greater than what is currently available.
- Public transportation is limited in some areas of the state which prohibit rural, disabled, and other residents from accessing healthcare services.
- A shortage of physicians, including Medicaid providers and specialists, present a problem for access to quality care.
- Availability of insurance and services alone does not “fix” access to health care problems. Services must be accessible and acceptable to the consumers they aim to serve.

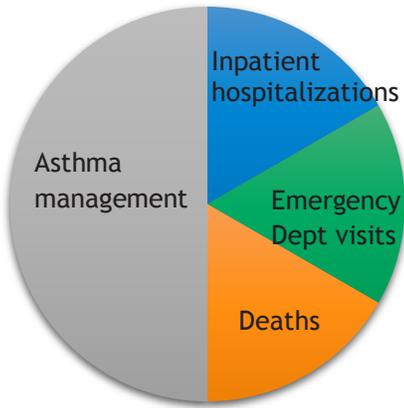
ASSETS

- Federally Qualified Health Centers (FQHCs) deliver high quality health care to all people regardless of their ability to pay. They provide a wide range of services which include Comprehensive Primary and Preventive Health Care, Pediatric Services, Dental Care, Women's Health, Behavioral/Mental Health, Lab Services, HIV/AIDS Counseling and Testing, and much more.
- New Jersey's regional collaboratives and accountable care organizations in Camden, Trenton, Newark, and Paterson are focused on improving access to care for New Jersey's most vulnerable populations. They each have or are building affiliated Health

Information Exchanges which allow for sharing of essential information across health systems, to support better treatment for patients.

- Oral health education programs are provided for children and their families through schools and community groups.
- Fetal and Infant Mortality Review (FIMR) is a structured process set up to continually assess, monitor, and improve service systems and community resources for women, infants, and families.
- Prenatal Care
 - Pediatric healthcare provider training, such as the Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN) Fetal Heart Monitoring courses, breastfeeding and postpartum depression education, and perinatal addictions screenings.
 - Access to Prenatal Care Patient Navigators provide intensive case management services for women in geographically, racially, ethnically, and linguistically diverse communities.
 - The Improving Pregnancy Outcomes program is a health-service grant funded by the New Jersey Department of Health, in collaboration with the state's regional Maternal and Child Health Consortia (MCHC), to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic, and economic disparities in those outcomes through a collaborative coordinated community driven approach through the use of Community Health Workers and Central Intake Hubs.
- New Jersey HIV Collaborative Model links non-clinical testing sites that perform an HIV rapid test to clinical partners that can provide a second HIV rapid test, and immediately links HIV positive persons to care.
- DOH supports the evidence-based "Take Control of Your Health: Chronic Disease Self-Management Program (CDSMP)" which empowers adults with chronic disorders and their caregivers to better manage their conditions and improve their physical and mental health.

Status of objectives



- Met
- Improving
- No change
- Worsening
- Insufficient data

AMONG PERSONS WITH ASTHMA

53%

children who've missed days of school because of asthma

36%

adults who've missed days of work because of asthma

57%

children with an asthma action plan

35%

adults with an asthma action plan

44%

children advised to make changes at home, school, or work to improve their asthma

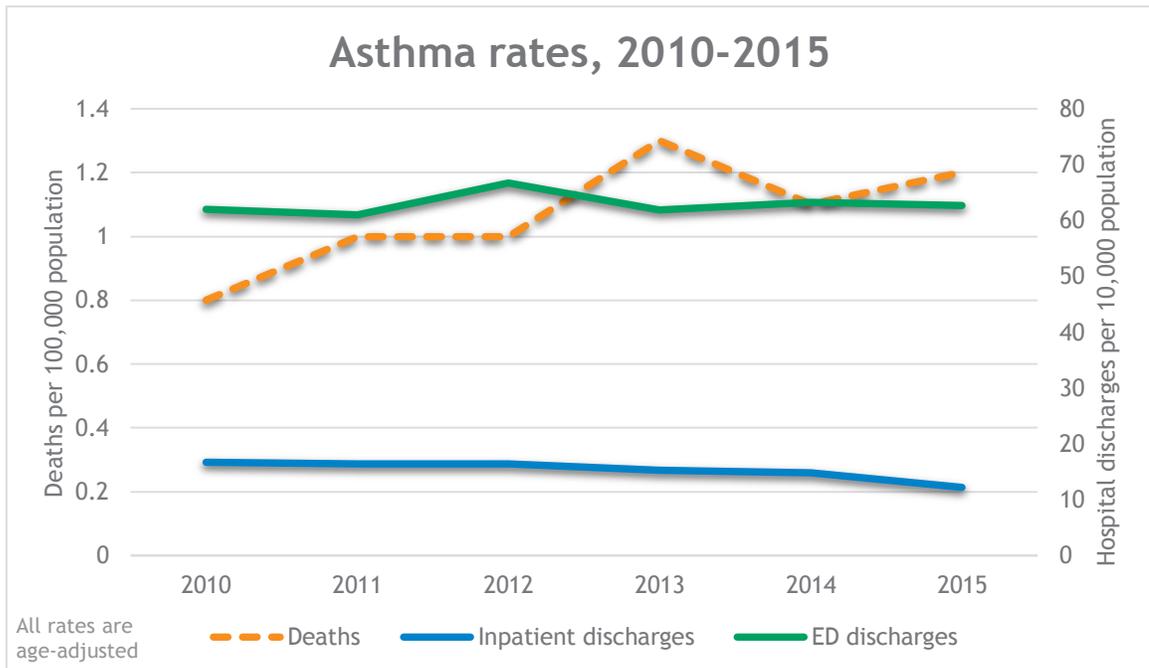
45%

adults advised to make changes to home or work to improve their asthma

2013-2014 data

2014 data

Asthma rates, 2010-2015



Sources: NJ Death Certificate Database, NJ Discharge Data Collection System, and Asthma Call-Back Survey; New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met
 ■ Improving
 ■ No Change
 ■ Worsening
 ■ Insufficient Data

		Age:		
		<5	5-64	65+
AS-1	Deaths		■	■
AS-2	Inpatient hospitalizations	■	■	■
AS-3	Emergency department visits	■	■	■
		Age:		
		< 18	18+	
AS-4	Work and school days missed	■	■	
AS-5	Asthma action/management plan	■	■	
AS-6	Advised to make changes to improve asthma	■	■	

DISPARITIES

- The statewide asthma hospitalization rate continues to be highest among children under 5 years old.
- The asthma hospitalization rate for Black residents in 2015 was about 4 times that of White residents.
- The asthma hospitalization rate for Hispanic residents in 2015 was more than 1.5 times that of White residents.
- Hispanic workers associated with the commercial cleaning industry, manufacturing plants, and painting-related businesses have high rates of occupational asthma.

POLICIES

- Standards 2.1-2.4, and 2.6 in the New Jersey Core Curriculum Content Standards (CCCS) for Comprehensive Health and Physical Education (2009) require students in grades 2, 4, 6, 8, and 12 to receive instruction on communicable and non-communicable diseases and health conditions, diagnostic and preventive measures for diseases including asthma, health and fitness services, the health risks of tobacco use and second-hand smoking on nonsmokers, and the impact of vigorous exercise and activity on personal fitness.
- N.J.S.A. 18A:40-12.3 (Self-administration of medication by pupil) permits students to self-administer medication for asthma or other potentially life-threatening illnesses and allows such students to carry an inhaler at all times.
- N.J.S.A. 18A:40-12.7 (Nebulizer required in schools) requires every NJ school to have and maintain at least one nebulizer in the nurse's office for use by students.
- N.J.S.A. 18A:40-12.8 (Regulations for use of nebulizer in schools) requires each public school board of education to develop policies for the administration of asthma medication through the use of a nebulizer by the school nurse or other trained and

authorized person and requires that students authorized to use asthma medication or a nebulizer have a physician-prepared asthma treatment plan.

- In New Jersey, N.J.A.C. 8:58-1.5 mandates that physicians and advanced practice nurses report individuals diagnosed with work-related asthma to the DOH Occupational Health Surveillance Unit.

CHALLENGES

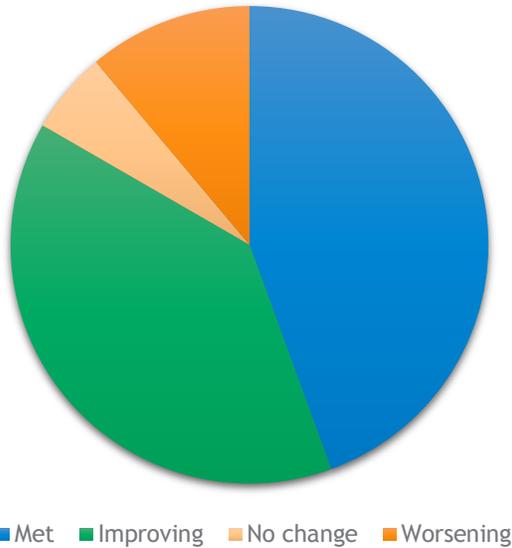
- Education and awareness of asthma triggers and maintenance planning is limited.
- The cost of asthma prevention and treatment medications is high.
- Environmental issues, such as emissions exposures, impact asthma outcomes.

ASSETS

- The Pediatric/Adult Asthma Coalition of New Jersey (PACNJ) works with health care providers, schools, child care providers, environmental agencies, patients, and caregivers to provide resources and tools to help individuals manage their asthma. PACNJ provides free materials and resources that are immediately accessible on its website.
- The Partnership for Prescription Assistance connects qualified, low-income individuals with discount prescription drugs, direct from the pharmaceutical manufacturer.

CANCER

Status of objectives



See next page for full list of objectives and their statuses.

INCIDENCE AND MORTALITY

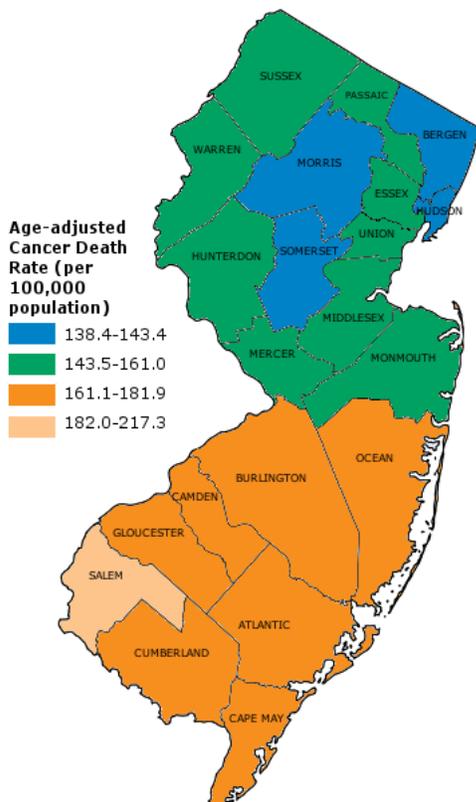
479 Number of new cancer cases per 100,000 NJ residents in 2015

4.0% Decrease in the annual cancer incidence rate between 2010 and 2015

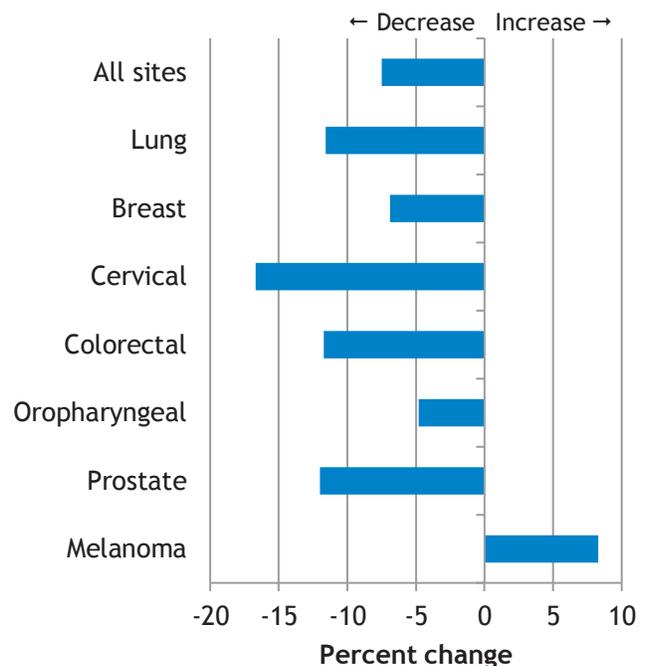
156 Number of cancer deaths per 100,000 NJ residents in 2014

7.5% Decrease in the annual cancer death rate between 2010 and 2014

CANCER MORTALITY RATES, 2014



Change in death rate, 2010-2014



Sources: NJ Death Certificate Database and NJ State Cancer Registry; New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

CA-1	Cancer deaths	■
CA-2	Lung cancer deaths	■
CA-3	Female breast cancer deaths	■
CA-4	Cervical cancer deaths	■
CA-5	Colorectal cancer deaths	■
CA-6	Oropharyngeal cancer deaths	■
CA-7	Prostate cancer deaths	■
CA-8	Melanoma cancer deaths	■
CA-9	Invasive colorectal cancer incidence	■
CA-10	Invasive cervical cancer incidence	■
CA-11	Late-stage female breast cancer incidence	■
CA-12	Oral and pharyngeal cancers detected early	■
CA-13	Five-year survival	■
CA-14	Cervical cancer screening	■
CA-15	Colorectal cancer screening	■
CA-16	Breast cancer screening	■
CA-17	Prostate cancer screening	■
CA-18	Sunburn	■

DISPARITIES

- In the total New Jersey population and among each racial/ethnic group, males have higher cancer incidence and death rates than females.
- The age-adjusted incidence rate due to invasive cancer, which had been highest among Black males in New Jersey for many years, has recently been surpassed by White males.
- The age-adjusted death rate due to cancer is highest among Blacks in New Jersey, but the gap is narrowing.
- Lung cancer death rates among Whites and Blacks are more than double those of Hispanics and Asians.

POLICIES

- N.J.S.A. 18A:40-42 requires public school districts to distribute to parents and guardians of students in grades seven through 12 an educational fact sheet about the causes, symptoms, and means of transmission of HPV (the leading cause of cervical cancer as well as a cause of other types of cancer), and where additional information can be obtained.

- N.J.S.A. 26:2D-82.1 prohibits minors under 17 from using commercial tanning beds in New Jersey and those under 14 are banned from spray-tanning procedures in tanning facilities to reduce the incidence of melanoma and other skin cancers.
- P.L. 106-354 (Breast and Cervical Cancer Prevention and Treatment Act of 2000) gives states the option to provide medical assistance through Medicaid to eligible women who were screened for and found to have breast or cervical cancer, including precancerous conditions, through the National Breast and Cervical Cancer Early Detection Program.

CHALLENGES

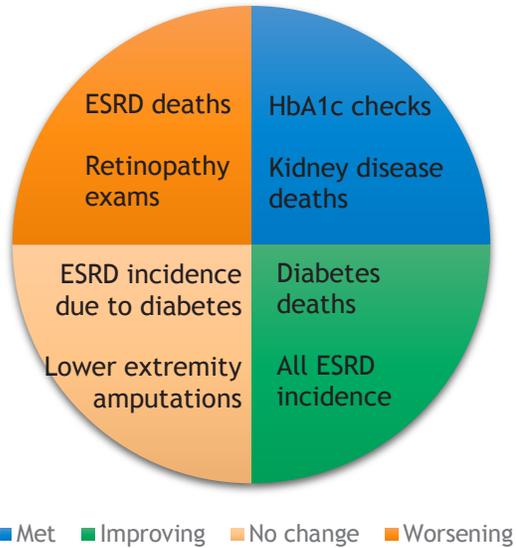
- The New Jersey Cancer Education and Early Detection Screening Program (NJCEED) cannot provide lung cancer screening because of the high cost.

ASSETS

- The NJ State Cancer Registry (NJSCR) is a high-quality cancer registry funded by both the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute (NCI) and the National Program of Cancer Registries. NJSCR's high quality rating by the North American Association of Central Cancer Registries and large case counts make NJ a prime location for cancer research and surveillance.
- DOH helps to promote and facilitate important research in NJ through its partnership with the Rutgers Cancer Institute and Rutgers School of Public Health.
- The DOH Office of Cancer Control and Prevention coordinates 10 Regional Chronic Disease Coalitions (RCDC), which are volunteer groups of over 2,000 individuals and organizations including regional health providers and hospitals, non-profit organizations, faith-based organizations, local health departments, and corporate partners.
- Tobacco Free for a Healthy New Jersey (TFHNJ) regional coordinators facilitated the adoption of 326 (as of January 2018) smoke-free outdoor recreational ordinances through community-based tobacco control coalitions called Integrated Municipal Advisory Councils. TFHNJ and its partners helped to reduce youth access to cigarettes, electronic nicotine delivery systems, and hookah by implementing point-of-sale strategies in establishments that sell these products, particularly within municipalities where retailers are in close proximity to schools.
- The Choose Your Cover initiative is a free, state-wide skin cancer screening and education program coordinated by RCDCs and the Melanoma Workgroup of the Task Force on Cancer Prevention, Early Detection, and Treatment in New Jersey.

CHRONIC KIDNEY DISEASE AND DIABETES

Status of objectives



DEATH RATES

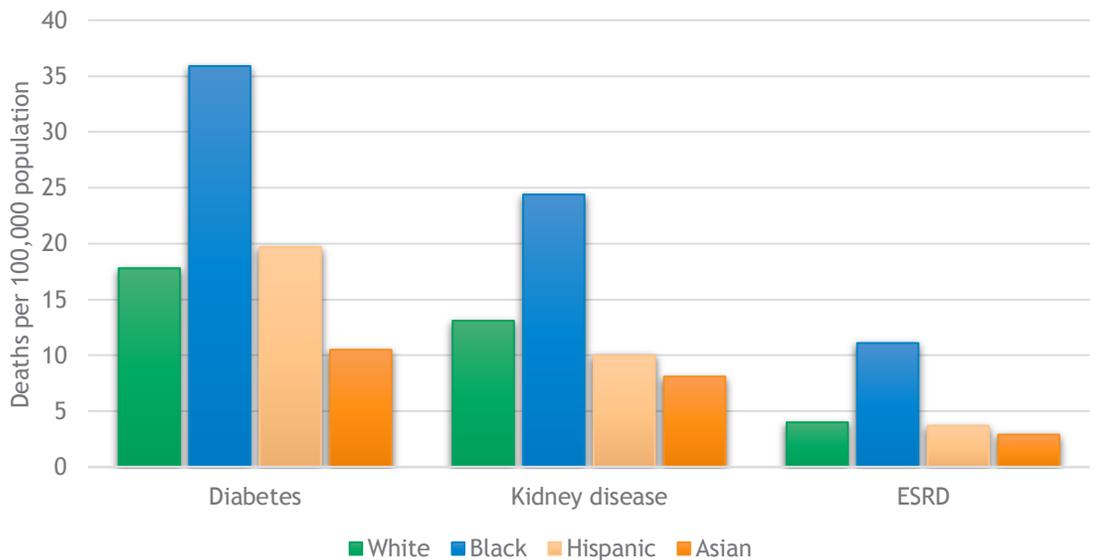
19.4 Diabetes

13.9 Kidney disease

4.6 End-stage renal disease (ESRD)

Rates are age-adjusted per 100,000 residents (2014)

Mortality by race/ethnicity, 2014



All rates are age-adjusted

Sources: NJ Death Certificate Database, New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

CKD-1	Kidney disease deaths	■
CKD-2	End-stage renal disease (ESRD) incidence	■
CKD-3	ESRD incidence due to diabetes	■
CKD-4	End-stage renal disease (ESRD) deaths	■
DM-1	Diabetes deaths	■
DM-2	Lower extremity amputations due to diabetes	■
DM-3	Dilated eye exams among those with diabetes	■
DM-4	Glycosylated hemoglobin (HbA1c) screening	■

DISPARITIES

- As of 2014, the diabetes mortality rate among Blacks was double that of Whites and Hispanics, and over three times that of Asians.
- Blacks with diabetes are more likely to need lower extremity amputations than persons with diabetes of other racial/ethnic groups.
- Similar racial disparities are seen in outcomes related to preventive care such as receiving an annual dilated eye exam and having a glycosylated hemoglobin measurement taken at least twice a year.
- The percentage of Hispanics with diabetes receiving an annual dilated eye exam and having a glycosylated hemoglobin measurement taken at least twice a year are also lower compared to the corresponding estimates for Whites and Asians with diabetes.

POLICIES

- N.J.S.A. 26:2-142.1 requires three state agencies - the Departments of Health (DOH), Human Services (DHS), and Children & Families (DCF) - to collaborate and conduct an evaluation on the impact of diabetes in New Jersey, and create a biennial report to the Governor and the legislature, which includes a set of actionable items that will reduce the burden of diabetes.
- N.J.S.A. 26:2H-18.72 Licensed ambulatory care facilities that provide chronic renal dialysis services must also provide uncompensated outpatient renal dialysis treatment, services, and medication associated with dialysis treatment for uninsured low-income persons.

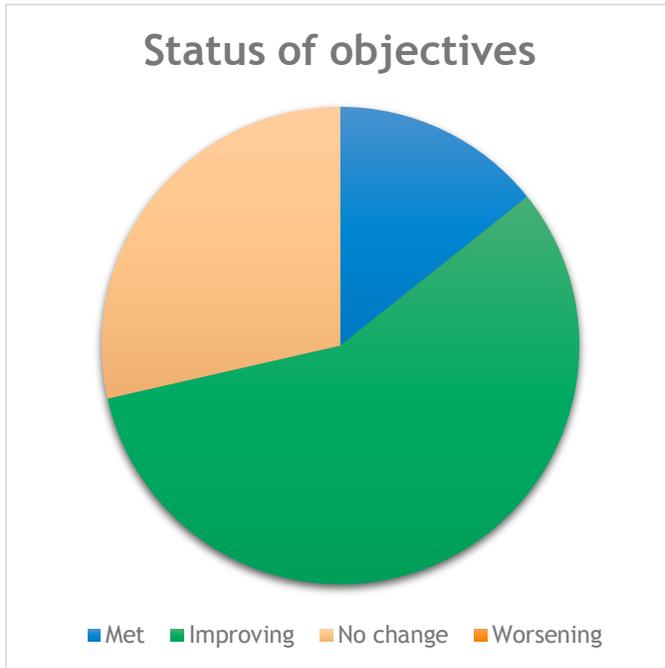
CHALLENGES

- There are not enough community-based prevention and self-management programs to meet the need. Further, the high cost and lengthy duration of the programs often impede participation or completion by those targeted for intervention.

- Lack of health care provider confidence in community-based prevention and self-management programs results in limited referrals to existing programs and interventions.

ASSETS

- The Diabetes Self-Management Program (DSMP) Synergy work group is comprised of representatives from the DOH Diabetes Prevention and Control Program (DPCP), DHS Division on Aging, and the DOH Office of Minority and Multicultural Health, to share data, leverage funds and resources, and align programmatic efforts to increase capacity of DSMP.
- The DOH Diabetes Prevention and Control Program (DPCP) established the Diabetes Prevention Program Network, a statewide group of diabetes prevention stakeholders, to address service gaps and identify opportunities for increasing prevention programs.
- DPCP leads the implementation of the New Jersey Diabetes Action Plan (N.J.S.A. 26:2-142.1).
- Diabetes Resources Coordination Centers (DRCC), funded by the Centers for Disease Control and Prevention (CDC) through the New Jersey Department of Health, work to promote diabetes self-management education for New Jerseyans diagnosed with diabetes, as well as lifestyle intervention programs for residents at risk for type 2 diabetes.



See next page for full list of objectives and their statuses.

BY THE NUMBERS

8 Unhealthy air quality days¹

20 Beach closings²

30 % of homes tested for radon²

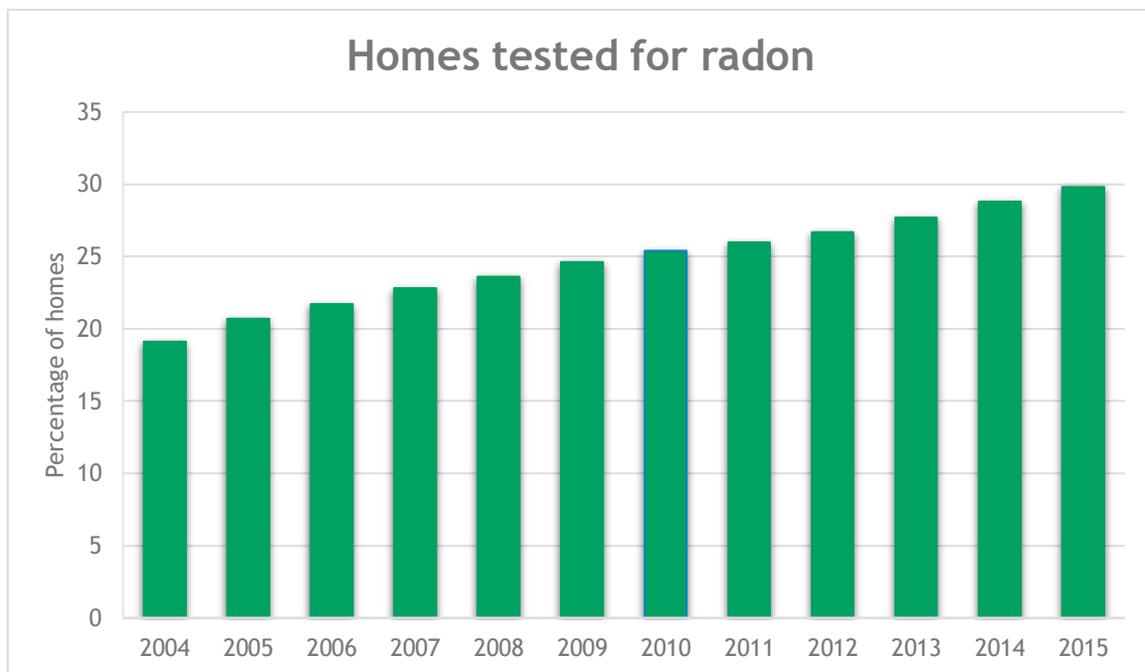
47 % of high radon homes mitigated²

% of Community Water Systems meeting:

95 Microbiological requirements¹

98 Radiological requirements¹

99 Chemical requirements¹



Sources: Air Radiation Monitoring System, Radon Database, Safe Drinking Water Information System, and Beach Monitoring System; New Jersey Department of Environmental Protection

¹ 2014 data, ² 2015 data

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

EH-1	Air quality	■ No Change
EH-2	Radon testing	■ Improving
EH-3	Radon mitigation	■ Improving
EH-4	Drinking water requirements compliance:	
a	Chemical	■ Improving
b	Radiological	■ No Change
c	Microbiological	■ Improving
EH-5	Beach closing	■ Target Met

DISPARITIES

- Poor air quality disproportionately affects people who live or work in close proximity to sources of air pollution. Those most impacted are low income, minority populations, who live near high traffic roads, heavy industry, and/or incinerators.

POLICIES

- N.J.A.C. 7:27 Air Pollution Control
- N.J.A.C. 7:27A Air Administrative Procedures and Penalties
- N.J.A.C. 7:27B Sampling and Analytical Procedures
- N.J.A.C. 7:28-27 Certification of Radon Testers and Mitigators
- N.J.A.C. 5:23-10 Radon Hazard Subcode of the Uniform Construction Code
- N.J.A.C. 7:10 Safe Drinking Water Act Rules
- New Jersey Department of Environmental Protection (DEP) conducts statewide beach water monitoring and daily web posting of results

CHALLENGES

- Air quality in NJ is highly impacted by pollution from motor vehicles and other forms of transportation.
- Point source air pollution from surrounding states contributes to poor air quality.
- NJ has been highly industrialized for more than 100 years and, unfortunately, also has a long history of air, water, and soil pollution.

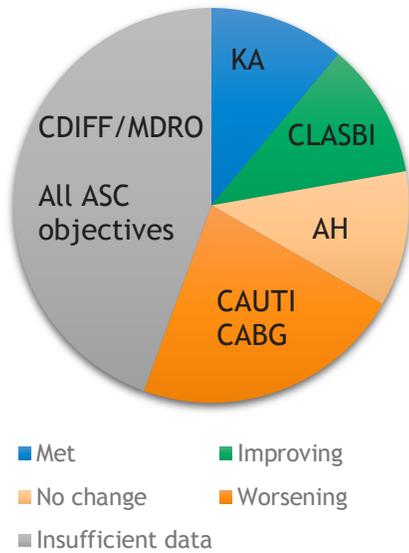
ASSETS

- The DEP collects a robust set of private well, radon, air, and community water datasets. The DOH Environmental and Occupational Health Surveillance Program maintains a strong partnership with DEP.

- DOH and DEP receive CDC funding for NJ's Environmental Public Health Tracking (EPHT) program, and collaborate within and across agencies to improve environmental health in NJ communities.
- EpiCenter, a real-time emergency department visit notification software system, is used by the EPHT Network to monitor statewide ED admissions due to carbon monoxide poisoning, heat-related illnesses, and chemical poisoning.

HEALTHCARE ASSOCIATED INFECTIONS

Status of objectives



DOH was unable to collect CDI/MDRO data and the number of surgical site infections acquired in ASCs is too small to calculate reliable rates

Abbreviations:

AH = surgical site infections (SSI) in Abdominal Hysterectomies in hospitals

ASC = Ambulatory Surgery Center

CABG = surgical site infections (SSI) in Coronary Artery Bypass Grafts

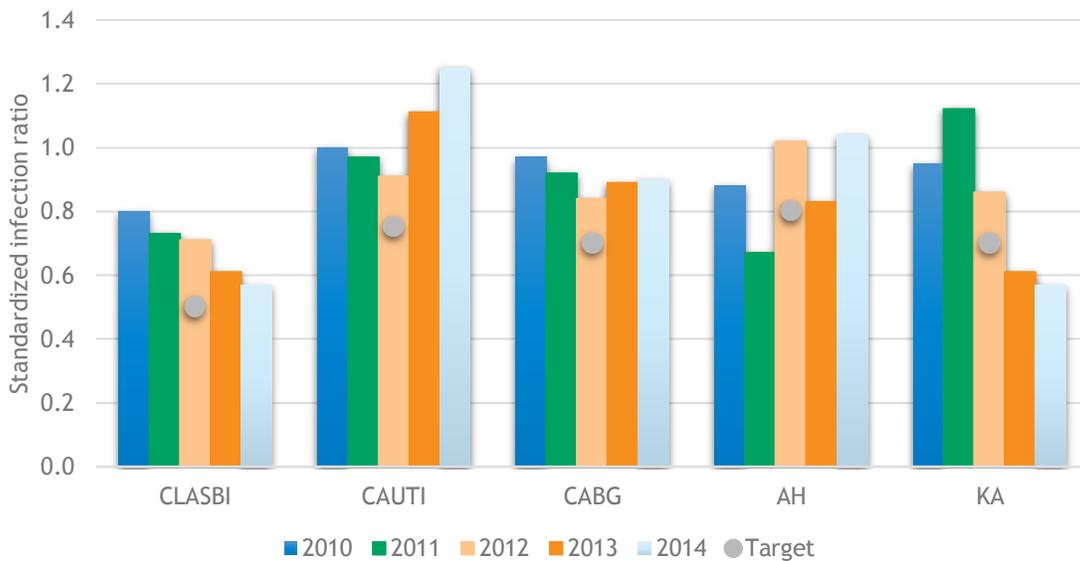
CAUTI = Catheter Associated Urinary Tract Infections

CDIFF/MDRO = Clostridium Difficile/Multidrug Resistant Organism infections

CLASBI = Central Line-Associated Bloodstream Infections

KA = surgical site infections (SSI) in Knee Arthroplasties in hospitals

Standardized infection ratios, 2010-2014



Standardized Infection Ratio = # of observed infections / # of expected infections derived from the national baseline

Source: CDC National Healthcare Safety Network (NHSN)

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

HAI-1	CLASBI	■
HAI-2	CAUTI	■
HAI-3	CDIFF/MDRO	■
HAI-4	SSI in CABGs	■
HAI-5	SSI in abdominal hysterectomies	■
HAI-6	SSI in knee arthroplasties	■

DISPARITIES

- The elderly and those with compromised immune systems are at increased risk for Healthcare Associated Infections (HAI).

POLICIES

- N.J.A.C. 8:56 Health Care Facility Infection Reporting Regulations
- N.J.A.C. 8:57 Communicable Disease Reporting Regulation
- Both regulations require the reporting of HAIs to DOH which guides prevention efforts by following up with facilities that are having issues with certain diseases or outbreaks.

CHALLENGES

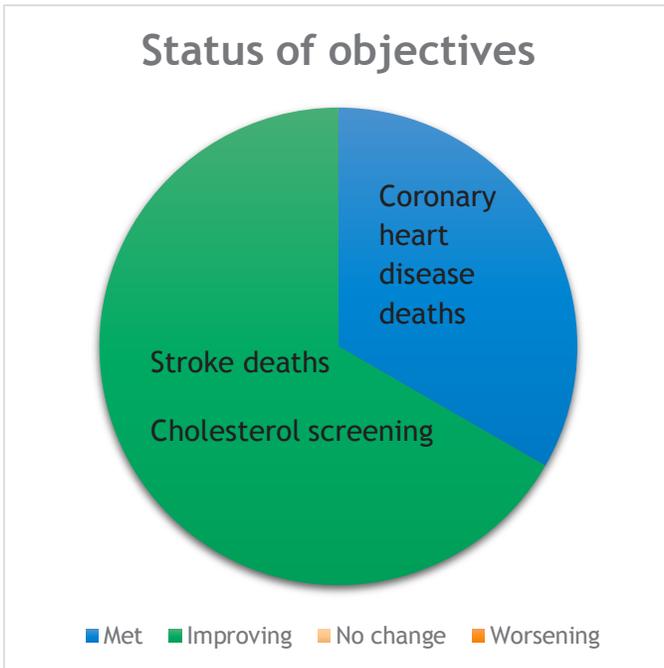
- Race and gender are not required fields for the National Healthcare Safety Network (NHSN) database, so health disparities cannot be analyzed.
- NHSN data is self-reported and verified by hospitals, but there is a lack of staffing and funding to conduct data audits to assess accuracy.

ASSETS

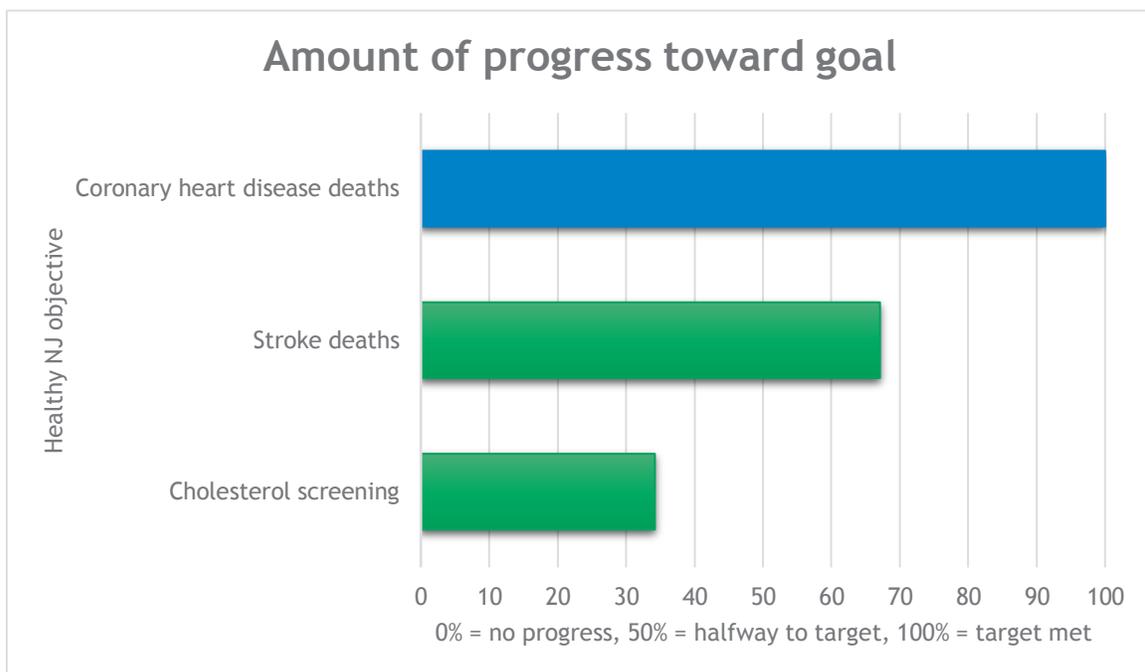
- DOH applies a non-punitive approach when providing HAI prevention and infection control technical assistance to facilities in CDC's National Healthcare Safety Network (NHSN) or when investigating outbreaks. This encourages reporting and leaves facilities more open to suggestions and prevention strategies.
- New Jersey is one of thirteen states that collect and publicly report HAIs associated with Coronary Artery Bypass Graft (CABG) procedures. NJ is one of only eleven states that collect and publicly report HAIs associated with knee arthroplasty procedures.
- CDC's NHSN is the nation's most widely used HAI tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections.

HEART DISEASE AND STROKE

RATES BY RACE/ETHNICITY



*Age-adjusted per 100,000



Sources: NJ Death Certificate Database and NJ Behavioral Risk Factor Survey, New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

HDS-1	Coronary heart disease deaths	■
HDS-2	Stroke deaths	■
HDS-3	Cholesterol screening	■

DISPARITIES

- The coronary heart disease death rate is highest among Blacks but the larger disparity is between males and females.
- Blacks have the highest stroke death rate and are the only racial/ethnic group for whom the rate among males is significantly higher than among females.
- Death rates for both diseases are much higher in South Jersey than in North and Central Jersey.
- Heart disease and stroke burden is higher among minority, rural, and low-socioeconomic populations.

POLICIES

- N.J.A.C. 26:2H-12.28 designated general hospitals that meet certain standards as either Primary or Comprehensive Stroke Centers and established minimum criteria for the Centers.

CHALLENGES

- The rising prevalence of obesity and diabetes, which are strong determinants of later heart disease and stroke, contribute to death and morbidity from this cause.

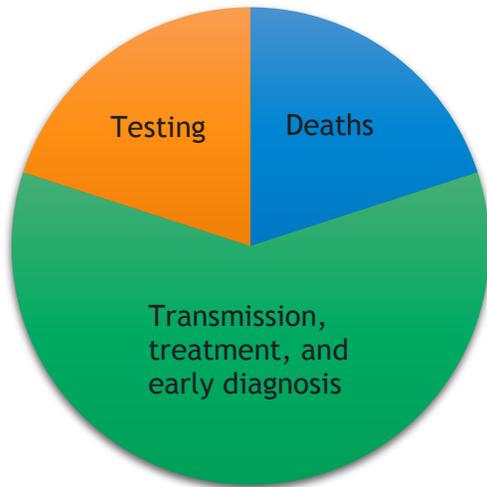
ASSETS

- The NJ Acute Stroke Registry, Open Heart Surgery Registry, and the Cardiac Catheterization and Angioplasty Data Registry are DOH data collection systems that measure and improve the quality of cardiac- and stroke-related treatment and care within New Jersey comprehensive and primary stroke centers, cardiac surgery hospitals, and cardiac catheterization laboratories.
- The DOH Heart Disease and Stroke Prevention (HDSPP) program designed the Team-based care/Electronic health record Enhancement (TEE) assessment to document and evaluate Federally Qualified Health Centers' (FQHC) capacity to use health information technology and care coordination protocols to control high blood pressure. Findings from the TEE assessment inform evidence-based recommendations for the FQHCs to enhance electronic health record performance and/or team-based care.
- HDSPP partners with Regional Planning Collaboratives to incorporate clinical decision support systems for the management of patients with high blood pressure into their health information exchange. This ensures that all those engaged in the care process

have the information they need to make sound decisions and take appropriate actions that will lead to improved outcomes for patients with high blood pressure.

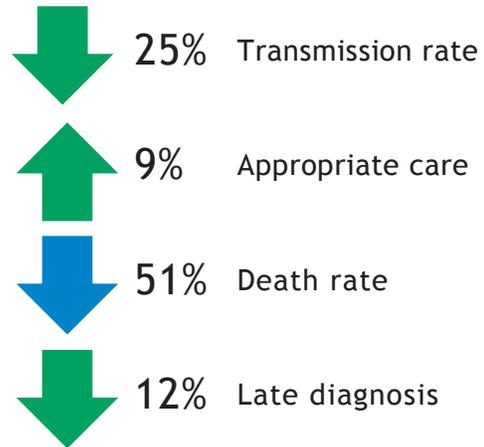
- The HDSPP partners with accountable care organizations to adopt evidence-based strategies to promote awareness of high blood pressure among patients.

Status of objectives



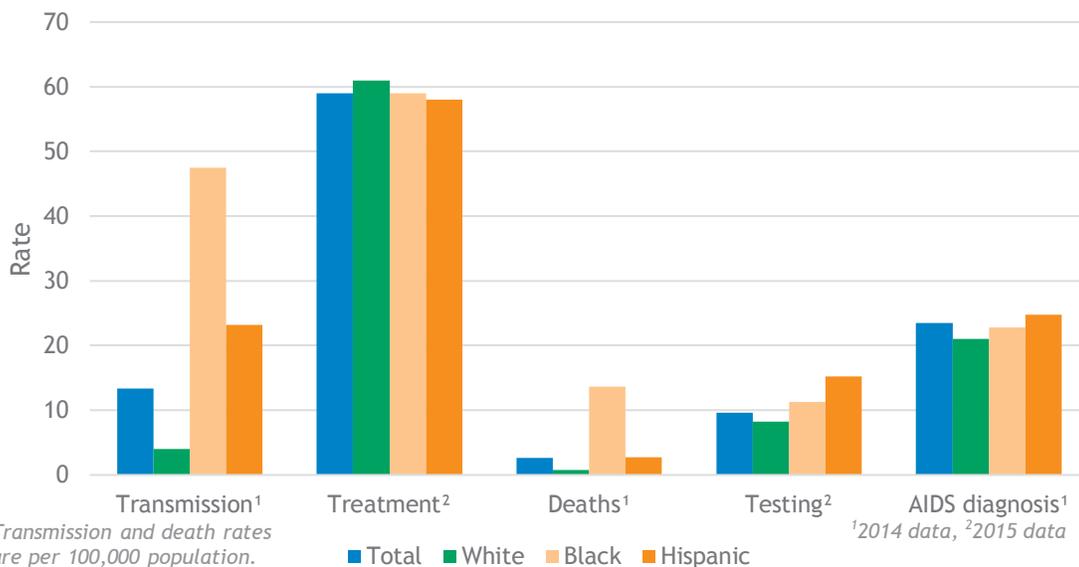
■ Met ■ Improving ■ No change ■ Worsening

IMPROVEMENT FROM BASELINE



In 2013, the US Preventive Services Task Force (USPSTF) released updated recommendations for HIV testing. This objective will be updated in future reports to meet current standards.

HIV infection in New Jersey, 2014-2015



Sources: Enhanced HIV/AIDS Reporting System, NJ Death Certificate Database, and NJ Behavioral Risk Factor Survey; New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

HIV-1	HIV transmission	■
HIV-2	HIV care and treatment	■
HIV-3	HIV deaths	■
HIV-4	HIV testing (annual)	■
HIV-5	Simultaneous diagnosis of HIV and AIDS	■

DISPARITIES

- Gay, bisexual, and other men who have sex with men (GBO), in particular young GBO under 25, of all races and ethnicities have higher incidence and prevalence rates of HIV and AIDS compared to the rest of New Jersey's population.
- About 75% of those living with HIV/AIDS are Black or Hispanic.
- Nearly 80% of those living with HIV/AIDS are 40 years old or older.
- Racial/ethnic minorities account for 77% of HIV/AIDS cases ever reported to DOH, and 79% of all persons living with HIV.
- Thirty-six percent of new HIV infections between July 1, 2015 and June 30, 2016 occurred among gay/bisexual men and 3% among injecting drug users.

POLICIES

- N.J.A.C. 8:57-2 Reporting of AIDS and Infection with HIV to DOH
- N.J.A.C. 8:61-3.4 - 3.6 AIDS Drug Distribution Program (ADDP)

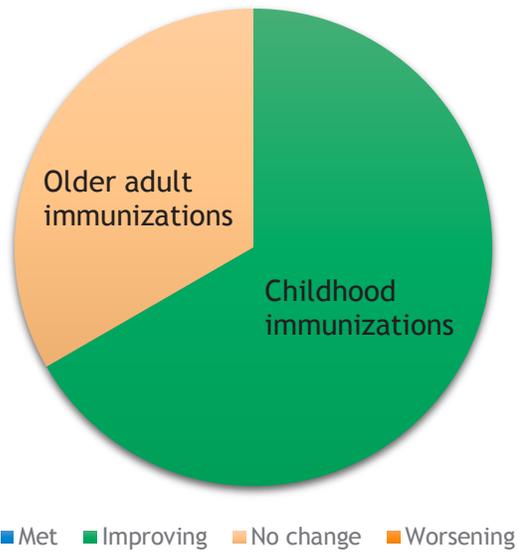
CHALLENGES

- Continued HIV-related stigma, both within communities and among health care providers.
- Homelessness among HIV positive persons remains a significant barrier to medication adherence that impacts viral suppression.

ASSETS

- An extensive network of well-established and effective HIV care and prevention providers within the state work as community partners with DOH to deliver HIV services to high risk and HIV-infected individuals.
- The DOH Division of HIV, STD, and TB Services collaborates with other HIV funding entities in New Jersey to leverage assets and prevent duplication of funding.
- The AIDS Drug Distribution Program (ADDP) serves as a safety net for HIV treatment, with an open formulary, providing new antiretroviral (ART) medications immediately upon approval by the FDA. Through a systems approach, the DOH HIV Prevention and Care program has integrated HIV testing, linkage, and access to treatment services allowing clients to access ART as soon as possible.

Status of objectives

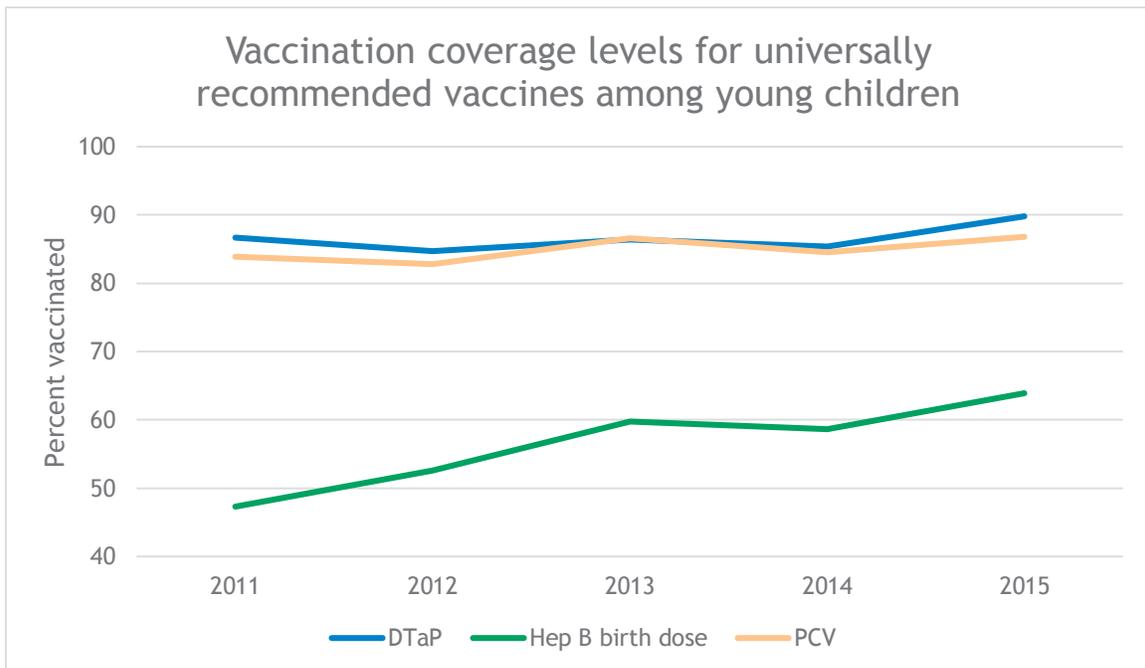


VACCINATION COVERAGE RATES

- 89.8** % with diphtheria-tetanus-acellular pertussis (DTaP) vaccine by age 19-35 months
- 86.8** % with pneumococcal conjugate vaccine (PCV) vaccine by age 19-35 months
- 76.5** % with all recommended vaccines by age 19-35 months
- 63.9** % with Hepatitis B (Hep B) vaccine birth dose
- 65.1** % age 65+ with pneumococcal vaccine
- 60.7** % age 65+ with annual flu vaccine

All are 2015 data above

Vaccination coverage levels for universally recommended vaccines among young children



Source: CDC National Immunization Survey and NJ Behavioral Risk Factor Survey, New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

IMM-1	Universally recommended vaccines	
a	Diphtheria-tetanus-acellular pertussis (DTaP)	■
b	Hepatitis B (HepB) birth dose	■
c	Pneumococcal conjugate vaccine (PCV)	■
IMM-2	All recommended childhood immunizations	■
IMM-3	Pneumococcal vaccination among adults aged 65+ years	■
IMM-4	Influenza vaccination among adults aged 65+ years	■

DISPARITIES

- Black and Hispanic older adults are less likely to be immunized against pneumococcal infections and seasonal flu than Whites.

POLICIES

- N.J.A.C. 8:43G-19.2 (Hospital Licensing): All pregnant women admitted to the hospital with unknown or undocumented hepatitis B surface antigen (HBsAg) assay results shall be immediately screened for the hepatitis B virus using the HBsAg test or other standardized hepatitis B tests. Test results should be available within 24 hours but no later than 48 hours.
- N.J.A.C. 8:57-1.6 (Communicable Diseases): Confirmed cases of hepatitis B, including positive HBsAg test in a pregnant woman, should be reported to the local health department within 24 hours of diagnosis.
- N.J.A.C. 8:57-4 (Immunization of Pupils in School): Sets minimum immunization requirements for school attendance in NJ.
- N.J.A.C. 8:52 (Local Health Performance Standards): Requires local health departments to audit childcare/preschools and schools annually.
- NJ Assembly Joint Resolution. No. 95 (8/1/2016) designates August of each year as Adult Vaccine Preventable Disease Awareness and Improvement Month.

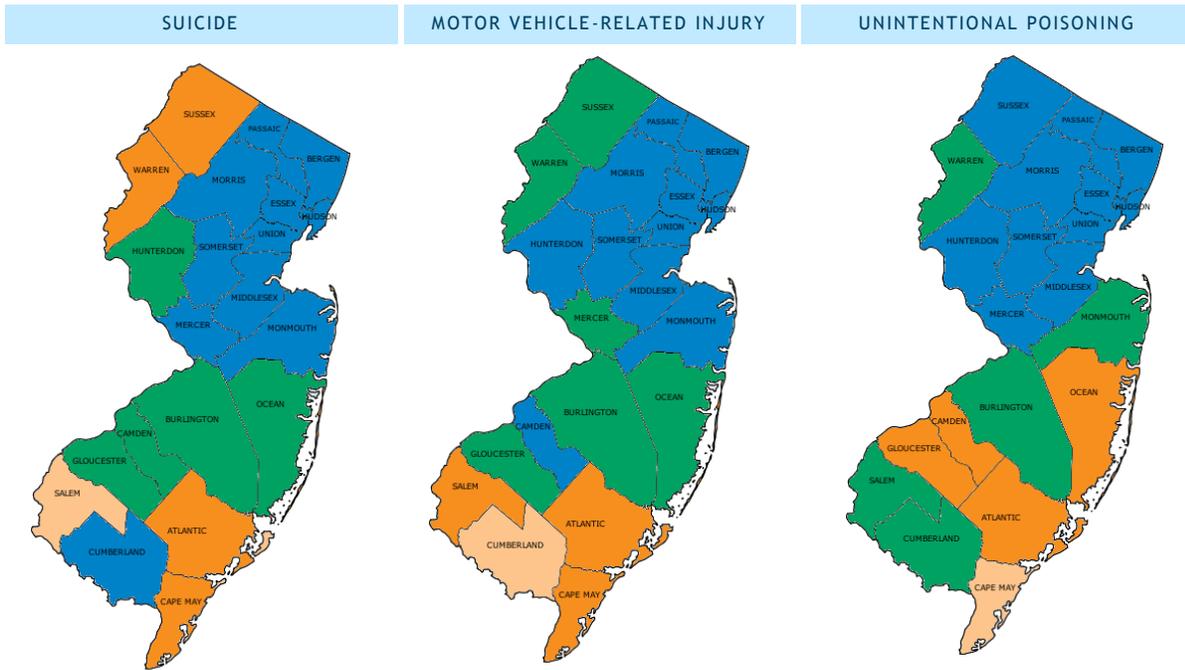
CHALLENGES

- Local health departments are charged with enforcing vaccination requirements and are facing staffing/resource challenges.
- Currently, providers are only required to report immunizations for children up to 7 years of age, limiting the data available in the NJ Immunization Information System (NJIS) for older children.
- DOH must rely on National Immunization Survey (NIS) data for childhood vaccination coverage rates, which does not provide data by race or ethnicity.

ASSETS

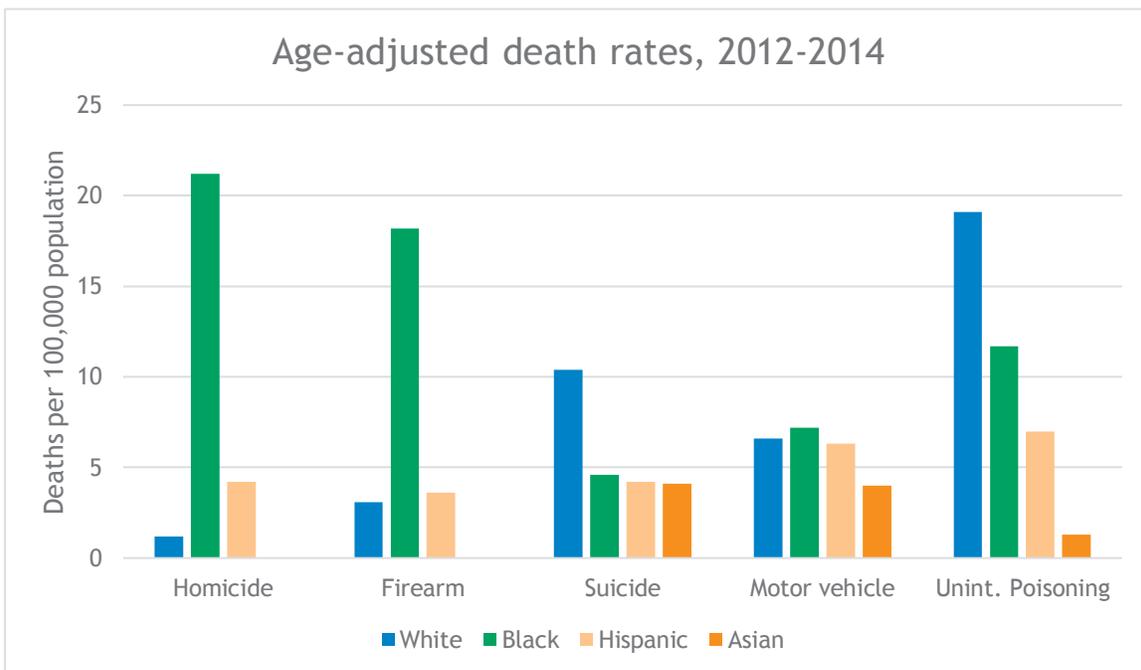
- DOH Vaccine Preventable Disease Program (VPDP) provides access to vaccines for the uninsured and underinsured through the administration of the Vaccines for Children (VFC) Program. In 2015, the VFC program provided approximately 1.6 million doses of vaccines to providers throughout NJ.
- New Jersey 317-Funded Adult Program, which is available at most Federally Qualified Health Centers (FQHCs) and local health departments, provides adult vaccinations to patients who are 19 years of age and older with no insurance coverage for the Advisory Committee on Immunization Practices (ACIP)-recommended vaccines, or seeking vaccines during outbreak response and public health emergencies.
- Adult Immunization Sourcebook, developed by the New Jersey Immunization Network, in partnership with the American College of Physicians, contains information for health care providers and professionals on topics such as adult vaccines, vaccine safety and administration, recommendation guidelines, and vaccinating special populations.
- VPDP mandates annual reporting for schools and childcare facilities in order to assess immunization compliance rates and identify gaps.
- Local health departments (LHD) have the authority to provide corrective action and fine schools that have enrolled children who do not have required immunizations. Furthermore, LHDs can provide corrective action to those institutions that have not completed the annual report.
- The New Jersey Immunization Information System receives immunization data through interfaces with pharmacies, hospitals, family practices, internal medicine practices, and other providers who immunize patients across the lifespan.
- New Jersey Hepatitis B Coalition—in collaboration with the Center for Asian Health, St. Barnabas Medical Center, DOH Office of Minority and Multicultural Health, and DOH Vaccine Preventable Disease Program—coordinates efforts in the prevention and control of hepatitis B through education, screening, and linkage to care programs.

INJURY AND VIOLENCE PREVENTION



Map color key: Lowest rates Low rates High rates Highest rates

All rates are age-adjusted per 100,000 resident population and are for data years 2012-2014 combined.



Source: NJ Death Certificate Database, New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met
 ■ Improving
 ■ No Change
 ■ Worsening
 ■ Insufficient Data

	Age:	all	15-19	20-34
IVP-1 Homicide		■	■	■
IVP-2 Firearm-related injury deaths		■	■	
IVP-3 Suicide		■		
IVP-3 Suicide attempts among high school students		■		
IVP-5 Motor vehicle-related injury deaths		■		
IVP-6 Unintentional poisonings		■		
		18+	HS students	Observed
IVP-7 Seat belt usage		■	■	■

DISPARITIES

- The homicide rate among Blacks is 17 times the rate among Whites. The highest rate is among Black males aged 15-34 years.
- The firearm-related death rate among Blacks is 5.4 times the rate among Whites and Hispanics. Highest rates are among young Black males.
- Urban areas have much higher homicide and firearm injury-related death rates than suburban and rural parts of the state.
- Suicide is the third leading cause of death among New Jersey residents aged 15-24 years and second among those aged 25-34. Rates are highest in southern and northwestern New Jersey.
- The majority (60%) of suicides are White males and the age-adjusted death rate among this group is more than double that of any other racial/ethnic/sex group. Among high school students, Hispanics have the highest suicide attempt rate.
- The motor vehicle-related death rate among males is 2.5 times that of females and rates in South Jersey far outpace North and Central Jersey rates.
- Pedestrian fatalities are much higher in urban areas than in rural areas, and males are generally three times more likely to be a pedestrian fatality than females. Fatality rates increase with age.
- The unintentional poisoning death rate has been higher among Whites than among Blacks and Hispanics since 2010 and the gap is widening. Males have higher rates than females and South Jersey has the highest rates.

POLICIES

- Motor Vehicle-Related:
 - Child Safety Seats (New Jersey Child Passenger Restraint Law. (Title 39:3-76.2a): Children under age 2 (and <30 lbs.) must be in a rear-facing infant seat; under age 4 (and <40 lbs.) must be in a child safety seat; under age 8 (and <57" tall) must be in a child safety or booster seat and in the rear seat, if available.
 - Graduated Driver Licensing (N.J.S.A. 39:3-10, 39:3-13 through 39:3-13.8): NJ is one of 8 states to require age 16 for the learning stage, the only state to require age 17 for the intermediate stage, and one of 8 states to require age 18 for full driving privileges.
 - Drunk Driving (P.L. 2003, c.314): NJ is one of only two states with 0.08 as the lowest blood alcohol content (BAC) at which penalties apply. Our open container, repeat offender, and ignition interlock laws meet or exceed federal standards.
 - Distracted Driving (N.J.S.A. 39:4-97.3): NJ has primary enforcement laws banning hand-held devices and text messaging. Cell phones that are not hand held are still banned for use by school bus drivers and novice drivers.
 - Helmets: NJ enacted its Universal Helmet Law for motorcyclists (P.L. 39:3-76.7) in 1968 and requires all bicyclists under age 17 to wear a helmet (P.L. 39:4-10.1).
 - Seat Belts (N.J.S.A. 39:3-76.2f): NJ seat belt laws are primary for front seat passengers of any age and secondary for rear seat passengers of any age, except younger children covered under child safety seat requirements.
- Unintentional Poisoning:
 - In 2017, New Jersey enacted legislation limiting initial opioid prescriptions for acute pain to 5 days, and requires insurers to cover up to 6 months of treatment for substance use disorders without preauthorization.
 - New Jersey Patient Safety Act (P.L. 2004, c.9) established a medical error reporting system for health care providers.
 - Overdose Prevention Act (P.L. 2013, c.46) provides immunity from arrest and prosecution for drug possession for those who call 911 for suspected overdoses and makes naloxone available to non-health professionals.
 - The scope of the New Jersey Prescription Monitoring Program (NJMPMP) expanded as a result of the 2015 law to require physicians to check the NJMPMP when patients request refills on opioid medications.

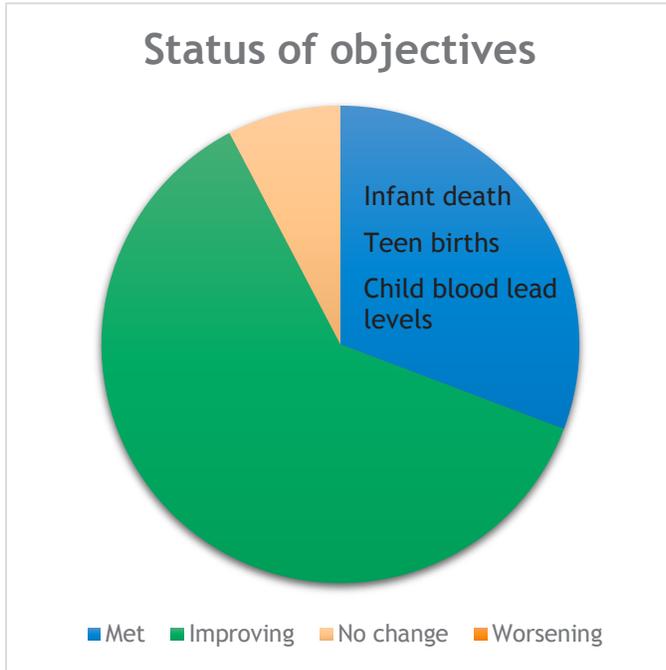
CHALLENGES

- The lack of a centralized injury prevention program results in limited coordinated injury and violence prevention strategy, difficulty in setting goals, and difficulty applying for and receiving funding.
- Lack of access to safe, equitable, and reliable public transportation can hinder recovery after an injury.

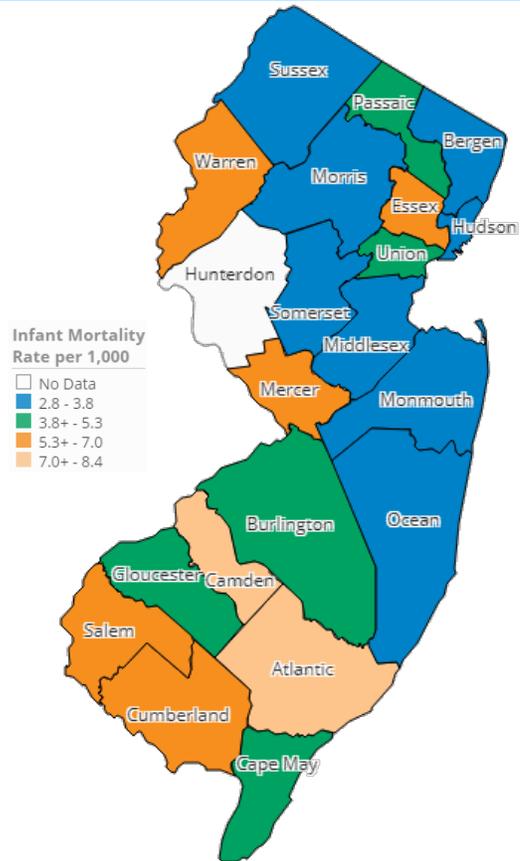
ASSETS

- NJ's State Opioid Taskforce provides a forum for state agencies to exchange information and share best practices to combat the opioid crisis.
- New Jersey Poison Information & Education System, the state's only poison control center, operates a 24/7 hotline and provides the public with immediate help and information about poisoning emergencies and concerns.
- DOH is the central reporting agency for vital events, hospital and emergency room discharges, and many other state data collection initiatives.
- Governor's Study Commission on Violence, established by N.J.S.A. 52:17B-239 et seq., was charged to study violence in order to raise awareness about it as one of the country's most significant public health crises.
- NJ participates in CDC's National Violent Death Reporting System (NVDRS). NJVDRS is a surveillance system that links data from multiple sources into a single standardized record of a violent death. It provides state-level data on violence trends which can be used to drive policy and prevention efforts.
- The Governor's Council on Drug Addictions was established by N.J.S.A. 26:2BB to perform policy and planning, public awareness and education, and administer the Alliance to Prevent Alcoholism and Drug Abuse Program. The Council is an active and collaborative participant in the planning and coordination of New Jersey's addiction prevention, treatment, prevention policy and services.

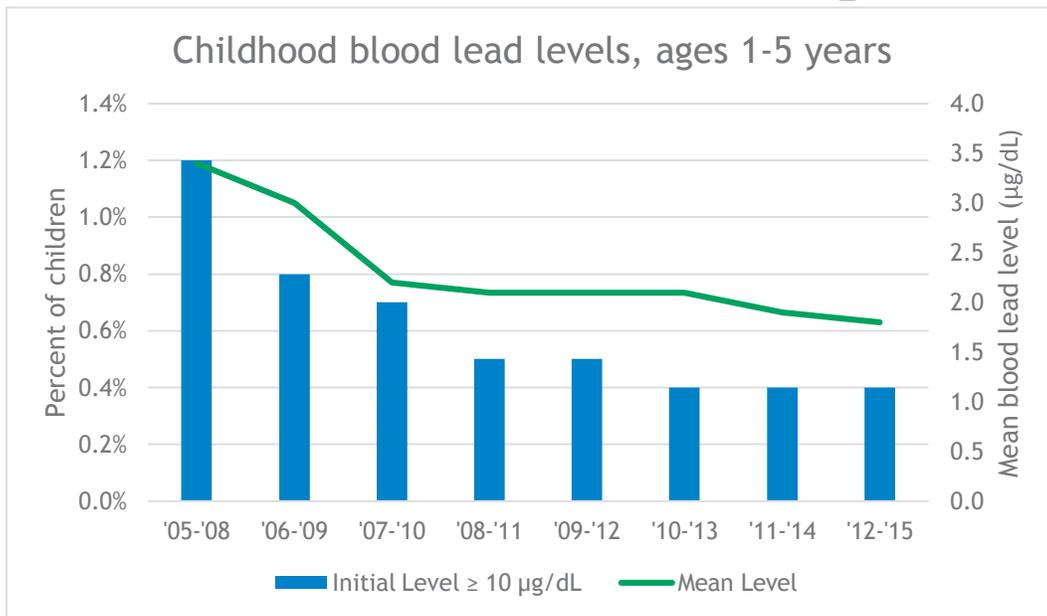
MATERNAL AND CHILD HEALTH



INFANT MORTALITY, 2011-2015



See next page for full list of objectives and their statuses.



Sources: New Jersey Department of Health: Birth Certificate Database, Infant Death-Birth Match Database, PRAMS, LeadTrax, Special Child Health and Early Intervention Services; CDC: Breastfeeding Report Card

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

MCH-1	Infant mortality	■
MCH-2a	Low birth weight	■
MCH-2b	Very low birth weight	■
MCH-3	First trimester prenatal care	■
MCH-4	Alcohol abstinence during pregnancy	■
MCH-5	Cigarette abstinence during pregnancy	■
MCH-6	Infant sleep position	■
MCH-7	Breastfeeding	■
MCH-8	Formula supplementation	■
MCH-9	Baby-Friendly hospitals	■
MCH-10	Teen births (ages 15-17 years)	■
MCH-11	Initial blood lead level	■
MCH-12	Average blood lead level	■
MCH-13	Newborn hearing screening	■

DISPARITIES

- The Black infant mortality rate (IMR) is three times the White IMR. New Jersey has one of the lowest Black IMRs in the nation but has the third highest disparity between Blacks and Whites.
- The low birth weight rate for Blacks is double that of Whites.
- The teen (15-17 years old) birth rate among Hispanics is 11 times and among Blacks is 9 times the rate among Whites.
- Breastfeeding initiation rates are lowest among Blacks.

POLICIES

- N.J.A.C. 8:18 (Newborn Biochemical Screening Program) provides the rules for testing newborn children for early detection and treatment of biochemical disorders.
- N.J.A.C. 8:19 requires that every baby born in New Jersey be screened for disorders that can cause serious health problems. All babies born in New Jersey are required to be tested for fifty-five (55) disorders within 48 hours of birth.
- N.J.A.C. 8:20 - 1.1 et seq. The NJ Birth Defects Registry monitors children with specific birth defects and serves as the primary entry point into the local, community-based case management system of the DOH Special Child Health and Early Intervention Services Program.
- N.J.A.C. 8:20-2 The DOH Autism Registry requires the reporting of diagnoses of autism and the maintenance of an up-to-date Autism Registry of all reported cases of autism

that occur in NJ for use in conducting thorough and complete epidemiologic surveys of autism.

- N.J.A.C. 8:33C Certificate of Need and Licensure: Regionalized Perinatal Services and Maternal and Child Health Consortia contains licensure requirements for Maternal and Child Health Consortia (MCHC) and perinatal centers, and ensures provision of maternal and child health services in a coordinated and cooperative, prevention-oriented manner which is accessible to those in need of care.
- N.J.A.C. 8:43G Hospital Licensing Standards contains the State's obstetric standards and mandates that prenatal and pediatric services be in accordance with the HealthStart Standards, that routine prenatal care incorporates use of a comprehensive perinatal record, that high-risk infants have follow-up service, and that hospitals have written policies and procedures for infant feeding and postpartum and newborn care patient services.
- N.J.A.C. 8:51 (Childhood Elevated Blood Lead Levels) provides rules for local health departments when a child is identified with an elevated blood lead level
- N.J.A.C. 8:51A (Screening of Children for Elevated Blood Lead Levels) provides rules for health care providers to educate parents, assess the need for earlier or more frequent screening of young children, and perform age-appropriate screening.
- N.J.S.A. 26:2-111.4 (Critical Congenital Heart Defects Screening) requires birth facilities to perform a pulse oximetry screening on newborns.
- N.J.S.A. 26:5D (SIDS Assistance Act) established the SIDS Center of New Jersey.

CHALLENGES

- Education gaps, income disparity, and housing and transportation factors present challenges to expectant mothers in receiving adequate prenatal and postnatal care.
- The Supplemental Nutrition Program for Women, Infants, and Children (WIC) faces challenges in retaining toddlers and young children in the program.

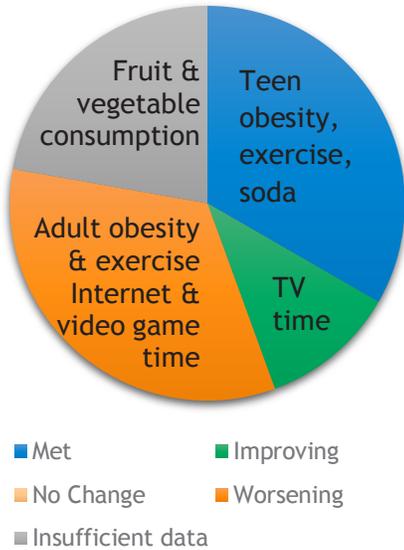
ASSETS

- NJ's three Regional Maternal and Child Health Consortia are private, non-profit organizations, licensed and regulated by DOH as central service facilities. Their members include perinatal and pediatric providers, hospitals, consumers, and community-based agencies, including any group or individual with an interest in health services for families. The consortia's primary functions are to provide prevention activities, consumer and professional education, total quality management, data analysis, infant and pediatric follow-up, coordination of perinatal/pediatric transport systems, and the development of comprehensive perinatal/pediatric regional plans.
- DOH is a core partner and steering committee member of the CDC-funded statewide perinatal quality collaborative (PQC) coordinated by the New Jersey Hospital

Association. The PQC is used by hospitals and community based organizations to support quality improvement projects and to improve maternal and child health.

- DOH Division of Family Health Services (FHS) has access to multiple sources and types of data. Some data allow for retrospective analyses while others provide real-time monitoring of health indicators that are a part of DOH's priorities.
- Inter- and intra-departmental collaborations and cooperation from local health departments
- The DOH Newborn Biochemical Screening Program is a national leader in terms of expansion of disorders screened at birth and extent of follow-up.
- New Jersey implemented the first Critical Congenital Heart Defects Screening program in the nation and it is a national model.
- DOH program staff are a rich source of technical and program expertise and have provided technical assistance in areas such as hearing screening, autism registry, and critical congenital heart defects screening to other states, territories, and even other countries, such as China.
- Regional Lead and Healthy Homes Coalitions provide prevention-based statewide services.
- Healthy Families/Temporary Assistance for Needy Families (TANF) Initiative for Parents (TIP) program is a home visitation program that targets pregnant women and new mothers with infants less than 3 months, and offers real-life parenting skills and support, continuing education, and employment services.
- DOH's Maternal Mortality Review Program is a statewide initiative that identifies and systematically reviews all pregnancy-associated deaths using a multidisciplinary approach in order to reduce and prevent the number of deaths related to pregnancy and childbearing among New Jersey residents.

Status of objectives

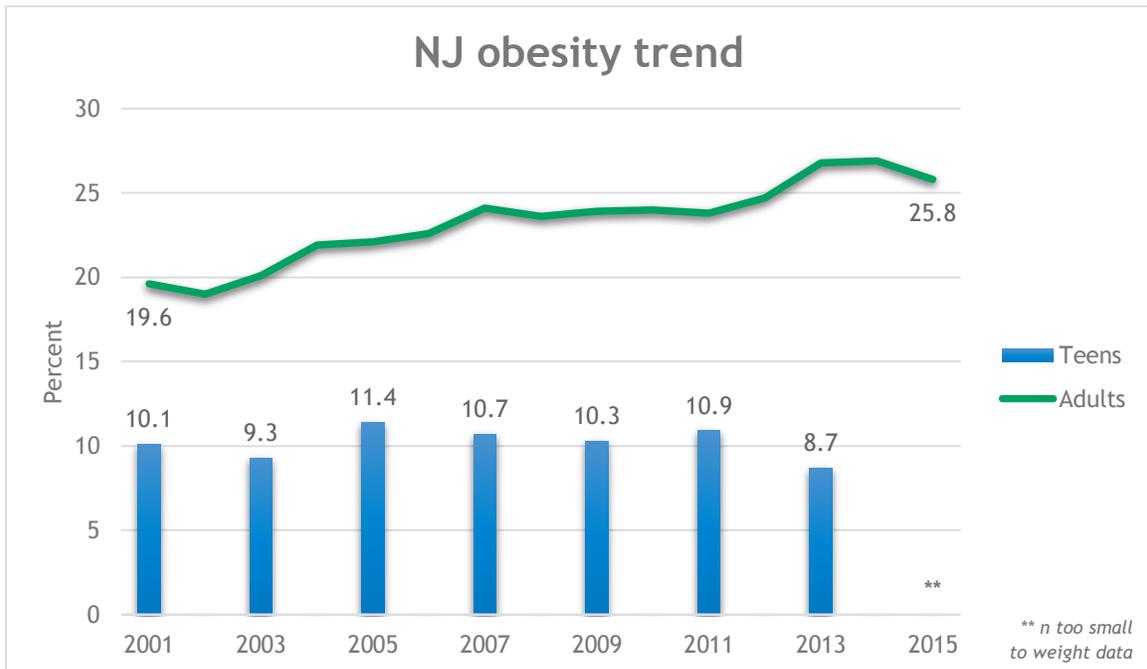


The fruit and vegetable objectives will be updated in future reports to meet current standards.

BY THE NUMBERS

- 72** % of NJ teens watch < 2 hours of TV daily
- 63** % of NJ teens with < 2 hours of gaming and internet use daily
- 49** % of NJ adults get enough exercise
- 49** % of NJ teens get enough exercise
- 26** % of NJ adults are obese
- 12** % of NJ teens drink 1+ soda daily
- 9** % of NJ teens are obese

Teen data: 2013; Adult data: 2015



Sources: NJ Behavioral Risk Factor Survey of Adults, New Jersey Department of Health and NJ Student Health Survey of High School Students, New Jersey Department of Education

OBJECTIVE STATUS

■ Target Met
 ■ Improving
 ■ No Change
 ■ Worsening
 ■ Insufficient Data

		Age:	High school	18+
NF-1	Obesity			
NF-2	Fruit and vegetable consumption			
NF-3	Physical activity			
NF-4a	TV time			
NF-4b	Computer/video game time			
NF-5	Soda consumption			

DISPARITIES

- State obesity rates are persistently high, particularly for young, vulnerable, low-income populations and in certain parts of South Jersey.
- The obesity rate for Black adults in New Jersey is more than 1.5 times that of White adults and more than triple that of Asian adults.
- Hispanic high school (HS) students (grades 9-12) remain almost twice as likely to be obese as White HS students.
- Black, Hispanic, and Asian HS students are less likely to meet physical activity guidelines compared to White HS students.
- Black and Hispanic HS students are more likely to watch TV for more than two hours a day than are White and Asian HS students, however there is less variation among racial/ethnic groups for computer, internet, and video game time.
- Hispanic HS students are almost twice as likely to drink more than one soda a day compared to White HS students.

POLICIES

- The Healthy, Hunger-Free Kids Act of 2010 (US P.L. 111-296) authorizes funding and sets policy for the USDA's core child nutrition programs: The National School Lunch Program; the School Breakfast Program; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the Summer Food Service Program; and the Child and Adult Care Food Program. In school year 2014-15, the Smart Snacks in School regulation was implemented requiring that all foods sold at school during the school day meet nutrition standards. This applies to foods sold a la carte, in the school store, vending machines, and any other venues where food is sold to students.
- CDC grant DP13-1305 - State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity, and Associated Risk Factors and Promote School Health - is a multifaceted initiative to improve health for all Americans through coordinated chronic disease prevention programs.

- N.J.S.A.18A:33-16 requires that foods of minimal nutritional value, food and beverage items listing sugar in any form as a first ingredient, and all forms of candy not be served, sold, or given away as a free promotion anywhere on school property before the end of the school day. The statute sets limits on the amount of fat and trans fats allowed in snacks and the portion size of beverages, other than milk, sold or served on school property. NJ elementary schools may only serve milk, water, and 100% juice.
- N.J.S.A.18A:35-7&8 requires every pupil attending public schools in grades 1 through 12 to participate in 150 minutes per week of health, safety, and physical education.
- The Child Nutrition Act (as amended through P.L. 111-296, effective Dec.13, 2010) requires the WIC Program to provide breastfeeding support and promotion. Obesity rates are significantly lower among breastfed infants.
- The Child Nutrition Act also requires WIC to increase access to fruits and vegetables by providing vouchers for specific dollar amounts for fruits and vegetables and for New Jersey-grown produce at farmers' markets.

CHALLENGES

- Ensuring consistency and reach of health messaging, and a lack of culturally appropriate nutrition and physical activity promotion compound problems with education on obesity prevention topics.
- The term “obesity” has a stigma attached to it.
- Healthy food and beverages are often more expensive and more difficult to access than unhealthy foods and beverages. There are many USDA/CDC defined “food deserts” throughout New Jersey, especially South Jersey.
- Even though N.J.S.A.18A:35 requires that all students in grades 1-12 participate in at least 2.5 hours of health, safety, and physical education each school week (150 minutes), it does not require the recommended schedule of 30 minutes per day for elementary school students and 45 minutes per day for secondary school students of physical education, not including health or safety classes, and is not enforced or monitored.
- The vast number of school districts in New Jersey (599) makes it difficult to implement and maintain consistent school physical education and nutrition policies.

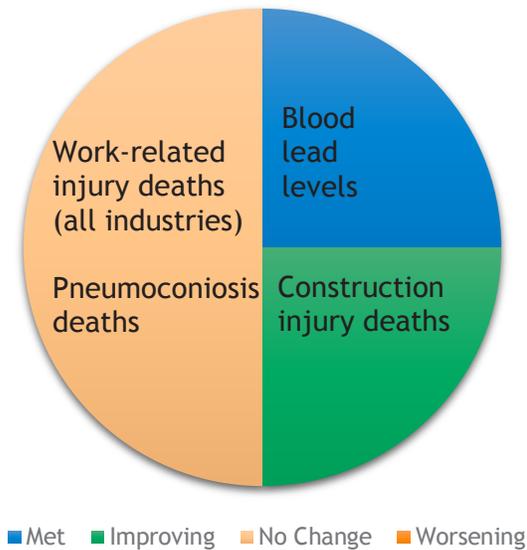
ASSETS

- The New Jersey Healthy Communities Network Steering Committee is comprised of partners who guide the movement and identify and share financial and capacity building resources that focus on improving healthy eating and active living through evidence-based strategies and shared measures.
- CDC funding through grant program DP13-1305 is available across health care, early childhood care and education, school, worksite, and community settings. Recipient

grantees incorporate obesity prevention evidence-based strategies into their daily work.

- Existing state data sources including New Jersey Behavioral Risk Factor Survey (NJBRFS), Maternity Practices in Infant Nutrition (mPINC), and Youth Risk Behavioral Surveillance System (YRBS) allow for obesity and physical activity surveillance.
- The New Jersey Department of Transportation's (DOT) Statewide Complete Streets policy requires that future roadway projects include safe accommodations for pedestrians, bicyclists, and transit users of all ages and abilities, as part of New Jersey's transportation network. This policy is implemented through the planning, design, construction, maintenance, and operation of new or rehabilitated transportation facilities within public rights of way that are federally or state funded, including projects processed or administered by DOT. Municipalities and counties that pass a Complete Streets policy receive extra points for their applications to DOT grant programs.
- The Department of Education (DOE) and DOT's Safe Routes to School Program enables and encourages all K-8 students, including children with disabilities, to walk and bicycle to school safely, which promotes physical activity as part of students' daily life.
- Nutritional education is available for all stages of life via WIC Nutrition education (DOH), Family Success Centers (DCF), and Area Agencies on Aging Culturally Appropriate Nutrition Education (DHS).
- N.J.S.A. 18A-35 School Physical Activity Standards and Nutrition Mandates that NJ high school graduation requirements must include health, physical education, and safety.
- NJ Department of Agriculture's Breakfast after the Bell program provides a nutritious, well-balanced breakfast to children under 18. It promotes sound eating habits and fosters good health and academic achievement in school age children.

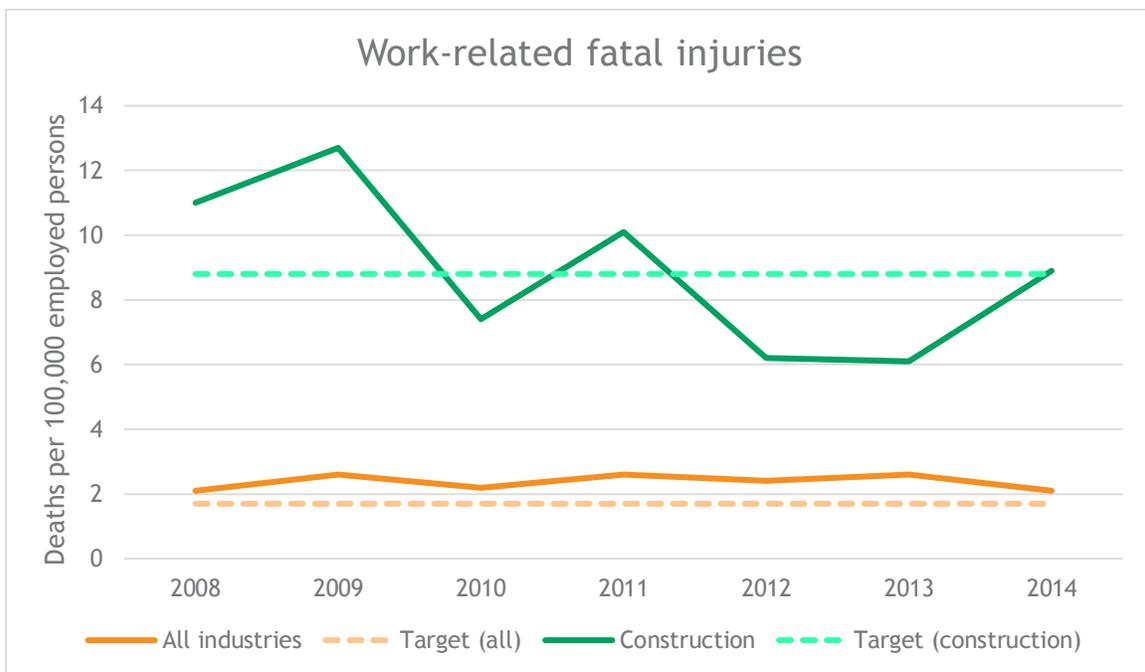
Status of objectives



BY THE NUMBERS

- 2.1** Work-related injury deaths per 100,000 employed persons in any industry
- 8.9** Work-related injury deaths per 100,000 construction workers
- 6.9** Pneumoconiosis deaths per 1,000,000 persons aged 15 and older
- 1.3** Cases of elevated ($\geq 25\mu\text{g/dL}$) blood lead concentration from work exposure per 100,000 persons aged 16 and older

2014 data except 2013 for pneumoconiosis deaths



Source: NJ Census of Fatal Occupational Injuries and Adult Blood Lead Epidemiology and Surveillance, New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

OSH-1a	Work-related injury deaths - all industries	■ No Change
OSH-1b	Work-related injury deaths - construction	■ Improving
OSH-2	Pneumoconiosis deaths	■ No Change
OSH-3	Work-related lead exposure	■ Target Met

DISPARITIES

- Most (95%) fatal occupational injuries are among males because they are more likely to work in high-risk occupations
- Hispanics are at higher risk of occupational injury and illness due to:
 - Disproportionate employment in higher risk occupations
 - Higher proportionate work in hazardous industries
 - Language and cultural barriers which may result in lack of training and sometimes personal protective equipment or being unaware of safety regulations

POLICIES

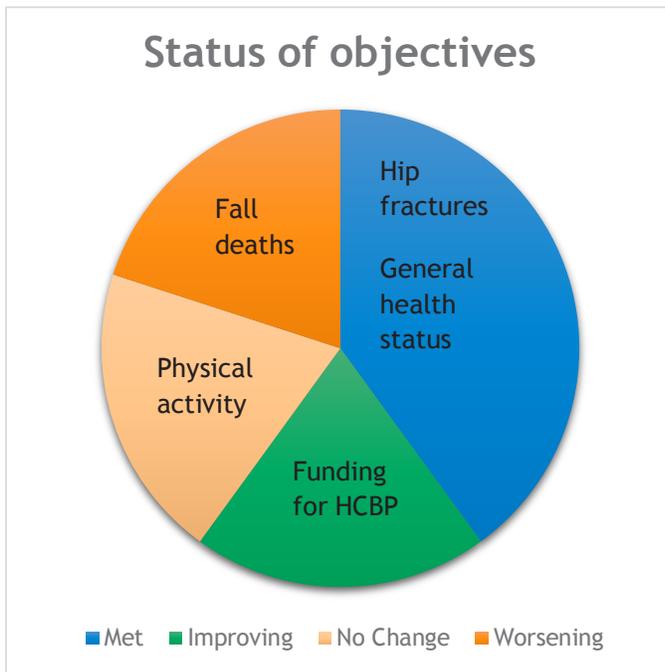
- N.J.A.C. 8:58-1.4, 1.6, 1.7: The administrator of any hospital in which any person has been diagnosed with reportable occupational diseases, injuries, or poisonings shall report such disease or poisoning to DOH.
- N.J.A.C. 8:58-1.5, 1.6, 1.7: The health care provider attending any person who is ill or diagnosed with any reportable occupational diseases, injuries, or poisonings shall, within 30 days after diagnosis or treatment, report such conditions to DOH.
- N.J.A.C. 8:44-2.11: Laboratory supervisors shall report the results of laboratory examinations for hazardous substances (lead, mercury, arsenic, and cadmium) in blood and urine to DOH within 48 hours of the completion of the analysis.

CHALLENGES

- New Jersey has a very diverse, multi-lingual working population. It can be difficult to reach undocumented workers, day laborers, and temporary workers to educate them about occupational exposures and risks.

ASSETS

- The DOH Occupational Health Surveillance (OHS) unit collects data and has access to data sources such as EpiCenter (real-time emergency department data), the DOH Communicable Disease Reporting and Surveillance System (electronic lab records), and hospital discharge data. Education and outreach are done based on these data and have provided useful information to other groups outside of OHS.



The Division of Aging Services in the NJ Department of Human Services (DHS) is a single point of access for seniors and people with disabilities, and their caregivers, regardless of Medicaid eligibility; better coordination of Federal and State funded programs for seniors and people with disabilities; a continuum of coordinated and integrated disability and long-term care resources; and more opportunity and the ability for aging adults to remain at home with proper support.

BY THE NUMBERS

668 Hip fractures per 100,000 women aged 65+¹

345 Hip fractures per 100,000 men aged 65+¹

30.0 Fall-related deaths per 100,000 persons aged 65+²

32.8 % of persons aged 65-74 who engage in no leisure-time physical activity¹

44.1 % of persons aged 75+ who engage in no leisure-time physical activity¹

68.0 % of funds allocated to nursing homes as compared to Home and Community Based Programs³

23.9 % of persons aged 65+ reporting fair or poor health status¹

¹2015 NJ Behavioral Risk Factor Survey, New Jersey Department of Health

²2012-2014 NJ Death Certificate Database, New Jersey Department of Health

³3FY2016 NJ Department of Human Services data

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

OA-1a	Hip fracture (females 65+)	■
OA-1b	Hip fracture (males 65+)	■
OA-2	Fall-related deaths (65+)	■
OA-3a	Physical activity (ages 65-74)	■
OA-3b	Physical activity (ages 75+)	■
OA-4	Funding for home care vs. institutional	■
OA-5	General health status (65+)	■

DISPARITIES

- Hip fracture and fall-related death rates among Whites are more than double that of other racial/ethnic groups.
- Hispanic and Black older adults are more likely to be physically inactive than their White and Asian counterparts.
- Half of older Hispanics report fair or poor general health compared to one-third of Blacks and less than one-fifth of Whites and Asians.

POLICIES

- N.J.S.A. 26:1A-107 established a Division of Aging Services (DoAS) in DHS, consisting of a director and the New Jersey State Commission on Aging in accordance with the provisions of section 398 of P.L.2012, c.17 (C.30:1A-14).
- N.J.S.A. 26:1A-108 created the New Jersey State Commission on Aging, consisting of 15 citizen members.

CHALLENGES

- The needs of the aging population of New Jersey (and the US) will continue to have an effect on the economy, housing, and health care.³⁷
- Seventy percent of the physical decline associated with aging is due to poor lifestyle behaviors³⁸ which also lead to an increased incidence of chronic diseases.

ASSETS

- The Department of Human Services' Division of Aging Services (DoAS) provides over 30 services and supports including Community Choice, Falls Prevention, Assistance for Community Caregiving, the Otago Exercise Program, and Project Healthy Bones.

³⁷ Anderson, L.A., Goodman, R.A., Holtzman, D., Posner, S.F., Northridge, M.E. 2012. [Aging in the United States: Opportunities and challenges for public health](#). American Journal of Public Health, 102 (3): 393-395.

³⁸ New Jersey Department of Health. [Blueprint for Healthy Aging in New Jersey](#).

Status of objectives



- Met
- Improving
- No Change
- Worsening
- Insufficient Data

BY THE NUMBERS

4
of 19

Community colleges offering public health or related associate degrees and/or certificate programs:

- Brookdale
- Mercer
- Middlesex
- Morris

2
of 90

Local health departments (LHD) have been accredited by PHAB: Bloomfield Department of Health & Human Services
Camden County Health Department

3

LHDs have been awarded grants to prepare for, undertake, or accelerate public health accreditation readiness activities

95%

LHDs actively participating in community public health partnerships

While there is insufficient data on community public health partnerships, the Public Health Practice Standards of Performance for Local Boards of Health in New Jersey indicate that each county or multi-county area shall establish a community public health partnership to perform a Community Health Assessment and a Community Health Improvement Plan (CHIP). Local health agencies shall participate in the partnerships, and assure that the partnership assesses public health needs and delivers public health services in their jurisdiction (N.J.A.C. 8:52-9.2). CHIPs are being established through collective action in communities across New Jersey to address priority health issues such as, but not limited to: chronic disease, substance abuse, mental health, access to care, and obesity. The emergence of these tangible plans demonstrates the viability of NJ’s community public health partnerships.

Sources: Local Health Department Survey, New Jersey Department of Health; Rutgers University School of Public Health’s Office of Public Health Practice (OPHP); and Public Health Accreditation

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

PHI-1	Community colleges with public health degrees or certificate programs	■
PHI-2	Community public health partnership participation	■
PHI-3	Community public health partnership collaboration	■
PHI-4	Public health accreditation	■

POLICIES

- N.J.A.C. 8:52 Public Health Practice Standards of Performance for Local Boards of Health in NJ establish standards of performance, designate activities which are required by all LHDs, encourage active collaboration with community partners, align LHD performance standards with National Public Health Performance Standards and National Model Community Standards, build a reliable and cost-effective public health system, and support the goals of the Healthy New Jersey initiative. Community Health Assessment and Community Health Improvement Plans are required for each county in the state.
- N.J.A.C. 8:7 Licensure of Persons for Public Health Positions sets the standards for health officers and Registered Environmental Health Specialists (REHS).
- N.J.S.A. 26 Health Statutes set local regulations, duties of local health officials, rules for local boards of health, powers of local health departments (LHD), and consequences of failure to perform.

CHALLENGES

- While DOH can help LHDs meet regulatory standards, a lack of state control per Article IV, Section VII (11) of the New Jersey Constitution and the Home Rule Act of 1917 N.J.S.A. 40:42 et. seq., makes coordination difficult between DOH and LHDs.
- NJ's public health workforce is aging and retiring.
- Local health departments face staffing shortages and resource limitations in the execution of their regular duties.
- Local health department personnel who attend a series of focus group sessions in 2016 identified several "wish list" items in which local capacity building is needed. These items were organized into four general categories including: communication with community members, support from DOH, professional development, technical assistance.

ASSETS

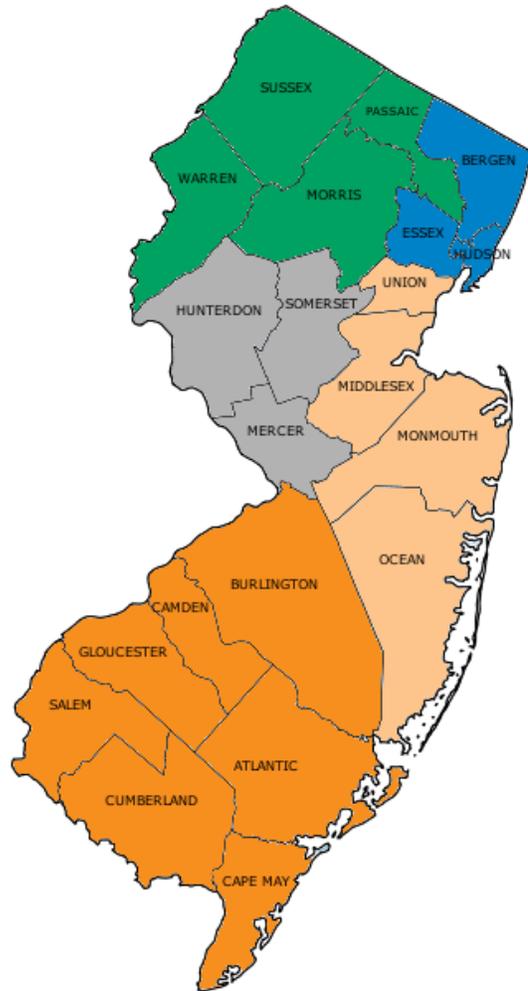
- The New Jersey Climate Change and Public Health Working Group is a network of diverse organizations from throughout the State which works to build capacity to address public health impacts of climate change in New Jersey.

- NJ Learning Management Network (NJLMN) is an online source of continuing education for NJ's public health, safety, and emergency preparedness workforce that provides easy access to professional training.
- The Office of Continuing Professional Education at Rutgers offers many public health-related courses.
- The DOH Office of Local Public Health Licenses Regional Environmental Health Specialists and health officers, and is currently revising the health officer examination to reflect current practice.
- Data are collected annually from local health department personnel ranging from finances and staffing to public health and safety activities. The data are utilized to highlight statewide public health activities, determine public health practice trends, and identify factors affecting public health.
- NJ Local Information Network and Communications System (NJLINCS) is a statewide public health electronic communication tool that allows DOH, local health departments, and community organizations to share timely information to protect the public's health.

Status of objectives



NJ PUBLIC HEALTH REGIONS AND HEALTH CARE EMERGENCY PREPAREDNESS COALITIONS



IMPROVEMENT FROM BASELINE



12.5%

Time to issue official information to the public about a public health emergency



50.0%

Time to activate designated personnel in response to a public health emergency



55.6%

Time to establish after action reports and improvement plans following responses to public health emergencies and exercises

Sources: New Jersey Local Information Network Communications System (NJLINCS) and Situational Awareness Network Software, New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

PHP-1	Time to issue official public health emergency information to the public	■
PHP-2	Time to activate emergency response personnel	■
PHP-3	Time to establish after-action reports and improvement plans	■

POLICIES

- N.J.S.A. 26:13-1 et. seq. Emergency Health Powers Act provides express authority to the Governor to declare a public health emergency and augments the emergency authority of the Commissioner of Health to detect, prevent, prepare for, and respond to public health emergencies, and specifically enumerates procedures that would be used during a public health emergency to exercise those powers.
- N.J.S.A., Appendix A:9-30 et al. NJ Civil Defense and Disaster Control Act centralizes control of all civilian activities having to do with an emergency under the Governor and gives the Governor control over state, county, and local government resources necessary to cope with any condition that shall arise out of such emergency.
- NJ State Emergency Operations Plan guides the coordination of all emergency response through the NJ Office of Emergency Management.
- NJ Emergency Support Function 8 (NJESF#8) involves supplemental assistance to local governments in identifying and meeting the public health and medical services needs to victims of a major emergency or disaster.
- DOH Health Emergency Preparedness and Response Strategy and Master Plan details how DOH is to prepare for and respond to public health emergencies and outlines specific responsibilities and activities before, during, and after emergencies.

CHALLENGES

- Resource limitations and the reduction of federal funding to support health emergency preparedness exist.
- The various structures of county and municipal government in New Jersey can hamper delegation of authority and responsibility.
- Struggling member recruitment and sustainment among Health Care Emergency Preparedness Coalitions.

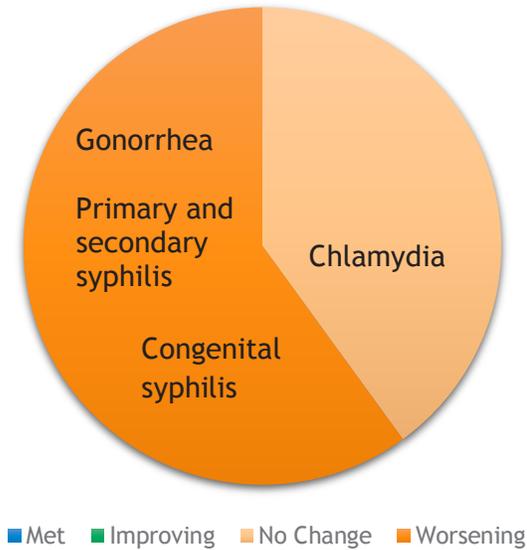
ASSETS

- There are five regional Health Care Emergency Preparedness Coalitions and Medical Coordination Centers, and a number of Governmental Public Health Partnerships that work together to share information and provide multiagency coordination for the public health system.

- The DOH Health Command Center in Trenton is a modern command, control, and communications hub during emergencies, which works in concert with the State Emergency Operations Center.
- The NJ EMS Task Force provides an organized team of specialized, modular component resources to support an emergency operation or preplanned event.
- NJ has highly skilled preparedness staff and updated equipment and processes due to consistent training and exercises with DOH, Health Care Emergency Preparedness Coalitions, and other partners.

SEXUALLY TRANSMITTED DISEASES

Status of objectives

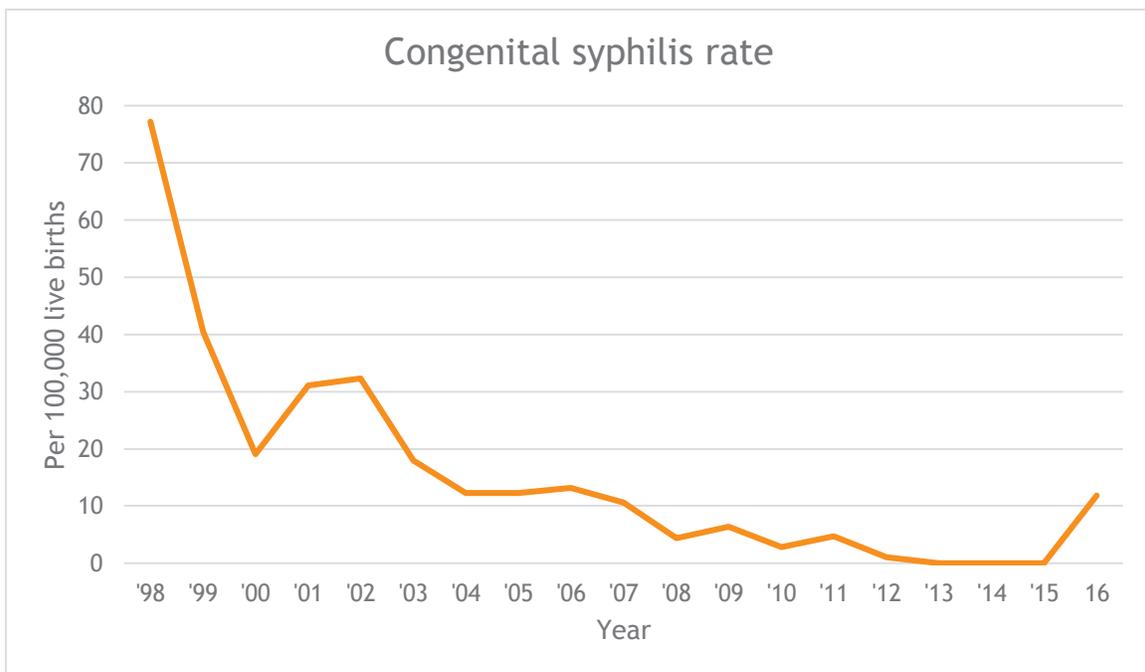


BY THE NUMBERS

- 2,762** Chlamydia cases per 100,000 females aged 15-24
- 15.5%** Family planning and STD clinic patients diagnosed with chlamydia
- 208** Men aged 15-44 with gonorrhea per 100,000
- 171** Women aged 15-44 with gonorrhea per 100,000
- 12** Cases of congenital syphilis in 2016
- 4.2** Primary and secondary syphilis cases per 100,000 persons

2015 data unless otherwise noted

Congenital syphilis rate



Source: Sexually Transmitted Disease (STD) Program, New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

STD-1	Chlamydia (females 15-24)	■
STD-2	Chlamydia (persons 15-24)	■
STD-3	Gonorrhea	■
STD-4	Primary and secondary syphilis	■
STD-5	Congenital syphilis	■

DISPARITIES

- Men who have sex with men (MSM) are disproportionately affected by primary and secondary syphilis.
- The primary and secondary syphilis rate among Blacks in 2016 was more than five times higher than that of Whites (14.0 per 100,000 population as compared with 2.6).
- Anecdotal evidence suggests Blacks and Hispanics are disproportionately affected by STDs but without accurate race and ethnicity data this cannot be verified.

POLICIES

- N.J.A.C. 8:57-1 Communicable Diseases Regulations contains the requirements for reporting cases of STDs to DOH.
- DOH's congenital syphilis investigation protocol calls for field staff to complete syphilis investigations within 30 days. In addition, congenital syphilis investigations must be submitted to CDC within 60 days from the baby's date of birth or blood draw.
- DOH provides recommendations to the NJ Department of Corrections for managing STDs in the prison population.

CHALLENGES

- Only about half of STD reports submitted to DOH have complete race and ethnicity data included. Some explanations for this limitation are:
 - Missing information fields on forms
 - Attitudes of medical provider personnel who collect the data
 - Unwillingness of patients to report race and ethnicity data
- Congenital syphilis, a sexually transmitted disease passed from a mother to her fetus in pregnancy, is recently on the rise in New Jersey. In 2016, the state had 12 cases of congenital syphilis, following three years of no reported cases. The sudden increase in congenital syphilis in New Jersey is an important public health issue that requires increased attention to important prenatal care and screening among pregnant women.
- During 2012-2016, the incidence rate of gonorrhea among men under 30 years old in New Jersey increased 34% (129 to 173 cases per 100,000 males), while the rate among women under 30 decreased 9% (179 to 163 cases per 100,000 females).

- Primary and secondary syphilis rate increased 89% in New Jersey between 2010-2016. As of 2016, the primary and secondary syphilis rate among Blacks is 1.7 times that of Hispanics and more than 5 times that of Whites.

ASSETS

- Several public health campaigns are underway to urge individuals to get tested and then treated for sexually transmitted diseases. These campaigns were launched within the Department of Health in 2017 to promote testing among adolescents, seniors, and pregnant women. Campaign posters are available in multiple languages.
- The DOH STD Program has partnerships with hospital infection control units, State Public Health and Environmental Laboratories (PHEL), and major private laboratories to get information.
- STD reporting is managed through the DOH Communicable Disease Reporting and Surveillance System (CDRSS).
- DOH medication program provides free STD medications to non-profit or health service grant clinics, easing the financial burden on them and assuring that they will be stocked with medication for treating the infected and their partners.

Protect Your Baby from SYPHILIS

Know The Dangers...

Your baby could be	Prevent
Blind	Death
Deaf	Meningitis
Premature	Anemia
	Low birth weight

Protect Your Family...

- ✚ Talk to your doctor
- ✚ Use condoms
- ✚ Get tested in 1st and 3rd trimesters
- ✚ Get treated

800-624-2377
nj.gov/health/teSTD4baby

Get #teSTD4baby

NJ Health
New Jersey Department of Health

REALLY?!
(THAT HAS TO BE A MISTAKE, RIGHT?)

1 IN 2 Will Get an STD by Age 25 if Sexually Active.

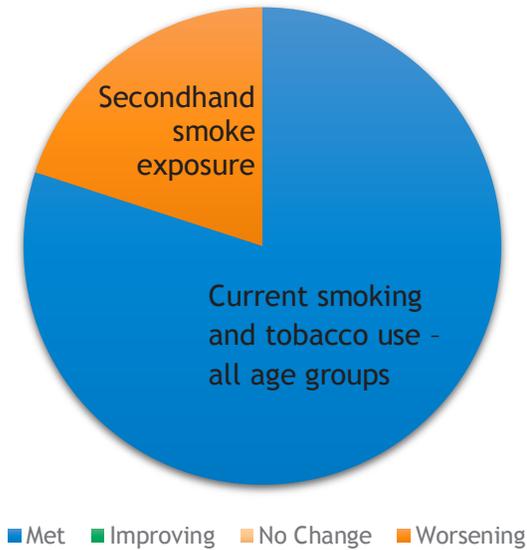
Get #TeSTD

GYT
Get Yourself Tested

gettested.cdc.gov
800-624-2377

NJ Health
New Jersey Department of Health

Status of objectives



BY THE NUMBERS

13.8 % of adults who are current smokers¹

8.2 % of high school (HS) students who are current smokers²

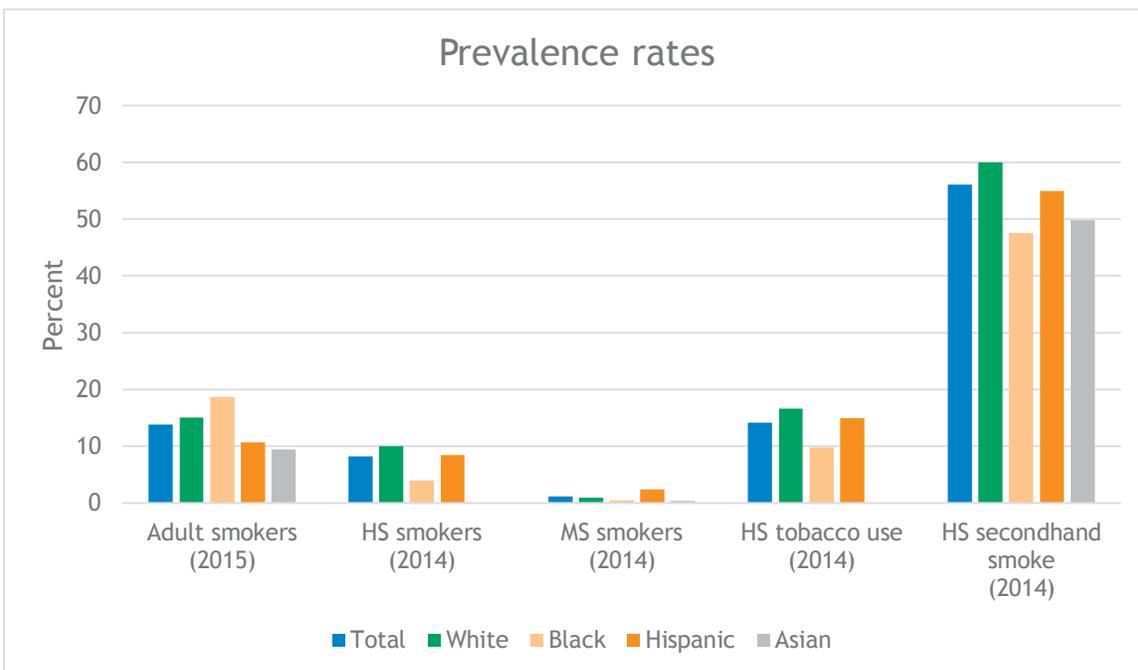
1.2 % of middle school (MS) students who are current smokers²

14.2 % of HS students who currently use any tobacco (cigarettes, cigars, bidis, smokeless tobacco, etc.)²

56.1 % HS student nonsmokers exposed to secondhand smoke²

*“Current” = in past 30 days
¹2015 data; ²2014 data*

Prevalence rates



Sources: NJ Behavioral Risk Factor Survey and Youth Tobacco Survey, New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

TU-1a	Current smokers: adults	■
TU-1b	Current smokers: high school students	■
TU-1c	Current smokers: middle school students	■
TU-2	Tobacco use: high school students	■
TU-3	Secondhand smoke exposure: high school students	■

DISPARITIES

- Low socioeconomic status populations have higher prevalence rates of smoking.
- Rural and urban communities have higher prevalence rates than suburban communities.

POLICIES

- Effective November 1, 2017, New Jersey raised the legal age to buy cigarettes and tobacco products from age 19 to 21 years old.
- New Jersey Smokefree Air Act: P.L. 2009, c.182 prohibits smoking in an indoor public place or workplace, and in any area of any building of, or on the grounds of, any public or nonpublic elementary or secondary school, regardless of whether the area is an indoor public place or is outdoors.
- 323 Municipal Outdoor Recreational Ordinances restrict smoking in parks and other recreational areas statewide.
- U.S. Department of Housing and Urban Development's (HUD) Smoke-Free Public Housing Policy will require public housing developments nationwide to provide a smoke-free environment for their residents by July 31, 2018.

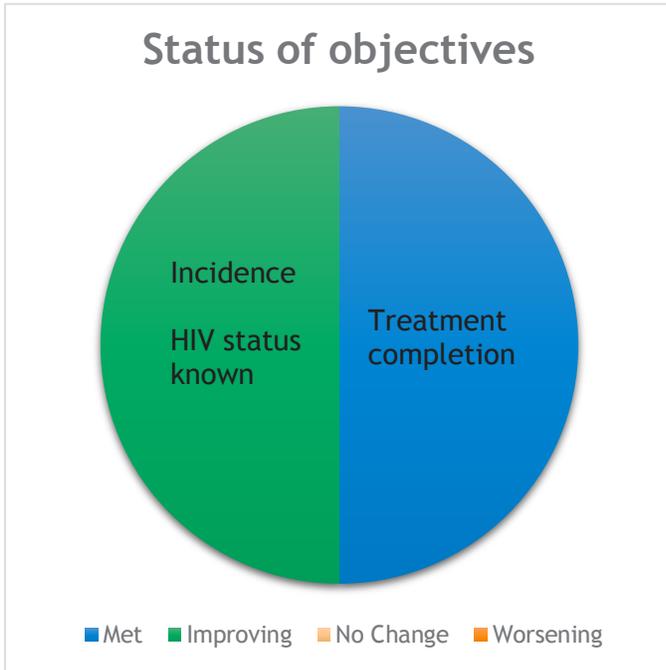
CHALLENGES

- Outreach and education resources are limited in the southern regions of the state which have higher prevalence of smoking.
- High cost of media messaging campaigns because NJ is in the most expensive media market in the nation (Philadelphia/New York).
- Other tobacco products are taxed at a lower rate than cigarettes.

ASSETS

- Several prevention programs are in place statewide:
 - Point of Sale strategies, such as reducing the number and density of tobacco retail outlets, increasing the cost of tobacco products through non-tax approaches, implementing prevention and cessation messaging, and restricting advertising and product placement

- Worksite Wellness smoke-free worksite policies
- Tobacco Age of Sale Enforcement
- FDA Compliance Check Inspections of tobacco product retailers to determine compliance with federal laws and regulations.
- Cessation programs for adults and youth are available:
 - “2As and R” (Ask, Advise, and Refer) Brief Tobacco Intervention trainings are provided to healthcare providers statewide.
 - Tobacco Free for a Healthy New Jersey (TFHNJ) regional coordinators facilitate the adoption of smoke-free outdoor recreational ordinances through community-based tobacco control coalitions called Integrated Municipal Advisory Councils.
 - TFHNJ and its partners help to reduce youth access to cigarettes, ENDS (electronic nicotine delivery systems), and hookah by implementing point-of-sale strategies in establishments that sell these products, particularly where retailers are near schools.
 - The Rutgers Tobacco Dependence Program and Rutgers Cancer Institute of New Jersey provide tobacco mitigation training to community physicians and partners as well as tobacco mitigation programs for consumers.



BY THE NUMBERS

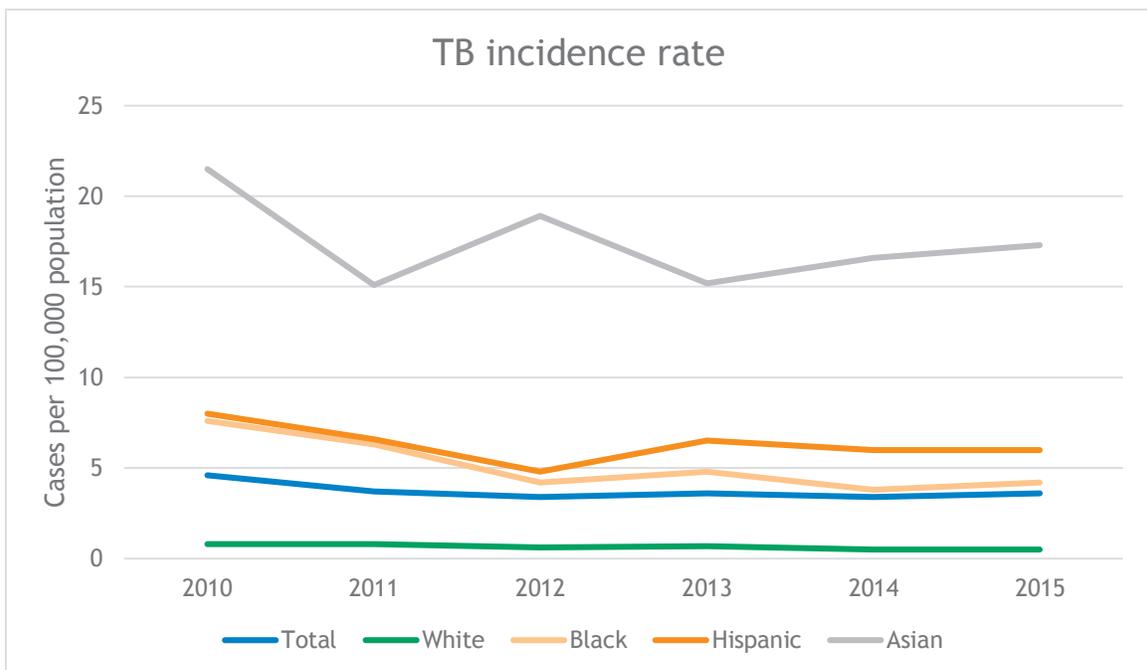
3.6 Incidence per 100,000 population¹

93% Completed treatment within 12 months²

85% Completed treatment among contacts to sputum smear-positive cases diagnosed with latent tuberculosis infection (LTBI)²

84% Cases for which HIV status is known¹

¹2015 data; ²2014 data



Source: Tuberculosis Information Management System, New Jersey Department of Health

OBJECTIVE STATUS

■ Target Met ■ Improving ■ No Change ■ Worsening ■ Insufficient Data

TB-1	TB incidence	■
TB-2	TB treatment completion - all TB cases	■
TB-3	TB treatment completion - latent TB cases	■
TB-4	TB cases with HIV status known	■

DISPARITIES

- The foreign-born population has a much higher TB incidence rate than the U.S. born population.
- Low socioeconomic status, homeless, and other marginalized persons are more likely to contract TB.

POLICIES

- N.J.A.C. 8:57 Communicable Diseases Regulations contain the requirements for reporting cases of TB to DOH and for the management of TB.
- N.J.A.C. 6A:16-2.2(c) requires that each NJ school district perform TB tests on students using methods required by DOH, and when specifically directed to do so by DOH, based upon the incidence of TB or reactor rates in specific communities or population groups pursuant to N.J.S.A. 18A:40-16.
- The standards for Community Residences for Individuals with Developmental Disabilities, N.J.A.C. 10:44A, for Community Care Residences, N.J.A.C. 10:44B, and for Community Residences for Persons with Head Injuries, N.J.A.C. 10:44C, all require that both staff and persons served receive the Mantoux Skin Test, or physician's certification of the absence of contagion, upon admission or hire, and then annually thereafter.
- N.J.A.C. 10A:10-3.8 requires the Classification Department Supervisor or designee of the correctional facility where an inmate is housed to prepare a classification summary which contains results of TB, HIV, and Hepatitis C tests to be forwarded to the Administrator.

CHALLENGES

- Because the incidence rate of TB is low in the United States, there is a growing lack of expertise as fewer medical professionals diagnose and treat TB.³⁸

³⁸ K. Lönnroth, G.B. Migliori, I. Abubakar, et al. [Towards tuberculosis elimination: an action framework for low-incidence countries](#). The European Respiratory Journal, 45 (4) (2015), pp. 928-952.

ASSETS

- One of the Global Tuberculosis Institute's five Regional Training and Medical Consultation Centers (RTMCC) is located in Newark, NJ. It is a national center of excellence for TB treatment and medical consultation.
- DOH provides funding for local health nurses to receive training at the Newark RTMCC.
- There is one TB nurse case manager in each county.



5

Appendices

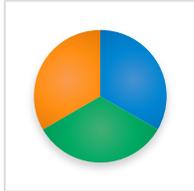
Progress Dashboard by Topic Area	95
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APPENDIX 1: PROGRESS DASHBOARD BY TOPIC AREA

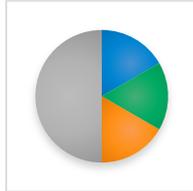
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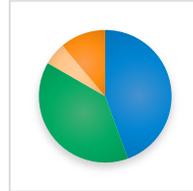
Access to Health Services



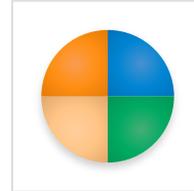
Asthma



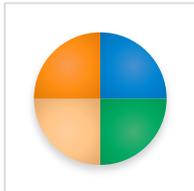
Cancer



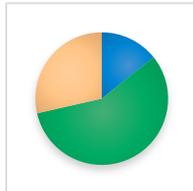
Chronic Kidney Disease



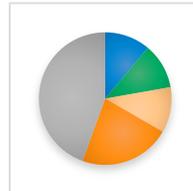
Diabetes



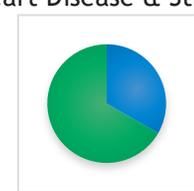
Environmental



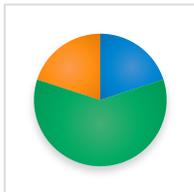
Healthcare-Associated Infections



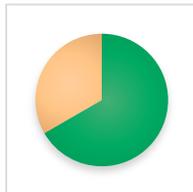
Heart Disease & Stroke



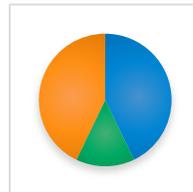
HIV/AIDS



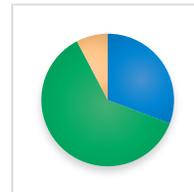
Immunization



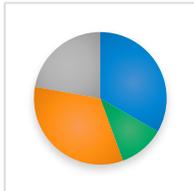
Injury & Violence Prevention



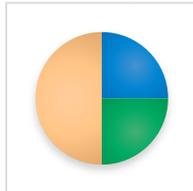
Maternal & Child Health



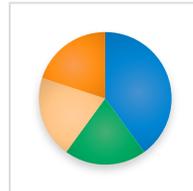
Nutrition & Fitness



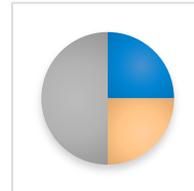
Occupational Health & Safety



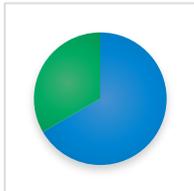
Older Adults



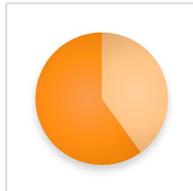
Public Health Infrastructure



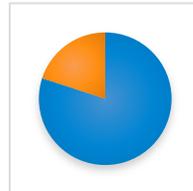
Public Health Preparedness



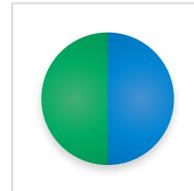
Sexually Transmitted Diseases



Tobacco Use



Tuberculosis



Target Met Improving No Change Worsening Insufficient Data

APPENDIX 2: OBJECTIVE STATUS BY RACE/ETHNICITY

ACCESS TO HEALTH SERVICES	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. a. Health insurance coverage (age < 65)	Improving	Improving	Improving	Improving	Insufficient Data
1. b. Health insurance coverage (age < 19)	Target Met	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data
2. Primary care provider	Worsening	No Change	No Change	Worsening	Worsening
ASTHMA	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. a. Deaths (age 35-64)	Worsening	Worsening	Worsening	Insufficient Data	Insufficient Data
1. b. Deaths (age 65+)	Worsening	Worsening	Improving	Insufficient Data	Insufficient Data
2. a. Hospitalizations (age < 5)	Target Met	Target Met	Improving	Target Met	Target Met
2. b. Hospitalizations (age 5-64)	Target Met	Target Met	Improving	Target Met	Target Met
2. c. Hospitalizations (age 65+)	Target Met	Target Met	Target Met	Target Met	Target Met
3. a. ED visits (age < 5)	Improving	Improving	Improving	Improving	Improving
3. b. ED visits (age 5-64)	No Change	Improving	Worsening	Improving	Target Met
3. c. ED visits (age 65+)	Worsening	Worsening	Worsening	Worsening	Worsening
4. Work or school days missed	Sample size is too small to analyze data by race/ethnicity				
5. Asthma action/management plans	Sample size is too small to analyze data by race/ethnicity				
6. Advised to make changes to improve asthma	Sample size is too small to analyze data by race/ethnicity				
CANCER	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. Deaths (all cancer sites)	Target Met	Target Met	Target Met	Improving	Improving
2. Lung cancer deaths	Target Met	Target Met	Improving	Improving	Target Met
3. Female breast cancer deaths	Target Met	Target Met	Improving	Worsening	Target Met
4. Uterine cervix cancer deaths	Improving	Target Met	Target Met	Target Met	Target Met
5. Colorectal cancer deaths	Target Met	Target Met	Target Met	Target Met	Improving
6. Oropharyngeal cancer deaths	Target Met	No Change	Target Met	No Change	Worsening
7. Prostate cancer deaths	Target Met	Target Met	Target Met	Target Met	Target Met

	Target Met	Improving	No Change	Worsening	Insufficient Data
8. Melanoma cancer deaths					
9. Invasive colorectal cancer incidence					
10. Invasive uterine cervix cancer incidence					
11. Late-stage female breast cancer incidence					
12. Oral and pharyngeal cancers detected early					
13. Five-year survival					
14. Cervical cancer screening					
15. Colorectal cancer screening					
16. Breast cancer screening					
17. Prostate cancer screening					
18. Sunburn					
CHRONIC KIDNEY DISEASE	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. Kidney disease deaths	No numeric targets were set.				
2. ESRD incidence					
3. ESRD incidence due to diabetes					
4. ESRD deaths					
DIABETES	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. Diabetes deaths					
2. Lower extremity amputation					
3. Dilated eye exams					
4. Glycosylated hemoglobin screening					
HEART DISEASE AND STROKE	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. Coronary heart disease deaths					

■ Target Met
 ■ Improving
 ■ No Change
 ■ Worsening
 ■ Insufficient Data

2. Stroke deaths					
3. Cholesterol screening					
HIV/AIDS	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. HIV transmission					
2. HIV care and treatment					
3. HIV deaths					
4. HIV testing					
5. Simultaneous diagnosis of HIV and AIDS					
IMMUNIZATION	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. DTaP, HepB, and PCV childhood vaccines	No targets were set for racial/ethnic groups.				
2. Childhood immunization series	No targets were set for racial/ethnic groups.				
3. Pneumococcal vaccination					
4. Flu vaccination					
INJURY AND VIOLENCE PREVENTION	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. a. Homicide (all ages, age-adjusted)					
1. b. Homicide (males age 15-19)					
1. c. Homicide (age 20-34)					
2. a. Firearm-related injury deaths (all ages, age-adjusted)					
2. b. Firearm-related injury deaths (males age 15-19)					
3. Suicide					
4. Suicide attempts					
5. Motor vehicle-related injury deaths					
6. Unintentional poisoning deaths					

Target Met Improving No Change Worsening Insufficient Data

7. a. Seat belt usage (age 18+)	No Change	No Change	Improving	No Change	No Change
7. b. Seat belt usage (high school students)	Worsening	No Change	Worsening	Worsening	Insufficient Data
7. c. Seat belt usage (observed)	No targets were set for racial/ethnic groups.				
MATERNAL AND CHILD HEALTH	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. Infant mortality	Target Met	Improving	Improving	Improving	Target Met
2. a. Low birth weight	Improving	Target Met	Improving	Improving	Worsening
2. b. Very low birth weight	No Change	Target Met	No Change	Target Met	Worsening
3. First trimester prenatal care	Improving	Worsening	Improving	Improving	Worsening
4. Abstinence from alcohol during pregnancy	No Change	No Change	No Change	No Change	No Change
5. Abstinence from cigarette smoking during pregnancy	Improving	No Change	Worsening	Worsening	No Change
6. Back to sleep	No targets were set for racial/ethnic groups.				
7. Breastfeeding	No targets were set for racial/ethnic groups.				
8. Formula supplementation	No targets were set for racial/ethnic groups.				
9. Ten Steps to Successful Breastfeeding	No targets were set for racial/ethnic groups.				
10. Births to females aged 15-17 years	Target Met	Target Met	Target Met	Target Met	Insufficient Data
11. Initial blood lead level	No targets were set for racial/ethnic groups.				
12. Average blood lead level	No targets were set for racial/ethnic groups.				
13. Newborn hearing screening	Improving	Improving	Improving	Improving	Improving
NUTRITION AND FITNESS	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. a. Obesity (age 18+)	Worsening	Worsening	Worsening	No Change	No Change
1. b. Obesity (high school students)	Target Met	Target Met	Target Met	No Change	Insufficient Data
2. Fruit and vegetable consumption	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data
3. a. Physical activity (age 18+)	Worsening	Worsening	Worsening	Worsening	Worsening
3. b. Physical activity (high school students)	Target Met	Target Met	Target Met	Target Met	Insufficient Data
4. a. TV time	Improving	No Change	Target Met	Improving	Insufficient Data
4. b. Computer and video game time	Worsening	Worsening	Worsening	Worsening	Insufficient Data

	Target Met	Improving	No Change	Worsening	Insufficient Data
5. Soda consumption	Target Met	Target Met	Target Met	Improving	Insufficient Data
OLDER ADULTS	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. a. Hip fractures (females age 65+)	Target Met	Improving	Improving	Target Met	Target Met
1. b. Hip fractures (males age 65+)	Target Met	No Change	Target Met	Target Met	Target Met
2. Fall-related deaths	Worsening	Worsening	Worsening	Worsening	Insufficient Data
3. a. Physical inactivity (age 65-74)	No Change	No Change	Target Met	Target Met	Insufficient Data
3. b. Physical inactivity (age 75+)	No Change	No Change	No Change	Target Met	Insufficient Data
4. Funds allocation	Not applicable.				
5. General health status	Target Met	Target Met	Worsening	No Change	Insufficient Data
SEXUALLY TRANSMITTED DISEASES	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. Chlamydia infections among females aged 15-24 tested anywhere	No targets were set for racial/ethnic groups.				
2. Chlamydia infections among persons aged 15-24 tested at family planning and STD clinics	No Change	Worsening	Improving	Worsening	No Change
3. Gonorrhea incidence	No targets were set for racial/ethnic groups.				
4. Primary and secondary syphilis incidence	Worsening	Worsening	Worsening	Worsening	Worsening
5. Congenital syphilis incidence	Worsening	Worsening	Worsening	Worsening	Worsening
TOBACCO USE	TOTAL	WHITE	BLACK	HISPANIC	ASIAN
1. a. Current smokers (age 18+)	Target Met	Target Met	Target Met	Target Met	Worsening
1. b. Current smokers (high school students)	Target Met	Target Met	Target Met	Target Met	Insufficient Data
1. c. Current smokers (middle school students)	Target Met	Target Met	Target Met	Target Met	Target Met
2. Tobacco use by high school students	Target Met	Target Met	Target Met	Target Met	Insufficient Data
3. Secondhand smoke exposure	Worsening	Worsening	Worsening	Worsening	Worsening
The following topic areas had no race/ethnicity-specific targets: Environmental Health, Healthcare-Associated Infections, Occupational Health And Safety, Public Health Infrastructure, Public Health Preparedness, and Tuberculosis.					

APPENDIX 3: STATE AND NATIONAL RATES AND RANKINGS

TOPIC/OBJECTIVE	NJ RANK*	NJ RATE	US RATE	DATA YEAR
ASTHMA				
Asthma death rate	36	1.2	1.1	2013-15
CANCER				
Cancer death rate	12	150.8	158.5	2015
Colorectal cancer screening	30	67.7%	68.8%	2014
CHRONIC KIDNEY DISEASE				
Kidney disease death rate	31	14.4	13.4	2015
End-Stage Renal Disease death rate	28	5.1	5.0	2013-15
DIABETES				
Diabetes death rate	7	17.9	21.3	2015
Diagnosed prevalence (adults)	20	8.6%	9.1%	2014
HEART DISEASE AND STROKE				
Coronary heart disease death rate	28	104.8	108.3	2015
Stroke death rate	7	31.1	37.6	2015
IMMUNIZATION				
Children aged 19 to 35 months receiving the 4:3:1:3*:3:1:4 series	9	76.5%	72.2%	2015
INJURY AND VIOLENCE				
Homicide rate	24	4.6	5.3	2013-15
Suicide rate	3	8.3	13.3	2015
Motor vehicle-related death rate	4	6.3	11.4	2015
Seatbelt use (observed)	25	87.6%	87.0%	2014
Unintentional poisoning death rate	29	15.9	14.8	2015
MATERNAL AND CHILD HEALTH				
Infant mortality rate (per 1,000 live births)	8	4.8	5.9	2015
Teen birth rate (aged 15-19)	5	12.1	22.3	2015

NUTRITION AND FITNESS				
Obesity (adults)	14	27.4%	30.1%	2016
Physical activity (adults)	27	50.5%	50.5%	2013
SEXUALLY TRANSMITTED DISEASES				
Chlamydia (per 100,000 females aged 15-24)	6	336.0	456.1	2014
Gonorrhea (per 100,000 aged 15-44)	17	74.6	110.7	2014
Syphilis (primary & secondary)	18	3.3	6.3	2014
TOBACCO USE				
Smoking prevalence (adults)	7	14.0%	17.0%	2016
<p>* Rank is among the 50 states plus D.C., where 1=best and 51=worst.</p> <p>All death rates are age-adjusted and per 100,000 population.</p> <p>Choice of objectives included in this list is based solely on availability of comparable US data.</p> <p><i>Sources: CDC WONDER (deaths and teen births) and CDC Sortable Stats (all others)</i></p>				

APPENDIX 4: HEALTHY NEW JERSEY WORKGROUP

Staff from the following New Jersey Department of Health divisions and programs participated in the 2018 State Health Assessment.

- Population Health
 - Center for Health Statistics
 - Health Care Quality Assessment
 - Minority and Multicultural Health
- Family Health Services
 - Community Health and Wellness
 - Maternal and Child Health
 - Special Child Health and Early Intervention Services
 - WIC Services
- Epidemiology, Environmental, and Occupational Health
 - Cancer Epidemiology Services
 - Communicable Disease Service
 - Environmental Health
 - Occupational Health
- HIV, STD, and TB Services
 - HIV Prevention and Education
 - HIV Care and Treatment Program
 - Sexually Transmitted Disease Program
 - Tuberculosis Program
- Public Health Infrastructure, Laboratories, and Emergency Preparedness
 - Emergency Preparedness
 - Local Public Health

APPENDIX 5: HEALTHY NEW JERSEY ADVISORY COUNCIL

ORGANIZATION	MEMBER
AtlantiCare Regional Medical Center	Sandy Festa
Barnabas Health	Tamara Cunningham
Camden County Department of Health and Human Services	Paschal Nwako
Cumberland Cape Atlantic YMCA	Lisa Scheetz
Greater Newark Healthcare Coalition	Keri Logosso-Misurell
Morris County Organization for Hispanic Affairs	Xiomara Guevara
New Jersey Hospital Association	Aline Holmes
New Jersey Public Health Association	Kevin McNally
New Jersey Society for Public Health Education	Candice Davenport
North Jersey Health Collaborative	Chris Kirk
Ocean County Health Department	Daniel Regenye
Rutgers Center for State Health Policy	Margaret Koller / Manisha Agrawal
Sickle Cell Association of New Jersey	Mary LaMar Bentley
Trenton Health Team	Gregory Paulson
United Way of Central Jersey	Jagdish Vasudev

APPENDIX 6: HNJ SHA PUBLIC COMMENT FORM QUESTIONS

Below is the list of questions contained in the web-based survey that State Health Assessment Report reviewers were asked. All questions were optional except for the first two rating questions.

General Feedback

- Was the information in this State Health Assessment easy to understand?
 - 1 Star = No, not at all | 5 Stars = Yes, very clear
- After reading this report, do you have a better understanding of the health concerns that might affect you or your community's health?
 - 1 Star = No, not at all | 5 Stars = Yes, much better
- Are there other health data NOT identified in this report that you feel are important?
- What surprised you about the results of the State Health Assessment?
- Why are you interested in the State Health Assessment, and what made you interested in commenting?
- Would you like to provide more detailed comments on specific report sections?
 - Yes (*Survey continues below with Section 1*)
 - No thanks (*Survey skips to About You section*)
- SECTION 1: Introduction
- SECTION 2: New Jersey Resident Profile
- SECTION 3: Quality of Life in New Jersey

Health Topic Comments

- SECTION 4: State Health Assessment Data
Comment on any or all of the topic areas listed below.
 - Access to Health Services
 - Asthma
 - Cancer
 - Chronic Kidney Disease and Diabetes
 - Environmental Health
 - Healthcare-Associated Infections
 - Heart Disease and Stroke
 - HIV/AIDS
 - Immunization
 - Injury and Violence Prevention
 - Maternal and Child Health
 - Nutrition and Fitness
 - Occupational Safety and Health
 - Older Adults
 - Public Health Infrastructure
 - Public Health Preparedness

- Sexually Transmitted Diseases
- Tobacco Use
- Tuberculosis
- Any other comments?

- SECTION 5: APPENDICES

Comment on any or all of the appendices

About You

The New Jersey Department of Health would like to know a little bit about you. This kind of information tells us who reviews and utilizes public health data, so that we can learn how to improve our reporting. We thank you for taking the time to answer this part of the survey.

- What is your affiliation?
 - County or Local Health Department
 - Community / Non-profit / Faith-based Organization
 - College / University faculty or staff
 - Regional Public Health Coalition / Organization
 - Hospital / Healthcare Provider
 - Student
 - DOH Staff
 - Other health professional
 - NJ Resident
 - Other (please specify)
- What is your age?
 - Under 18 years
 - 18 - 24 years
 - 25 - 34 years
 - 35 - 44 years
 - 45 - 54 years
 - 55 - 64 years
 - 65 - 74 years
 - 75+ years
- What is your race / ethnicity?
 - American Indian or Alaska Native
 - African American / Black
 - Asian
 - Hispanic / Latino
 - Native Hawaiian or Other Pacific Islander
 - White / Caucasian
 - Other (please specify)
- Select the primary language you speak at home, if not English
 - Not applicable
 - Arabic

- Chinese
- Creole
- Gujarati
- Hindi
- Italian
- Korean
- Polish
- Portuguese
- Russian
- Spanish
- Tagalog
- Other (please specify)
- What is your gender?
 - Male
 - Female
 - Transgender
 - Prefer not to say
 - Other (please specify)
- What is the highest level of educational degree or certification you have achieved?
 - Less than high school
 - High school diploma or GED
 - Trade / technical / vocational training
 - Some college / Associate's degree
 - Bachelor's Degree
 - Master's Degree or higher
- What is the approximate amount of your family / household total yearly income?
 - Less than \$25,000
 - \$25,000 - \$49,999
 - \$50,000 - \$74,999
 - \$75,000 - \$100,000
 - More than \$100,000
- What is your usual source of health care?
 - Hospital / Emergency Rooms
 - Doctor's Offices
 - Free / Reduced Fee Clinics
 - Urgent Care Clinics
 - I don't have a usual place to go for healthcare services
 - Other (please specify)

Your Information

Optional: If you have submitted a question or concern that you would like us to answer, providing your name and contact information will ensure that you receive a response from us.

Please provide your contact information

- First Name
- Last Name
- Name of your organization
- Email

APPENDIX 7: PARTNER ORGANIZATIONS

- Academy of Nutrition and Dietetics
- American Academy of Family Physicians
- American Cancer Society
- American College of Nurse-Midwives
- American Congress of Obstetricians and Gynecologists (ACOG)
- American Heart Association
- Association of Women’s Health, Obstetric, and Neonatal Nurses
- Camden Coalition of Health Care Providers
- Center for Asian Health at St. Barnabas Medical Center
- Center for Protection of Worker’s Rights
- Centers for Disease Control and Prevention (CDC)
 - National Center for Health Statistics
 - National Center for Injury Prevention and Control, including
 - National Environmental Public Health Tracking (EPHT) Network
 - Rape Prevention and Education Program
 - TB Elimination Program
- Central Jersey Family Health Consortium
- Collaborative Improvement and Innovation Network to Reduce Infant Mortality (CoIIN) partners
- Committee for the Advancement of Arboriculture
- Council of State and Territorial Epidemiologists (CSTE)
- Diabetes Resources Coordination Centers
- Emergency Medical Services (EMS) organizations
- End Stage Renal Disease Network 3
- Federal Bureau of Investigation (FBI)
- Federally Qualified Health Centers (FQHCs)
- Global Tuberculosis Institute (GTBI)
- Governmental Public Health Partnerships (GPHP)
- Greater Newark Health Care Coalition
- Group Against Smoking Pollution (GASP)
- Healthcare Quality Strategies, Inc.
- Hep B United
- Isles, Inc. community development non-profit organization
- Local Health Departments (LHD)
- March of Dimes
- National Association of Pediatric Nurse Practitioners
- National Institute for Occupational Safety and Health (NIOSH)
- National Solid Waste Management Association
- National Violent Death Reporting System (NVDRS)
- New Labor, a NJ immigrant worker organization

- Nicholson Foundation
- NJ 211 is New Jersey's statewide, 24/7, multilingual, local health and human service resource hotline and website
- NJ Association for Professionals in Infection Control (APIC)
- NJ Association of County and City Health Officials (NJACCHO)
- NJ Cancer Education and Early Detection screening partners
- NJ Chapter, American Academy of Pediatrics (NJAAP)
- NJ Climate Change and Public Health Working Group
- NJ College Health Association (NJCHA)
- NJ Commission on Cancer Research
- NJ County Councils for Young Children (CCYC)
- NJ Department of Children and Families (DCF)
 - Child Death Review Team and the NJ Child Fatality and Near-Fatality Review Board
 - Division on Women and the NJ Domestic Violence Fatality and Near-Fatality Review Board
- NJ Department of Community Affairs (DCA)
- NJ Department of Corrections
- NJ Department of Education (DOE)
- NJ Department of Environmental Protection (DEP)
- NJ Department of Human Services (DHS)
 - Commission for the Blind and Visually Impaired
 - Division of Aging Services
- NJ Department of Labor and Workforce Development (LWD)
- NJ Family Planning League
- NJ Governor's Council on Alcoholism and Drug Abuse
- NJ Governor's Task Force on Cancer Prevention, Early Detection, and Treatment
- NJ Health Care Emergency Preparedness Coalitions
- NJ Healthy Communities Network Steering Committee
- NJ Hepatitis B Coalition
- NJ HIV/AIDS Planning Group's (NJHPG) Prevention and Care Collaborative Workgroup
- NJ Hospital Association (NJHA)
- NJ Immunization Network
- NJ Integrated HIV Planning Group
- NJ Local Boards of Health Association
- NJ Medical Coordination Centers (MCC)
- NJ Office of Homeland Security and Preparedness (OHSP)
- NJ Poison Information and Education System (NJPIES)
- NJ Prevention Network (NJPN)
- NJ Public Health Association
- NJ Southern Behavioral Health Collaborative
- NJ State Medical Examiner's Office

- NJ State Police
- NJ Work Environment Council (NJWEC)
- North Jersey Community Research Initiative AIDS service organization
- Occupational Safety and Health Administration (OSHA)
- Partnership for Maternal and Child Health of Northern New Jersey
- Population Health Action Team consisting of the NJ Departments of
 - Agriculture (DA),
 - Children and Families (DCF),
 - Consumer Affairs (DCA),
 - Education (DOE),
 - Environmental Protection (DEP),
 - Health (DOH),
 - Human Services (DHS), and
 - Transportation (DOT)
- Quality Improvement Network: Healthcare Quality Strategies Inc.
- Regional Chronic Disease Coalitions
- Regional Planning Collaboratives (RPCs)
- Rutgers, The State University
 - Behavioral Health Care
 - Cancer Institute of New Jersey
 - Center for State Health Policy
 - Office of Public Health Practice (OPHP)
 - Public Health Training Institute
 - School of Public Health
- Shade Tree Commission
- Shaping NJ
- SIDS Center of New Jersey (SCNJ)
- Southern New Jersey Perinatal Cooperative
- State and County Offices of Emergency Management
- State Innovation Models (SIM) Initiative stakeholders
- Statewide Parent Advocacy Network (SPAN)
- Susan G. Komen Foundation
- Sustainable Jersey
- Tobacco-Free for a Healthy New Jersey
- Trenton Health Team
- Tuberculosis clinics throughout the state
- Unintentional Injury Prevention, Prescription Drug Overdose Program
- US Bureau of Labor Statistics
- US Department of Health and Human Services, Assistant Secretary for Preparedness & Response (ASPR)
- US Department of Health and Human Services Region 2 Public Health Training Center
- US Department of Homeland Security

- Visiting Nurses Association of Central Jersey

And other organizations, such as

- Accountable care organizations
- Cancer coalitions
- Childcare/preschool directors
- Coalitions
- Colleges
- Community and faith-based organizations
- Community centers
- Hospitals
- Housing authorities
- Long-term care facilities
- HIV/AIDS regional collaboratives
- Hospital infection control practitioners
- Local law enforcement
- Regional collaboratives
- School nurses, principals, and administrators
- State and private laboratories

APPENDIX 8: DATA SOURCES

The New Jersey SHA uses a combination of qualitative and quantitative data to ensure that the limitations of one data type are balanced by the strengths of the other. The quantitative health data presented in this report, most often rates and percentages, were collected from a variety of sources managed by the New Jersey Department of Health (DOH), along with data from other state agencies, and federal sources such as the Census Bureau and the Centers for Disease Control and Prevention (CDC).

NEW JERSEY DEPARTMENT OF HEALTH DATA SOURCES

- Adult Blood Lead Epidemiology and Surveillance
- Asthma Call-back Survey
- Behavioral Risk Factor Survey
- Birth Certificate Database
- Census of Fatal Occupational Injuries
- Communicable Disease Reporting and Surveillance System
- Death Certificate Database
- Enhanced HIV/AIDS Reporting System
- Hospital Discharge Data Collection System
- LeadTrax
- Local Health Department Survey
- Local Information Network and Communications System
- Matched Infant Death-Birth Certificate Database
- Pregnancy Risk Assessment Monitoring System
- Sexually Transmitted Disease Program
- Situational Awareness Network Software
- Special Child Health and Early Intervention Services
- State Cancer Registry
- Tuberculosis Information Management System
- Youth Tobacco Survey

OTHER NJ STATE AGENCY DATA SOURCES

- Department of Education, Student Health Survey of High School Students
- Department of Environmental Protection, Beach Monitoring System
- Department of Environmental Protection, Bureau of Air Monitoring
- Department of Environmental Protection, Radon Database
- Department of Human Services, Division of Medical Assistance and Health Services
- NJ Public Health Training Center at Rutgers School of Public Health

OTHER DATA SOURCES

- CDC Breastfeeding Report Card
- CDC High School Youth Risk Behavior Surveillance System
- CDC National Healthcare Safety Network
- CDC National Immunization Surveys
- Public Health Accreditation Board
- Quality Insights Renal Network 3
- U.S. Census Bureau, American Community Survey
- U.S. Census Bureau, Small Area Health Insurance Estimates
- U.S. Department of Transportation, National Occupant Protection Use Survey

APPENDIX 9: ACRONYMS USED IN THIS REPORT

ORGANIZATIONAL AND GENERIC ACRONYMS

- Bureau of Labor Statistics (BLS)
- Centers for Medicare and Medicaid Services (CMS)
- Comprehensive Health and Physical Education (NJCCCS)
- Centers for Disease Control (CDC)
- Department of Children and Families (DCF)
- Department of Education (DOE)
- Department of Environmental Protection (DEP)
- Department of Health (DOH)
- Department of Human Services (DHS)
- Electronic Health Record (EHR)
- Federal Fiscal Year (FFY)
- Federally Qualified Healthcare Centers (FQHCs)
- Integrated Municipal Advisory Councils (IMACs)
- Local Health Department (LHD)
- Maternal and Child Health Consortia (MCHC)
- Maternal and Child Health Services (MCH)
- New Jersey Administrative Code (NJAC)
- New Jersey Behavioral Risk Factor Survey (NJBRFS)
- New Jersey Cancer Education and Early Detection (NJCEED)
- New Jersey Heart Disease and Stroke Prevention Program (NJHDSPP)
- New Jersey Hospital Association (NJHA)
- New Jersey Prevention Network (NJPN)
- New Jersey State Cancer Registry (NJSCR)
- New Jersey Statutes Annotated (NJSA)
- North American Association of Central Cancer Registries (NAACCR)
- Occupational Safety and Health Administration (OSHA)
- Office of Cancer Control and Prevention (OCCP)
- Regional Chronic Disease Coalitions (RCDC)
- State Fiscal Year (SFY)
- Tobacco Free for a Healthy New Jersey (TFHNJ)
- United States Department of Agriculture (USDA)
- United States Preventive Services Task Force (USPSTF)
- Women, Infants, and Children (WIC)

INDICATOR SPECIFIC ACRONYMS

- Assistant Secretary for Preparedness and Response (ASPR)
- Association for Professionals in Infection Control (APIC)
- Breastfeeding Peer Counseling Funds (BFPC)
- Chronic Disease Self-Management Program (CDSMP)
- Chronic Kidney Disease (CKD)
- Comprehensive School Physical Activity Program (CSPAP)
- Data-Driven Prevention Initiative (DDPI)
- Diabetes Resources Coordination Centers (DRCCs)
- Diabetes Self-Management Program (DSM)
- End-stage Renal Disease (ESRD)
- Environmental and Occupation Health Surveillance (EOHS) Program
- Healthcare Associated Infection (HAI)
- Healthcare Quality Strategies, Inc. (HQSI)
- Infant Mortality Rate (IMR)
- Sexually Transmitted Diseases (STDs)
- Surgical Site Infections (SSIs)
- Work Related Asthma (WRA)