Agenda

Funding and Support for LHDs

Update on COVID – 19
Other Respiratory Illness
Other Outbreaks
Other Selected Public Health Priorities
Lessons Learned
# Funding to Local Public Health

<table>
<thead>
<tr>
<th>Grant Name</th>
<th>3 Year Amount</th>
<th>Award Eligibility</th>
<th>Actual/Average Number of Grantees per Year</th>
<th>Funding Ends</th>
</tr>
</thead>
<tbody>
<tr>
<td>LINCS</td>
<td>$45.7M</td>
<td>LINCS (22 agencies)</td>
<td>22 grantees</td>
<td>6/30/23</td>
</tr>
<tr>
<td>Strengthening Local Public Health</td>
<td>$50.7M</td>
<td>Local health departments (81 agencies)</td>
<td>Average 65 grantees per year</td>
<td>6/30/23</td>
</tr>
<tr>
<td>Vaccine Supplemental Funding</td>
<td>$21.5M</td>
<td>County and local health departments (103 agencies)</td>
<td>Average 63 grantees per year</td>
<td>6/30/23</td>
</tr>
<tr>
<td>County Health Infrastructure</td>
<td>$41M</td>
<td>County health departments (21 agencies)</td>
<td>21 grantees</td>
<td>12/31/26</td>
</tr>
<tr>
<td>Enhancing Local Public Health Infrastructure</td>
<td>$75M +</td>
<td>County and local health departments (103 agencies)</td>
<td>NJACCHO will award/administer grants to local health departments</td>
<td>7/8/24</td>
</tr>
</tbody>
</table>
Overview and goals of Enhancing Local Public Health Infrastructure Grant as identified by NJDOH working team and LHD stakeholders

Context & overview of Enhancing Local Public Health Infrastructure Grant

- To further enhance LHD infrastructure over the long run, NJDOH awarded a grant to NJACCHO for grant funding to LHDs additional $75M Enhancing Local Public Health Infrastructure Grant
- Grant period: October 1, 2022 – June 30, 2024

Potential program goals based on the Rutgers Local Public Health Capacity report and LHD interviews on LHD infrastructure needs

LHDs may choose to utilize funds to address immediate needs across these categories:

1. Increase health equity for vulnerable and special populations
2. Streamline processes, supported by technology and automation
3. Strengthen organizational capacity to drive progress on public health priorities
4. Expand data collection and infrastructure to drive data-driven decision making with aim to improve equity
5. Develop multilingual and culturally appropriate communications/public-health campaigns and share across LHDs
6. Codify institutional knowledge and COVID-19 specific learnings
7. Enhance and/or continue ongoing COVID-19/communicable disease mitigation effort
8. Further refine NJDOH-LHD bidirectional communications and public health planning (use of Phase 2 funds)

Focus areas can be supplemented with a needs assessment completed by each LHD

1. As defined by the CDC, Public Health Infrastructure objectives address high-performing health departments, workforce development & training, data & information systems, planning, and partnerships

Source: NJDOH LHD Working Team, Interviews with 23 NJDOH stakeholders, 5 LHD stakeholders, stakeholders at partner organizations beyond the NJDOH (e.g., Rutgers Institute), and external experts in public health research institutes; https://healthapps.state.nj.us/noticeofgrant/noticegrants.aspx#

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## Potential Funding to LHDs: MOAs Distributed by Governor’s Office (ARP)

<table>
<thead>
<tr>
<th>Total budget, $</th>
<th>American Rescue Plan (ARP) funds distributed by the Governor’s office</th>
<th>~$41M (single tranche distribution)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Est. budget period</td>
<td>ELC COVID-19 Response Support grants to LHDs and Counties</td>
<td>~$153M ($75M in first tranche)</td>
</tr>
<tr>
<td>Recipient</td>
<td>County health departments</td>
<td>County health departments and local health departments</td>
</tr>
<tr>
<td>Potential purpose</td>
<td>Ensures that county health departments have the <strong>resources needed to fight the pandemic</strong> and support families struggling with its public health impact; <strong>maintain public services at the county level</strong>; and <strong>build a strong, resilient, and equitable recovery</strong> by making investments that support long-term growth and opportunity based on factors relevant to New Jersey.</td>
<td>Provide critical resources to state, local, &amp; territorial health departments in <strong>support of a broad range of COVID-19/SARS-CoV-2 testing &amp; epidemiologic surveillance related activities.</strong></td>
</tr>
</tbody>
</table>

1. Grant requires at least 40% (~$30M) of A1 workforce be allocated to LHDs up to $80M,  
2. Budget period based on grant schedule of Enhancing Local Public Health Infrastructure grant; grant may close one month prior to budget end date  


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Distribution of ARP funding ($41M) from Governor’s Office

Provided from GO to counties through MOA

<table>
<thead>
<tr>
<th>County</th>
<th>Population¹, K</th>
<th>Per capita based allocation¹, $M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bergen</td>
<td>954</td>
<td>4.25</td>
</tr>
<tr>
<td>Middlesex</td>
<td>861</td>
<td>3.83</td>
</tr>
<tr>
<td>Essex</td>
<td>855</td>
<td>3.81</td>
</tr>
<tr>
<td>Hudson</td>
<td>702</td>
<td>3.13</td>
</tr>
<tr>
<td>Ocean</td>
<td>649</td>
<td>2.89</td>
</tr>
<tr>
<td>Monmouth</td>
<td>645</td>
<td>2.87</td>
</tr>
<tr>
<td>Union</td>
<td>572</td>
<td>2.55</td>
</tr>
<tr>
<td>Camden</td>
<td>524</td>
<td>2.33</td>
</tr>
<tr>
<td>Passaic</td>
<td>518</td>
<td>2.31</td>
</tr>
<tr>
<td>Morris</td>
<td>511</td>
<td>2.28</td>
</tr>
<tr>
<td>Burlington</td>
<td>464</td>
<td>2.07</td>
</tr>
<tr>
<td>Mercer</td>
<td>386</td>
<td>1.72</td>
</tr>
<tr>
<td>Somerset</td>
<td>346</td>
<td>1.54</td>
</tr>
<tr>
<td>Gloucester</td>
<td>304</td>
<td>1.36</td>
</tr>
<tr>
<td>Atlantic</td>
<td>275</td>
<td>1.22</td>
</tr>
<tr>
<td>Cumberland</td>
<td>154</td>
<td>0.68</td>
</tr>
<tr>
<td>Sussex</td>
<td>146</td>
<td>0.65</td>
</tr>
<tr>
<td>Hunterdon</td>
<td>130</td>
<td>0.58</td>
</tr>
<tr>
<td>Warren</td>
<td>111</td>
<td>0.49</td>
</tr>
<tr>
<td>Cape May</td>
<td>96</td>
<td>0.43</td>
</tr>
<tr>
<td>Salem</td>
<td>65</td>
<td>0.29</td>
</tr>
</tbody>
</table>

1. Based on 2021 US Census Bureau population estimates provided by Governor’s office

Overview of CDC Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems Grant application submitted by NJDOH

Context & overview of CDC “Strengthening” Grant

- This grant will provide funding to improve critical public health infrastructure needs. This investment will help ensure that U.S. public health systems are ready to respond to public health emergencies like COVID-19 and to meet the evolving and complex needs of the communities and populations they serve.

- 40% of CDC grant award is required to support LHDs directly through grants/awards or through infrastructure improvements at the State DOH that will directly impact LHDs.

- Grant period: December 1, 2022 – 2025

Approach submitted as part of NJDOH grant application

- Establish a regional support model with 5 regional support units staffed and supported by key programs:

- A Local Health Liaison program to provide support to LHDs to expand and modernize programs aimed at developing the local public health workforce.

- A performance and grants management program to support PHAB accreditation, data, reporting, and grants management.

Source: https://www.cdc.gov/workforce/resources/infrastructuregrant/index.html

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Support for LHDs

Update on COVID – 19

Other Respiratory Illness

Other Outbreaks

Other Selected Public Health Priorities

Lessons Learned
COVID-19 disease progression US and New Jersey (as of November 14th)

<table>
<thead>
<tr>
<th>Cases, mortality, and hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>97,889,652</strong> Total reported confirmed cases in United States</td>
</tr>
</tbody>
</table>

**CDC Case Classification for “Probable”**

- Meets clinical criteria AND epidemiologic linkage with no confirmatory or presumptive laboratory evidence for SARS-CoV-2, OR
- Meets presumptive laboratory evidence, OR
- Meets vital records criteria with no confirmatory laboratory evidence for SARS-CoV-2

<table>
<thead>
<tr>
<th>Cases in New Jersey</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,379,919 PCR cases, 435,861 antigen cases</td>
</tr>
<tr>
<td>31,872 confirmed COVID-19 deaths, 3,116 probable COVID-19 deaths</td>
</tr>
</tbody>
</table>

## Overview of State Vaccine Administration as of 11/14/2022

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total vaccination doses administered(^1) in the State of New Jersey</td>
<td>~19.5M</td>
</tr>
<tr>
<td>People completed their primary vaccination series in the State of New Jersey</td>
<td>~7.0M</td>
</tr>
<tr>
<td>People with at least one vaccination dose administered in the State of New Jersey</td>
<td>~8.2M</td>
</tr>
<tr>
<td>Total Bivalent Doses administered in the State of New Jersey since 9/1/2022</td>
<td>~0.9M</td>
</tr>
</tbody>
</table>

### In NJ, as of Oct 10, 2022:
- 3.6M first (monovalent) booster doses were administered
- 0.7M second (monovalent) booster doses were administered

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\(^1\) Includes all individuals who were vaccinated within New Jersey (those who live, work, or study within New Jersey). Excludes vaccines administered through select federal programs (e.g., Bureau of Prisons, Veterans Health, Indian Health Service, and Department of Defense) as well as NJ residents vaccinated in other states.
Daily report on vaccination (as of 7am 11/14/2022)

### Bivalent doses administered in NJ by age cohorts (as of 11/14/22)

<table>
<thead>
<tr>
<th>Age cohorts under 5 are not eligible to receive Bivalent booster doses as of 11/14/2022.</th>
<th>3.1%</th>
<th>5.3%</th>
<th>4.8%</th>
<th>5.5%</th>
<th>9.2%</th>
<th>13.7%</th>
<th>28.3%</th>
<th>30.2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6mo - 2</td>
<td>8.4K</td>
<td>14.8K</td>
<td>8.0K</td>
<td>57.3K</td>
<td>179.8K</td>
<td>226.2K</td>
<td>304.4K</td>
<td>101.1K</td>
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<tr>
<td>3 - 4</td>
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<td>5 - 11</td>
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<td>65-79</td>
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</tr>
</tbody>
</table>

### Primary vaccine courses (NJ & non-NJ residents vaccinated in NJ) by age category, % of total population

<table>
<thead>
<tr>
<th>Total Primary series % coverage</th>
<th>6mo-2³</th>
<th>3 - 4³</th>
<th>5 - 11³</th>
<th>12 - 15</th>
<th>16 - 17</th>
<th>18 - 29</th>
<th>30 - 49</th>
<th>50 - 64</th>
<th>65 - 79</th>
<th>80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>6mo-2³</td>
<td>9.3%</td>
<td>16.8%</td>
<td>41.9%</td>
<td>71.3%</td>
<td>81.9%</td>
<td>94.8%</td>
<td>97.8%</td>
<td>100%²</td>
<td>100%²</td>
<td>100%²</td>
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<tr>
<td>3 - 4³</td>
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<td>5 - 11³</td>
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</tbody>
</table>

1. Values from 11/10, updated daily with a two-day delay due to data processing represents value two weekdays prior (e.g., if Monday, represents the previous Thursday). 2. Value over 100% due to numerator including NJ and non-NJ residents while eligible population includes NJ residents only. 3. Current primary series vaccinations are mostly administered to these age cohorts while other age cohorts’ primary series % coverage have passed 70%. Note: Includes all individuals who were vaccinated within New Jersey (those who live work or study within New Jersey). Excludes vaccines administered through select federal programs (e.g., Bureau of Prisons, Veterans Health, Indian Health Service, and Department of Defense) as well as NJ residents vaccinated in other states.

Source: NJIIS, Vtricks

Preliminary, pre-decisional, and deliberative. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.
## Bivalent booster coverage for 65+ population (as of 4pm November 14th)

<table>
<thead>
<tr>
<th>New Jersey Bivalent boosters administered to 65+ population&lt;sup&gt;1&lt;/sup&gt;</th>
<th>New Jersey 65+ potentially eligible population&lt;sup&gt;2&lt;/sup&gt;</th>
<th>New Jersey bivalent booster coverage % for 65+ population</th>
<th>National average bivalent booster % for 65+ population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>405,467</strong></td>
<td><strong>1,410,076</strong></td>
<td><strong>28.8%</strong></td>
<td><strong>26.9%</strong></td>
</tr>
</tbody>
</table>

**Total 899,943 bivalent boosters administered**

**494,476 additional bivalent Booster doses administered to individuals 5-64**

---

1. Includes all bivalent booster doses administered to the eligible population of individuals aged 65+.
2. Bivalent booster dose eligible population calculated as 65+ individuals who received completed primary series doses or monovalent booster doses at least 2 months ago.

Note: Administrations and eligibility numbers include NJ residents and non-NJ residents vaccinated in NJ, exclude NJ residents vaccinated out of state and by Federal programs; Values from 11/14, updated daily with a two-day delay due to data processing.

Source: NJIIS, CDC

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Daily report on vaccination (as of 11/14/2022)

Bivalent booster dose administration by county, % of eligible population

<table>
<thead>
<tr>
<th>County</th>
<th>Total Bivalent Booster Doses Administered</th>
<th>Total Eligible Population</th>
<th>% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATLANTIC</td>
<td>20,944</td>
<td>182,578</td>
<td>11%</td>
</tr>
<tr>
<td>BERGEN</td>
<td>101,008</td>
<td>734,166</td>
<td>14%</td>
</tr>
<tr>
<td>BURLINGTON</td>
<td>51,761</td>
<td>320,339</td>
<td>16%</td>
</tr>
<tr>
<td>CAMDEN</td>
<td>57,235</td>
<td>371,396</td>
<td>15%</td>
</tr>
<tr>
<td>CAPE MAY</td>
<td>10,476</td>
<td>65,699</td>
<td>16%</td>
</tr>
<tr>
<td>CUMBERLAND</td>
<td>8,636</td>
<td>89,998</td>
<td>10%</td>
</tr>
<tr>
<td>ESSEX</td>
<td>71,747</td>
<td>606,682</td>
<td>12%</td>
</tr>
<tr>
<td>GLOUCESTER</td>
<td>27,522</td>
<td>200,077</td>
<td>14%</td>
</tr>
<tr>
<td>HUDSON</td>
<td>50,059</td>
<td>539,533</td>
<td>9%</td>
</tr>
<tr>
<td>HUNTERDON</td>
<td>15,035</td>
<td>91,004</td>
<td>17%</td>
</tr>
<tr>
<td>MERCER</td>
<td>44,613</td>
<td>280,263</td>
<td>16%</td>
</tr>
<tr>
<td>MIDDLESEX</td>
<td>77,167</td>
<td>643,341</td>
<td>12%</td>
</tr>
<tr>
<td>MONMOUTH</td>
<td>63,290</td>
<td>451,320</td>
<td>14%</td>
</tr>
<tr>
<td>MORRIS</td>
<td>61,443</td>
<td>391,605</td>
<td>16%</td>
</tr>
<tr>
<td>OCEAN</td>
<td>47,065</td>
<td>348,653</td>
<td>13%</td>
</tr>
<tr>
<td>PASSAIC</td>
<td>30,049</td>
<td>366,988</td>
<td>8%</td>
</tr>
<tr>
<td>SALEM</td>
<td>4,780</td>
<td>37,961</td>
<td>13%</td>
</tr>
<tr>
<td>SOMERSET</td>
<td>42,674</td>
<td>270,581</td>
<td>16%</td>
</tr>
<tr>
<td>SUSSEX</td>
<td>12,544</td>
<td>93,711</td>
<td>13%</td>
</tr>
<tr>
<td>UNION</td>
<td>48,287</td>
<td>425,383</td>
<td>11%</td>
</tr>
<tr>
<td>WARREN</td>
<td>8,541</td>
<td>61,694</td>
<td>14%</td>
</tr>
</tbody>
</table>

Note: Bivalent booster dose eligible population calculated as 5+ individuals who received completed primary series doses or monovalent booster doses at least 2 months ago
Source: NJIIS, Vtrcks
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COVID-19 variant surveillance in NJ (as of 10/22/2022)

COVID-19 variant surveillance by specimen collected, week-cumulative summary as of 10/22/2022, %

Percentages represent the proportion found in the specified variant lineage. "Other" represents 173 additional and unassigned lineages not classified as variants of concern or variants of interest.

* Specimens collected 10/9/2022 – 10/22/2022 reflects data for 2 weeks with a total of 425 specimens.

Source: CDS

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Support for LHDs

Update on COVID – 19

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Lessons Learned
Respiratory Viruses Overview

- The U.S. and N.J. are experiencing a resurgence in the circulation of non-COVID-19 respiratory viruses, including influenza, rhinovirus/enteroviruses, and RSV, in addition to ongoing levels of COVID-19.

- Some infections are responsible for severe disease and hospitalization, especially in pediatric populations.

- High rates of co-circulating respiratory viruses may result in increased severe illness and hospitalizations as we progress into the holiday season and the time of year when respiratory illnesses typically peak.

Respiratory Viruses Vaccination and Guidance

- Vaccines are the most effective way to prevent COVID-19 and influenza hospitalization and death and all eligible residents should be encouraged to be up-to-date with these vaccines.

- Healthcare providers should be aware of treatment options that can reduce severe disease and hospitalization among high-risk patients with COVID-19 and influenza and that can prevent RSV-associated hospitalizations in eligible high-risk children.

Pediatric Hospital Capacity
Pediatric – Emergency Department visits trend over time from 10/05/2022 to 11/09/2022

Total number of daily Peds-ED visits related to COVID-19

<table>
<thead>
<tr>
<th>Date</th>
<th>Total Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/05/2022</td>
<td>250</td>
</tr>
<tr>
<td>10/12/2022</td>
<td>322</td>
</tr>
<tr>
<td>10/19/2022</td>
<td>397</td>
</tr>
<tr>
<td>10/26/2022</td>
<td>420</td>
</tr>
<tr>
<td>11/02/2022</td>
<td>444</td>
</tr>
<tr>
<td>11/09/2022</td>
<td>598</td>
</tr>
</tbody>
</table>

1. Based on data self-reported by 71 hospitals; Only includes active acute care sites as per NJHA
2. Only hospital reported data and any view on breakthrough cases needs to be verified by the CDS. CDS releases breakthrough data, using a standardized surveillance case definition with set time periods, exclusions, verified testing and vaccination records, etc., that aren’t captured here with the NJHA data

Source: NJHA survey
Preliminary, proprietary, and pre-decisional. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.
## Pediatric bed capacity at Acute Care Hospitals by region

<table>
<thead>
<tr>
<th>Region</th>
<th>All Staffed Pediatric Inpatient Beds¹</th>
<th>Staffed Pediatric Inpatient Bed Occupancy</th>
<th>All Staffed Pediatric ICU Beds²</th>
<th>Staffed Pediatric ICU Bed Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Region</td>
<td>425</td>
<td>72%</td>
<td>70</td>
<td>91%</td>
</tr>
<tr>
<td>Central Region</td>
<td>236</td>
<td>75%</td>
<td>54</td>
<td>89%</td>
</tr>
<tr>
<td>South Region</td>
<td>139</td>
<td>51%</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Statewide total</strong></td>
<td><strong>800</strong></td>
<td><strong>69%</strong></td>
<td><strong>130</strong></td>
<td><strong>91%</strong></td>
</tr>
</tbody>
</table>

1. Total number of pediatric beds in the facility that are currently set-up, staffed and able to be used for a patient within the reporting period. This count includes occupied and unoccupied inpatient pediatric beds including both PICU and med-surge beds (beds in which medical or surgical pediatric patients may be routinely placed). Include any surge/hallway/overflow beds that are open for use for a patient, regardless of whether they are occupied or available. This count excludes NICU, newborn nursery beds, and outpatient surgery beds unless they are beds designated for COVID-19 positive pediatric patients.

2. Total number of pediatric ICU beds in the facility that are currently set-up, staffed and are or could be used for a patient within the reporting period. This count includes occupied and unoccupied ICU beds, including any ICU beds that are, or could be, staffed and used for a pediatric patient. This count excludes NICU, newborn nursery, and outpatient surgery beds unless they are beds designated for COVID-19 positive pediatric patients. Note: All pediatric ICU beds should be considered, regardless of the unit on which the bed is housed. This includes ICU beds located in non-ICU locations, such as mixed acuity units.

Source: NJHA data as of 11/14/2022

Preliminary, proprietary, and pre-decisional. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.
Influenza and other Non-Covid Respiratory Illnesses
CDS: Influenza Activity Level Comparison (week ending Nov 5, 2022)


Preliminary, proprietary, and pre-decisional. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.
CDS: Influenza Activity Level Comparison (week ending Nov 05, 2022)

State Activity Level

- MODERATE

Regional Data

<table>
<thead>
<tr>
<th>Region</th>
<th>Activity Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest</td>
<td>MODERATE</td>
</tr>
<tr>
<td>Morris, Passaic, Sussex, Warren</td>
<td></td>
</tr>
<tr>
<td>Northeast</td>
<td>MODERATE</td>
</tr>
<tr>
<td>Bergen, Essex, Hudson</td>
<td></td>
</tr>
<tr>
<td>Central West</td>
<td>MODERATE</td>
</tr>
<tr>
<td>Hunterdon, Mercer, Somerset</td>
<td></td>
</tr>
<tr>
<td>Central East</td>
<td>MODERATE</td>
</tr>
<tr>
<td>Middlesex, Monmouth, Ocean, Union</td>
<td></td>
</tr>
<tr>
<td>Southwest</td>
<td>MODERATE</td>
</tr>
<tr>
<td>Burlington, Camden, Gloucester, Salem</td>
<td></td>
</tr>
<tr>
<td>Southeast</td>
<td>MODERATE</td>
</tr>
<tr>
<td>Atlantic, Cape May, Cumberland</td>
<td></td>
</tr>
</tbody>
</table>


Preliminary, proprietary, and pre-decisional. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.
## Influenza related hospitalizations by region

<table>
<thead>
<tr>
<th>Region</th>
<th>Total patients hospitalized confirmed influenza&lt;sup&gt;1&lt;/sup&gt;</th>
<th>ICU patients confirmed influenza&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Previous day deaths influenza</th>
<th>Total patients hospitalized confirmed influenza&lt;sup&gt;1&lt;/sup&gt;</th>
<th>ICU patients confirmed influenza&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Previous day deaths influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Region</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>69</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Central Region</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>43</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>South Region</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Statewide total</td>
<td>25</td>
<td>0</td>
<td>0</td>
<td>145</td>
<td>23</td>
<td>0</td>
</tr>
</tbody>
</table>

**1.** Enter the total number of patients (adult and pediatric) currently hospitalized in an inpatient bed who have laboratory-confirmed influenza virus infection. Include inpatient, overflow, observation, ED, ED awaiting orders for an inpatient bed, active surge/expansion, ICU, NICU, PICU, newborn and nursery.

**2.** Enter the total number of patients (adult and pediatric) currently hospitalized in a designated ICU bed with laboratory-confirmed influenza virus infection. This is a subset of Total patients hospitalized confirmed influenza.
Support for LHDs
Update on COVID – 19
Other Respiratory Illness

Other Outbreaks
Other Selected Public Health Priorities
Lessons Learned
Monkeypox
Monkeypox (hMPXV) Outbreak Global and US case count (as of 11/11/2022)

As of 11/11/2022

Case breakdown
Confirmed Global cases: 79,231
Countries affected: 110
Confirmed US cases: 28,881
US states and territories affected: 52
Confirmed NJ cases: 754

States with highest number of confirmed cases:
• California – 5,547
• New York – 4,134
• Florida – 2,771
• Texas – 2,764
• Georgia – 1,931


1 One Florida case is listed here but included in the United Kingdom case counts because the individual was tested while in the UK.
2 NJ case counts may vary from CDC case counts based on different reporting timeframes
3 Have declared state of emergency for monkeypox (hMPXV)
Monkeypox (hMPXV) positive cases and test rate in NJ (as of 11/09/2022) (1/3)

County | Positive case count (as of 11/09) | Previously reported cases
---|---|---
Hudson | 184 | 128
Essex | 71 | 70
Union | 46 | 42
Bergen | 40 | 37
Middlesex | 24 | 22
Camden | 20 | 17
Passaic | 13 | 13
Morristown | 9 | 8
Monmouth | 8 | 7
Atlantic | 6 | 5
Mercer | 4 | 3
Burlington | 3 | 2
Somerset | 2 | 1
Ocean | 1 | 1
Cumberland | 1 | 1
Gloucester | 1 | 1
Warren | 1 | 1
Hunterdon | 1 | 1
Salem | 1 | 1
Unknown | 1 | 1

Positive case count over time (statewide, by date)

Weekly Positive Test Rate\(^2\) (as of 11/05)\(^3\)

1 NJ case counts may vary from CDC case counts based on different reporting timeframes
2 Based on date of specimen collection
3 Laboratory testing data is included once negative results were received by NJDOH (PHEL 6/27/2022; LabCorp 7/8/2022; Quest 7/28/2022)

Source: NJDOH CDS: MPXV Report #59, Wednesday, November 09, NJ Monkeypox (hMPXV) Dashboard

PREPARED NOVEMBER 9, 2022 – DRAFT AND PRE-DECISIONAL
Monkeypox (hMPXV) cases in NJ (as of 11/09/2022) (2/3)

Positive case count state map

Positive Cases by Demographic (N = 754)

Positive Cases By Race

Positive Cases By Sex

1. Positive case totals by demographic may differ from overall case totals due to reporting timelines.

Preliminary, pre-decisional, and deliberative. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.

Source: NJDOH CDS: MPXV Report #59, Wednesday, November 09, NJ Monkeypox (hMPXV) Dashboard
Monkeypox (hMPXV) vaccines and treatment in NJ (as of 11/09/2022) (3/3)

15,752 individuals with at least one JYNNEOS dose in New Jersey as of 11/09/2022

62% of 15,192 eligible individuals have received the second dose of JYNNEOS as of 11/09/2022

Vaccines Administered by Demographic

By Race/Ethnicity

- Asian - NH
- Black/AA - NH
- Hispanic / Latino
- White - NH

By Sex

- Male
- Female
- Other3
- Unknown3
- Non-Binary

Vaccine Doses Administered in NJ (by type of dose as of 11/09)

- 15,752 individuals with at least one JYNNEOS dose
- 9,440 individuals with at least one JYNNEOS dose
- 80 individuals with at least one ACAM 2000 dose
- 687 individuals with at least one Missing Dose dose

Monkeypox (hMPXV) treatments administered

291 TPOXX bottles administered as of 11/09/2022

Preliminary, pre-decisional, and deliberative. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.

Source: NJDOH CDS: MPXV Report #59, Wednesday, November 09; NJ Monkeypox (hMPXV) Dashboard
Ebola
Ebola virus disease - Overview

As of November 7, 2022: The Centers for Disease Control and Prevention (CDC) issued a Health alert Network (HAN) Health Update on the Outbreak of Ebola virus disease (Sudan ebolavirus) in Central Uganda.

No suspected or confirmed EVD cases related to this outbreak have yet been reported in the United States or other countries outside of Uganda to date.


Preliminary, proprietary, and pre-decisional. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.
NJ Ebola Surveillance: Travelers from Uganda Monitored for Ebola

Travelers monitored by county of residence or destination (visitors)

Travelers by exposure risk level

Overall risk level
- To be determined
- No known exposure
- Very low not zero
- Low

Travelers monitored by date of departure from Ebola's affected countries

Preliminary, proprietary, and pre-decisional. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.
NJ Ebola Surveillance: Travelers from Uganda Monitored for Ebola

Travelers by county of residence or destination and exposure risk level

<table>
<thead>
<tr>
<th>County</th>
<th>To be determined</th>
<th>No known exposure</th>
<th>Very low but not zero</th>
<th>Low</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantic</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Bergen</td>
<td>3</td>
<td>1</td>
<td>9</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td>Burlington</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Camden</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Cape May</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>ESSEX</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Gloucester</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Hudson</td>
<td>4</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Hunterdon</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Mercer</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Middlesex</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Monmouth</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Morris</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Ocean</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Passaic</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Somerset</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Union</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>1</td>
<td>41</td>
<td>19</td>
<td>69</td>
</tr>
</tbody>
</table>

Travelers monitored by age

- <18: 8 (22%)
- 18-29: 15 (42%)
- 30-49: 9 (25%)
- 50-64: 3 (8%)
- 65+: 1 (3%)

Travelers monitored by sex

- Female: 19 (53%)
- Male: 17 (47%)
Polio
Polio Outbreak Overview

• As of 11/07/2022, no poliovirus has been detected in New Jersey.

• In late July 2022, a case of paralytic poliomyelitis, caused by vaccine-derived poliovirus type 2, was confirmed in an unvaccinated adult in Rockland County, New York. The infection was not travel related.

• One case of paralytic polio is considered an outbreak. Poliovirus has been detected in samples of wastewater (sewage) in several New York locations, indicating local circulation of poliovirus.

• 32 wastewater samples archived at CDC from 5 NJ sites (Essex, Hudson, Middlesex, Passaic, Union), that were previously collected for COVID-19 testing from May to August, were tested for poliovirus – all negative. We are not aware of any new wastewater samples pending testing.

Polio Vaccination and Guidance

• All children and adolescents who are unvaccinated or under-vaccinated should be brought up to date with all routine CDC-recommended inactivated polio vaccine (IPV) doses.

• Adults (18 years of age and older) who are unvaccinated or under-vaccinated and at increased risk of infection should receive polio vaccination as recommended by the CDC.

• This is particularly important if they live, work, attend school, or have frequent social interactions with communities in areas where poliovirus has been repeatedly detected in wastewater (sewage), including Orange, Rockland, and Sullivan counties; these groups are considered to be at greater risk for exposure to polioviruses than the general population.

• At this time, booster doses are not recommended for individuals visiting the New York City metropolitan area, including Orange, Rockland, and Sullivan Counties, merely because of their travel status.

• NJDOH has guidance for clinicians, public health, and the public on the NJDOH polio page: https://www.nj.gov/health/cd/topics/polio.shtml

Preliminary, proprietary, and pre décisional. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.
West Nile Virus
West Nile Virus Overview

- As of November 7th, there have been 17 human cases of WNV reported in 2022 from 8 counties, with 3 cases each reported in Bergen, Camden, and Monmouth counties. 15 of the 17 cases needed hospitalization, with an average length of stay of 11 days.

- West Nile virus is the leading cause of mosquito-borne disease in the U.S. and is most commonly spread to people by the bite of an infected mosquito.

- West Nile virus (WNV) is seen most often in New Jersey during the late summer and early fall months. Human cases and detections in mosquitoes are winding down for the season.

- About 1 out of 150 infected people develop a serious, sometimes fatal, illness. Severe cases are more likely to be tested for West Nile virus and reported to public health.

West Nile Virus Guidance

- There are no vaccines to prevent or medications to treat WNV in people.

- NJDOH works closely with NJDEP and county mosquito control agencies to ensure timely mosquito surveillance and control to prevent human illness.

Legionella
Legionella Overview

- There are ~250-350 cases of Legionnaires’ disease (LD) reported each year in NJ.
- In 2021, 33 new outbreak investigations were initiated, mostly impacting healthcare facilities.
- Reported incidence of LD in the United States has been rising since 2003, and the increase appears to be accelerating in recent years - reasons for the rise are unclear.
  - Rising incidence was not uniform and affected some demographic groups disproportionately.
  - This rise was most strikingly associated with increases in racial disparities, geographic focus, and seasonality.
- Many cases of LD are considered sporadic, meaning it is unknown if the case is connected to other cases or a known outbreak source.
  - In 2020, NJDOH developed and implemented automated analyses to flag clusters of cases that may otherwise go undetected.
  - In 2020, NJDOH initiated a CDC grant funded project to explore if single family homes are a potential source of Legionella growth and transmission.

Legionella Guidance

- NJDOH, in partnership with NJDEP, has been investigating Legionella occurrence in a public water system – consulting with CDC/EPA for guidance.
- Local Health Departments (LHDs) should ensure that all reported cases of LD are investigated in a timely manner.
  - Strong surveillance helps to quickly identify new cases, epidemiologic links between cases, and the need for outbreak investigations.
  - Outbreak investigations are critical for detecting sources of transmission and implementing control measures.
- Notify NJDOH by email or telephone when a patient reports exposure to a hot tub or spent time in a travel, healthcare, assisted living, senior living, correctional, or fitness/spa facility during their incubation period.
- NJDOH has guidance on legionella posted at [https://www.nj.gov/health/cd/topics/legion.shtml](https://www.nj.gov/health/cd/topics/legion.shtml)
Support for LHDs
Update on COVID – 19
Other Respiratory Illness
Other Outbreaks
Other Selected Public Health Priorities
Lessons Learned
HIV Surveillance
End the HIV Epidemic

On World AIDS Day 2018, Governor Phil Murphy announced that New Jersey would take steps to end the HIV epidemic by 2025. He called on all stakeholders to work strategically with NJDOH to end the HIV/AIDS epidemic.

In 2019, the Federal Government announced their goal to end the HIV epidemic in the United States within 10 years.

To address this pressing public health issue, the United States Department of Health and Human Services (HHS) launched the Ending the HIV Epidemic (EHE) initiative in February 2020. The primary focus of this initiative is to invest critical scientific knowledge and financial resources in high-risk communities for HIV prevention, diagnosis, and treatment of HIV/AIDS.
Ending the HIV Epidemic (EHE) Goals

New Jersey statewide EHE

- Reduce the number of new HIV infections by 75%;
- Promote access to testing so that 100% of persons living with HIV/AIDS know their status; and
- Promote access and linkage to care so that 90% of persons diagnosed with HIV/AIDS are virally suppressed.

https://www.nj.gov/health/hivstdtb/
Sexually Transmitted Disease (STDs)
# Status of STDs in US and NJ (2021)

<table>
<thead>
<tr>
<th>Disease</th>
<th>United States 2021</th>
<th>New Jersey 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Cases</td>
<td>Rate change since 2017</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>1.6 million</td>
<td>- 4.7%</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>696,764</td>
<td>+25%</td>
</tr>
<tr>
<td>Primary &amp; Secondary Syphilis</td>
<td>52,354</td>
<td>+71%</td>
</tr>
<tr>
<td>Congenital Syphilis</td>
<td>2,677</td>
<td>+185%</td>
</tr>
</tbody>
</table>
Disease Intervention Specialist (DIS)

STD Services was awarded $5.3 million every year between Jun 2021-Dec 2025

Focus was hiring and training DIS to be outbreak ready.

- Hosted and continue to host week-long training in Trenton every month to train up both state and local DIS on conducting STD investigations.
- Training focuses on understanding syphilis, but interview skills are transferable to other diseases

NJDOH has hired 26 of 27 DIS positions and 7 supervisors to oversee the work

- Team is mobile and able to deploy anywhere statewide – currently we are providing coverage to local health during vacations/staff turn-over, HIV testing during clinic hours, etc.
- If you need assistance in your local health department OR would like to have staff trained, please reach out to Greta Anschuetz @ greta.anschuetz@doh.nj.gov

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Harm Reduction Expansion
Harm reduction is critical to keeping people who use drugs alive and as healthy as possible and is a key pillar in the multi-faceted U.S. Department of Health and Human Services' Overdose Prevention Strategy. Harm reduction is a public health approach that emphasizes engaging directly with people who use drugs to:

- prevent overdose and infectious disease transmission,
- improve the physical, mental, and social wellbeing of those served, and
- offer low-threshold options for accessing substance use disorder treatment and other health care services

Research shows that harm reduction increases public health and wellbeing, without increasing drug use, violence, or crime. According to the CDC; people with access to a syringe access program are:

- less likely to die from an opioid related overdose
- five times more likely to stop substance use that causes them problems
- three times more likely to stop substance use altogether and
- 50% less likely to acquire HIV or Hepatitis C Virus (HCV)

Harm Reduction is globally understood to be a best practice in public health.
Current Harm Reduction Centers (HRC) in New Jersey

- Camden Area Health Education Center, Camden (mobile)
- Hyacinth AIDS Foundation, Jersey City
- Hyacinth AIDS Foundation, Paterson (mobile)
- Hyacinth AIDS Foundation, Trenton
- North Jersey Community Research Initiative, Newark
- South Jersey AIDS Alliance, Atlantic City
- Visiting Nurse Association of Central Jersey, Asbury Park

Services Offered at HRCs:
- Harm Reduction Supplies that include syringes, naloxone and fentanyl test strips
- Safe disposal of injection equipment
- Referral Services including referrals to drug treatment
- Low-threshold medication-assisted treatment
- Education for risk reduction and overdose prevention
- Testing for HIV, viral Hepatitis, and STIs
- Community Sweeps

2021 Harm Reduction Center Data
(cumulative data across all seven sites)

- Successful Referrals: 426
- Referrals for Drug Treatment: 269
- Narcan Education: 4,351
- Narcan Distributed: 4,892
- Newly Enrolled Participants: 1,267
- Unduplicated Participants: 3,162
- Total Exchanges: 15,594
- Syringes Dispensed: 1,449,887
- Syringes Returned: 1,217,336
Refugee screening for Tuberculosis
Uniting for Ukraine

On May 21, 2022, President Biden signed into law emergency supplemental appropriations (Public Law 117-128) that included funds for medical support, screening, and other public health activities related to populations displaced from Ukraine.

All people two years of age or older will need to be screened for TB by getting an interferon-gamma release assay (IGRA) test within 90 days after arrival to the United States.

- An IGRA is a blood test to tell if a person has been infected with TB.
- It does not tell whether the person has latent TB infection or has progressed to TB disease.

Uniting for Ukraine TB Testing Information

The NJ Dept of Health is now offering IGRA (the TB blood assay) at no cost to persons entering New Jersey through the Uniting for Ukraine program.

To access this no cost testing service, please determine your county of residence and use this list to contact your local TB program for more information.

LHD_TB_Program_List
### Total tests known to date: 1,041

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total tests known to date</td>
<td>1,041</td>
<td>100%</td>
</tr>
<tr>
<td>Total Positive to date</td>
<td>42</td>
<td>4.0%</td>
</tr>
<tr>
<td>Total Negative to date</td>
<td>969</td>
<td>93.1%</td>
</tr>
<tr>
<td>Total Borderline to date</td>
<td>19</td>
<td>1.8%</td>
</tr>
<tr>
<td>Total Test Not Performed</td>
<td>11</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Median age: 32 (Range: 2-91 years)

**Sex**
- Female: 598 (57.4%)
- Male: 435 (41.8%)
- UNK: 8 (< 1%)

**Test Type**
- T-Spot TB: 934 (89.7%)
- QFT-G: 105 (10.1%)
- TST: 2 (< 1%)

**Persons diagnosed with Tuberculosis disease:** 1

*Note: MDR TB diagnosed overseas*
Childhood Lead
Childhood Lead

NJDOH Childhood Lead Annual Report released for SFY 2020

CDC lowered the reference range for elevated blood lead levels to 3.5 µg/dL

• N.J.A.C. 8:51 under revision

• Will require increased education to an additional 3,000 families per year

July 2022: DCA rule

• Requires inspection of rental units every 3 years or with tenant turnover

Screening and Blood Lead Levels (BLL) by Year of Report (Children < 17 Years of Age)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Tested</th>
<th>BLL &gt;= 5 µg/dL</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY 2018</td>
<td>191,077</td>
<td>4,472 (2.3%)</td>
</tr>
<tr>
<td>SFY 2019</td>
<td>178,861</td>
<td>3,348 (2.2%)</td>
</tr>
<tr>
<td>SFY 2020</td>
<td>164,448</td>
<td>3,364 (2%)</td>
</tr>
</tbody>
</table>

Blood Lead Levels (BLL) by Year of Report (Children < 17 Years of Age)

<table>
<thead>
<tr>
<th>Year</th>
<th>BLL 3.5-4.9 µg/dL</th>
<th>BLL &gt;= 5 µg/dL</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY 2019</td>
<td>4,087</td>
<td>3,909</td>
</tr>
<tr>
<td>SFY 2020</td>
<td>2,973</td>
<td>3,348</td>
</tr>
<tr>
<td>SFY 2021*</td>
<td>2,809</td>
<td>3,364</td>
</tr>
</tbody>
</table>

*Data is preliminary. Preliminary, proprietary, and pre-decisional. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.
Governor’s Whole of Government Approach to Health Priorities
## Health Priorities

### Maternal Health
- **In 2019**, **Nurture NJ was launched**: a statewide program committed to reducing maternal and infant mortality in New Jersey and ensuring equitable care among women and children of all races and ethnicities.

- **In 2021**, the **Nurture NJ Maternal and Infant Health Strategic Plan** was unveiled: with the goal of reducing New Jersey’s maternal mortality by 50 percent over five years and eliminating racial disparities in birth outcomes.

- Nurture NJ has seen **43 pieces of maternal and infant health legislation** signed by Governor Murphy, developed and implemented groundbreaking programs and policies, hosted **annual Black Maternal and Infant Health Leadership Summits**, and more – positioning New Jersey as a leader in fighting the maternal and infant health crisis.

### Opioids Epidemic
- **January 2022**: Governor Phil Murphy signed **a series of bills to combat the state’s opioid crisis and expand harm reduction efforts**.

- The three bills reflect Governor Murphy’s **comprehensive approach** to end New Jersey’s opioid epidemic and increase access to lifesaving resources for individuals with substance use disorders.

- This package will build on investments included in the Governor’s budget in recent years to bring services to residents in need of **access** to clean syringes and prevent transmission of HIV and hepatitis, provide health screenings, and **connect individuals to treatment, vaccination, education, and recovery supports**.

- The package also creates **multidisciplinary local overdose fatality review teams**, which will provide invaluable insight into the circumstances surrounding fatal drug overdoses and identify opportunities for intervention that may prevent these fatalities in the future.
Maternal Health
Maternal health disparities

Black, non-Hispanic and Hispanic women were more likely to experience a pregnancy-related death compared to White, NH women in New Jersey.

Pregnancy-Related Mortality Ratio by Race/Ethnicity, New Jersey, 2016-2018 (Deaths Per 100,000 Live Births)

39.2

20.6

5.9

State level 14.4

Black, non-Hispanic
Hispanic
White, non-Hispanic

There are racial disparities in pregnancy-related mortality where Black, Non-Hispanic women are 6.6 times higher than White Non-Hispanic women and Hispanic women are 3.5 times higher than White, Non-Hispanic women.

Source: New Jersey Maternal Mortality Report 2016-2018
Maternal Health: Underlying Causes of Death

More than 80% of the top 4 pregnancy-related underlying causes of death were determined to be preventable.
Maternal Health: Underlying Causes of Death

More than 75% of the top 3 pregnancy-associated, but not related underlying causes of death were determined to be preventable.
Maternal Health: Reducing disparity and addressing maternal mortality

• NJ has many maternal health programs that focus on reducing this disparity in maternal mortality including all the work that is done by the maternal health innovations team, Healthy Women Healthy Families, and establishing a Maternal Care Quality Collaborative (MCQC) to guide maternal health in the state. The MCQC includes individuals from all sectors of the health care system.

• NJ DOH is also focused on building the perinatal workforce such as community health workers in local communities to assist birthing people in navigating the health care system, obtain information, and get connected to community resources.

• CHWs do and should continue to collaborate with local public health departments to disseminate information that is relevant to the community such as vaccination and other public health emergencies.

Source: New Jersey Maternal Mortality Report 2016-2018
Preliminary, proprietary, and pre-decisional. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.
Overdose Fatality Review
Team
Overdose Fatality Review Teams

Based on the established fatality review team model, Overdose Fatality Review Teams (ORFTS) uncover ecological factors or system gaps that may have contributed to a fatal overdose.

- OFRTs develop community-specific strategies, services, and policies to prevent future fatal overdoses.
- OFRTs strengthen multisector collaboration around overdose management.

OFRT Legislation (P.L.2021, c.430)

- The bill allows county health departments to establish a local OFRT to conduct a comprehensive review of confirmed overdose fatalities using an approach authorized by the Department of Health in consultation with the Office of the Chief State Medical Examiner.
NJ DOH has supported OFRT operations and technical assistance through a combination of state and federal dollars since 2020.

OFRT data complement NJ’s overdose surveillance to inform our statewide response, with a focus on social and systemic contributors to overdose death.
Agenda

Support for LHDs
Update on COVID – 19
Other Respiratory Illness
Other Outbreaks
Other Selected Public Health Priorities

Lessons Learned
Lessons learned

- Importance of **timely and frequent bidirectional communication** with LHDs
- Importance of having a **strong/Foundational public health infrastructure** before an emergency occurs
- LHDs, FQHCs, and independent pharmacies are critical for delivering access in harder to reach communities
- Importance of **OEM/State police and DOH as leads** of the public health emergency
- **Early goal setting** along the journey, including inventory stockpiling and monitoring
- The importance of **data, science, and vigilance**: hotspotting and CALI scores
- The importance of **dynamic reporting** that can both reflect the best-known information at any time and adjust as more information is understood
- Engaging with the **community and the state** (e.g., facilitating transparency, connecting to stakeholders, hosting press conferences, PAC etc.)
- **Hospitals as partners** in timely data reporting to understand disease progression, in collaborating and flexing capacity to manage surges, in vaccinating their patients, staff and communities
- The significance of **emergency management** planning for surges
- The need for **resiliency of the LTC industry**
- The value of the **call center**
- **Federal retail pharmacy partners** effectively delivered vaccination at scale in LTC and senior high rises for primary series
- The impact of **ambassador program** specifically for hard-to-reach populations
- **Static sites** are more successful than pop-ups and mobile sites for widescale vax programs