JFK Medical Center
Exceptional Care. Exceptional People.

COMMUNITY HEALTH NEEDS ASSESSMENT REPORT, 2016

JFK Medical Center
JFK Johnson Rehabilitation Institute

Report Prepared by

Seton Center for Community and Population Health
SCCPH

Contents

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Executive Summary

JFK Medical Center (JFKMC) and JFK Johnson Rehabilitation Institute (JRI) are pleased to present the 2016 Community Health Needs Assessment for JFKMC and JRI's primary service area. Meeting the requirements of the Affordable Care Act, this report provides the complete overview of the methods and process used to identify and prioritize significant community health needs for both JFKMC and JRI.

SERVICE AREA: Middlesex, Union and Somerset Counties

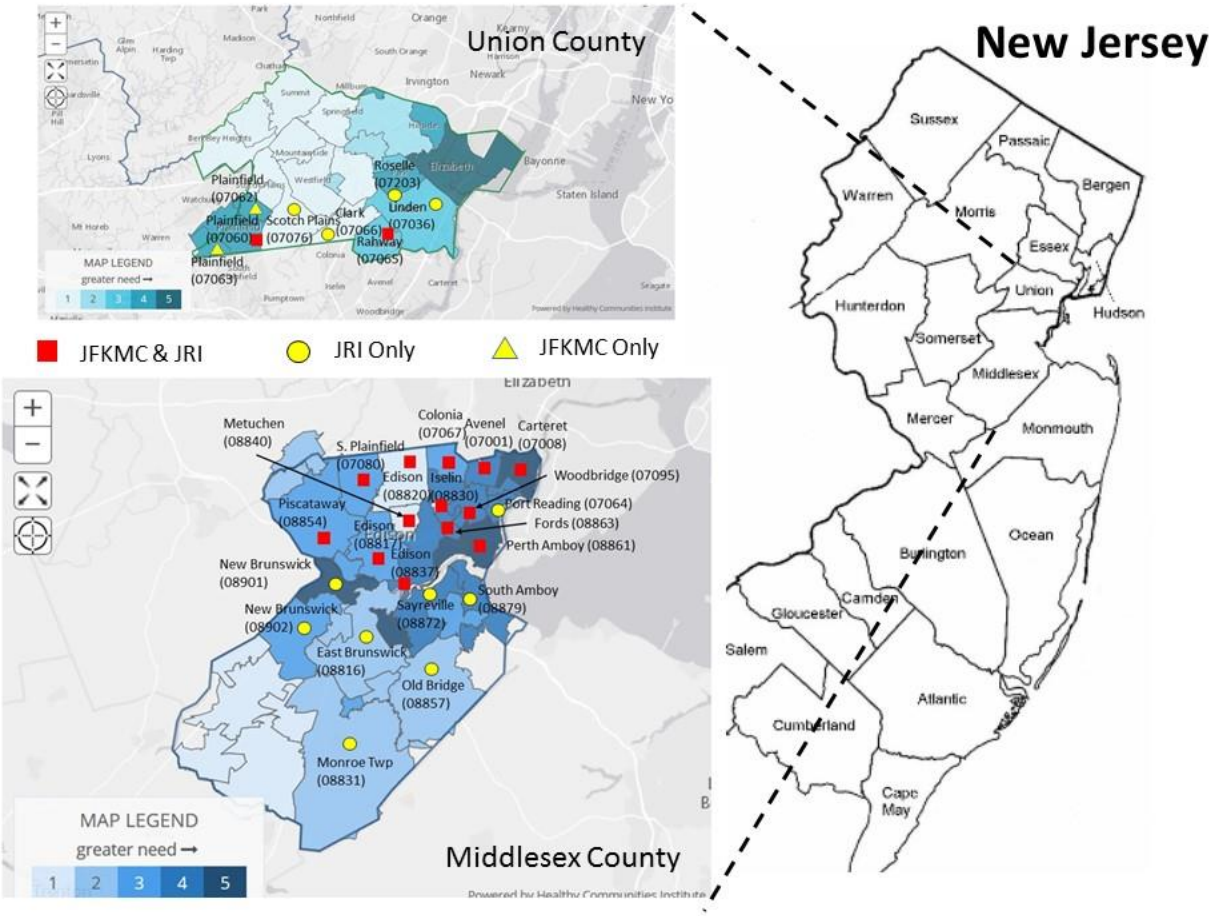
Table 1: Primary Service Area: JFK Medical Center (JFKMC) and Johnson Rehab. Inst. (JRI)

County	Town	Zip Code	Population	PSA
Middlesex	Avenel	07001	17,390	JFKMC+JRI
Middlesex	Carteret	07008	24,216	JFKMC+JRI
Middlesex	Port Reading	07064	3,747	JRI only
Middlesex	Colonia	07067	18,633	JFKMC+JRI
Middlesex	South Plainfield	07080	24,109	JFKMC+JRI
Middlesex	Woodbridge	07095	20,073	JFKMC+JRI
Middlesex	East Brunswick	08816	46,826	JRI only
Middlesex	Edison	08817	46,196	JFKMC+JRI
Middlesex	Edison	08820	39,758	JFKMC+JRI
Middlesex	Iselin	08830	18,977	JFKMC+JRI
Middlesex	Monroe Township	08831	49,890	JRI only
Middlesex	Edison	08837	16,378	JFKMC+JRI
Middlesex	Metuchen	08840	17,183	JFKMC+JRI
Middlesex	Piscataway	08854	59,885	JFKMC+JRI
Middlesex	Old Bridge	08857	41,941	JRI only
Middlesex	Perth Amboy	08861	57,625	JFKMC+JRI
Middlesex	Fords	08863	12,406	JFKMC+JRI
Middlesex	Sayreville	08872	18,456	JRI only
Middlesex	South Amboy	08879	23,712	JRI only
Middlesex	New Brunswick	08901	57,943	JRI only
Middlesex	New Brunswick	08902	42,248	JRI only
Somerset	Somerset	08873	52,999	JRI only
Union	Linden	07036	43,324	JRI only
Union	Plainfield	07060	45,390	JFKMC+JRI
Union	Plainfield	07062	14,233	JFKMC only
Union	Plainfield	07063	14,593	JFKMC only
Union	Rahway	07065	29,185	JFKMC+JRI
Union	Clark	07066	15,442	JRI only
Union	Scotch Plains	07076	24,144	JRI only
Union	Roselle	07203	21,542	JRI only

	PSA for JFK Medical Center & Johnson Rehab. Inst.
	PSA for Johnson Rehab. Inst. only
	PSA for JFK Medical Center only

Both licensed hospitals are located at the same physical location – Edison, New Jersey. The primary service area (PSA) is defined as zip codes which provide 65% of the market share and are provided in the table and map below. JFK and/or JRI's PSA covers 21 of 36 zip codes in Middlesex county, eight of 26 zip codes in Union county, and one zip code in Somerset county. JFKMC and JRI PSA's overlap in 50% (15 zip codes) of the 30 zip codes in their combined PSAs, 43% (13) are only JRI's PSA with the remaining 7% (2) being exclusively JFKMC's PSA.

Figure 1: Geographical Boundaries of Primary Service Area: JFK Medical Center (JFKMC) and Johnson Rehab. Inst. (JRI)



DEMOGRAPHICS

Middlesex County residents (940,900) and Union County residents (558,637) closely parallel New Jersey state rates for age and gender, but differ significantly in racial and ethnic diversity. Both counties show lower levels of Caucasian/White, but Middlesex has a lower Black/African American rate, while Union has a higher Black/African American rate. In Middlesex, the Asian resident rate is 2.5 times larger than the state comparison and for

foreign born people it is 10% higher. Both per capita income and poverty levels are slightly lower for Middlesex County but higher for Union County than the state averages. A significant number of retired Middlesex residents are JFK patients. Higher educational attainment in both counties rank above New Jersey average.

IDENTIFYING COMMUNITY HEALTH NEEDS: METHODOLOGY

Primary Data

The needs assessment process included a tailored community health needs assessment questionnaire completed by 745 respondents representing a diverse contingent of JFKMC and JRI stakeholders. Data obtained from a 23-item survey supplied ample evidence of stakeholder input. Additional health information was collected via focus interviews with community members who provided a fundamental understanding of the area's health needs and represented the broad interests of the community. Key informants shared valuable insights and input on the county's health challenges, the sub-populations most in need, and existing resources for county residents.

Secondary Data

The secondary data used in this assessment was obtained from the JFKMC and JRI Dashboard, developed by Healthy Communities Institute (HCI) and the Seton Center for Community and Population Health (SCCPH), < http://jfkmc.org/community-health-needs-assess > which includes a comprehensive dashboard of over 132 community health and quality of life indicators covering over 20 topic areas. Secondary data analysis was completed using data including: 100+ core indicators, community dashboard, demographics, a SocioNeeds index, maps and other features. The CHNA process also included data provided from New Solutions, Inc.

Indicator values for Middlesex and Union county zip code areas were compared to other counties in New Jersey and nationwide to score health topics and analyze significant areas of need. Other considerations for prioritizing health needs included: a) trends over time, b) Healthy People 2020 targets, and c) disparities by age, gender, and race/ethnicity. Quality of life and racial disparities indicators were also included in the data analysis process to assess social determinants and their impact on health status.

SIGNIFICANT COMMUNITY HEALTH NEEDS IDENTIFIED

Step 1 Identification of Community Health Needs and Triangulation Ranking

Primary and secondary data were evaluated to identify the significant community health needs of JFKMC and JRI's service area. These needs span the following topic areas and are often inter-connected, which supports the use of triangulation of both primary and secondary data and the

inclusion of direct community input. First, this table lists all of the 29 primary community health needs identified by the community. Second, it presents a ranking based on a review of all the various data sources and a detailed rating system based on scoring system weighted to highlight the greatest need for all 29 identified health needs.

Table 2: Prioritization of Community Health Needs, JFK CHNA, 2016

Community Health Issue	Disparity - HP2020 or US or NJ	Top Health Concern (Respondent)	Ranking of Community Issues	Greatest Perceived Community Concern	Focus Group	Interview	**Overall Score**
Transportation and Parking	1		1	3	3	3	**11**
Diabetes	2	2	2	1	2	1	**10**
Mental / Behavioral Health	2	1	1	2	3		**9**
Obesity	0	3	3	2		1	**9**
Wellness / Prevention		3	3	2			**8**
Cardiac / Heart Disease	2	1	1		2	1	**7**
Access	1		1	3	2		**7**
Cancer	1	1	2	2			**6**
COPD		2	3				**5**
Older Adults	0		2	3			**5**
Affordability	1			3		1	**5**
Vulnerable Population	1				1	3	**5**
Health Environment			3	1			**4**
Substance Abuse / Opioids	2		1				**3**
Weight Control	0		3				**3**
Oral Health			3				**3**
Rehab (Joint / Back Pain)		3					**3**
HIV/AIDS	1		1	1			**3**
Knowledge Sharing					3		**3**
Arthritis		2					**2**
Low Birth Weight	1		1				**2**
Caregiver Support					2		**2**
Language / Culture					2		**2**
Lingusitics	2						**2**
Physical Activity	1						**1**
Rehab Access			1				**1**
TB	1						**1**
Health Literacy						1	**1**
Emergency Care							

Notes:

Disparity in comparison to HP2020 or US or NJ value (0 - no disparity, 1 - in MX or Union, 2 in MX AND Union)
Top Health Concern for Respondent CHNA Survey - 3 if in top third, 2 if in middle third, 1 if in bottom third
Ranking of Community Health CHNA Survey - 3 if in top third, 2 if in middle third, 1 if in bottom third
Greatest Perceived Comm. Health CHNA Survey - 3 if in top third, 2 if in middle third, 1 if in bottom third
Focus Group - 3 - in all focus groups, 2 in two focus groups), 1 in one focus group
Interview - 3 in all interviews, 2, in two interview, 1 in one interview

Step 2 Prioritization of Community Health Needs Using Mission Criteria

The final prioritization process is based on recognizing the important role of JFK's mission and the ability to impact community health needs. The mission rating criteria included: (a) core relationship to mission (b) continuation of a 2013 priority (c) significant disparity with benchmark comparisons (d) identified as top health concern via the JFK-CHNA questionnaire findings and (e) appropriate for both JFK Medical Center and Johnson Rehabilitation Institute populations. All 29 of the health needs identified by the community (See Table 3) are categorized and prioritized by the above mission rating criteria.

Table 3: Prioritized and Categorized Community Health Needs

	Core to MISSION		**SHARED PARTNERSHIP**		**ENVIRONMENTAL / COMPLEX**
C1	Parking – issue indicated by community ranking, perceived concern, focus groups and key informant interviews	P1	Mental/Behavioral health - mental health provider rate	E1	Transportation – issue indicated by community ranking, perceived concern, focus groups and key informant interviews
C2	Community outreach (Community presence and engagement with other organizations)	P2	Obesity Rates (Percentage for Adults (20+))	E2	Access to care – availability of care for all populations (primary care provider rate)
C3	Diabetes (rate in Medicare population)	P3	Substance Abuse (% alcohol impaired driving deaths, Opioid use-community survey)	E3	Affordability of care for uninsured or under insured (% adults with health insurance)
C4	Access and availability of Community Wellness Events	P4	HIV/AIDS (prevalence rate)	E4	Vulnerable population - wheelchair bound / disabled appropriate facilities (% with disability in poverty)
C5	Cardiac/Heart Disease - % of Medicare population	P5	Knowledge sharing – indicated by focus groups as communication gap	E5	Healthy environment (lead, unsafe drinking water, food safety)
C6	Cancer (Age-adjusted death rate – breast cancer, Mammography screening in Medicare population)	P6	Arthritis – top health concern from community survey	E6	Linguistic Isolation (% non-English speaking households)
C7	COPD – top health concern from community survey	P7	Caregiver Support – identified as lacking by focus groups	E7	Health literacy (limited ability to understand basic health knowledge)

	Core to MISSION		SHARED PARTNERSHIP		ENVIRONMENTAL / COMPLEX
C8	Older adults – % of Medicare population with Alzheimer's/Dementia	P8	Physical activity – adults (20+) who are sedentary		
C9	Weight control for adults (20+) who are sedentary	P9	Tuberculosis rates – incidence rates in community population		
C10	Oral Health – survey ranking of community issues				
C11	Rehabilitative care – survey ranking of community Issues				
C12	Prenatal care - % of babies with low birth weight				
C13	Caregiver burnout/stress – training/relief as identified by focus groups				
C14	Language / culture – sensitivity to differences in service delivery				

Step 3 – Final Prioritization of Community Health Needs by Strategic Focus

The original 29 identified community health needs were first ranked by community relevance and importance, and secondly by using JFK mission criteria. The final prioritization step involved additional JFK strategic criteria: (a) relationship to existing programs, (b) the ability to make an impact within a reasonable time frame, (c) the financial and human resources required, and (d) whether there would be a measurable outcome to gauge improvement. The process also included a review of other community resources that might also be better suited to provide needed services or who were also providing similar services. (These organizations are listed in detail in Appendix E). These criteria were used to select the top community health needs priorities which align JFKMC and JRI's commitment to the community. The following JFK –CHNA Population Health Matrix is presented and shows the final community health needs priority areas placed under the three population health focus areas.

Table 4: Population Health and Prioritized Community Health Needs
POPULATION HEALTH FOCUS #1: HEALTH PROMOTION and WELLNESS for all Populations
Goal: To improve access to primary care, and deliver preventive care opportunities for all JFK service area populations. "Highlight Health Promotion and Wellness initiatives".
Community Outreach/Awareness/Physician Availability
Physical Activity/Weight Control
POPULATION HEALTH FOCUS #2: DISEASE MANAGEMENT for all Populations
Goal: Implement targeted initiatives for at-risk populations that reflect a strategy of "Right Care, Right Place, Right Time".
Diabetes
Cancer/Mammography Screening
Cardiac/Heart Disease
POPULATION HEALTH FOCUS #3: CONTINUITY of CARE for Vulnerable Populations
Goal: Focus on maintaining and facilitating the continuity of care especially for vulnerable populations. "Make Every Health Issue a Priority".
Emergency Care
Prenatal Care
Rehabilitative Care

As part of the CHNA comprehensive analysis, a systematic assessment of the 2013 Priority Needs outcomes was conducted. First, six Seton Hall University graduate students completed a progress report and presentation to JFKMC and JRI senior leadership on each of the six 2013 Priority Areas: Weight Control, Mammography Screenings, Emergency Care Services, Low Birth Weight Babies, Physical Activity, and Diabetes Screening. Next, the most recent CHNA-Implementation Strategy Update was reviewed using metric indicators to assess progress. Of the 60 CHIP strategies identified, 18 (30%) were totally completed and the remaining were in advanced stages of progress. Overall, the findings indicate significant progress for each of the priority health need areas.

CONCLUSION

JFK Medical Center (JFKMC) and the JFK Johnson Rehabilitation Institute (JRI) are located on the same campus in Edison, NJ. This report describes the process and findings of a comprehensive health needs assessment for the communities in JFKMC and JRI's service area. The prioritization of the identified significant health needs will provide a framework for community health improvement efforts. With results from this process, JFKMC and JRI will outline their plan to address the priority health needs in their Community Health Implementation Plan (CHIP).

Introduction

Every three years, the 2010 Patient Protection and Affordable Care Act, commonly known as the Affordable Care Act (ACA), requires non-profit, tax-exempt hospitals to conduct a Community Health Needs Assessment (CHNA). To meet stated requirements, hospitals must analyze and identify the health needs of their communities, and develop and adopt an implementation strategy to meet the identified needs.

As a non-profit, tax-exempt hospital system, JFK Medical Center (JFKMC) and JFK Johnson Rehabilitation Institute (JRI) are pleased to present the 2016 CHNA report, which provides an overview of the significant community health needs identified in JFKMC and JRI's primary service area. The purpose of this report is to present a meaningful analysis of the health needs in the community as well as to help prioritize and guide the hospital in its community benefit planning efforts, ultimately culminating with a strategic Community Health Implementation Plan (CHIP).

This report includes a description of:

- The community, demographics, social determinants, and population served;
- The methodology and multi-step process used to obtain, analyze, synthesize and triangulate primary and secondary data;
- The significant health needs in the community, with emphasis on vulnerable populations such as the uninsured, low-income, and marginalized groups;
- The criteria developed to clearly identify and prioritize significant community health needs.

About JFKMC and JRI

JFK Medical Center (JFKMC) and JFK Johnson Rehabilitation Institute (JRI) are part of JFK Health, a non-profit organization that encompasses a wide array of organizations, services, and facilities serving residents in the Central New Jersey region. The system includes the acute care hospital, JFK Medical Center and the Johnson Rehabilitation Institute as well as outpatient centers, nursing facilities, and specialized treatment programs. JFKMC and JRI remain on the cutting edge of technology, offering cardiac, imaging, neuroscience, men's and women's health, and surgical procedures that make life easier – providing comfort and assistance in a speedy recovery. Recently, when another local hospital closed, JFKMC stepped in to provide clinical services to an underserved area. JFKMC and JRI have successfully served the local community since 1967.

About Seton Center for Community and Population Health

Background Information on the Seton Center for Community and Population Health (SCCPH):

- Established in 2004 as an academic resource for collaboration, learning, and research to enhance the quality of life for individuals and communities in need.
- Located in the Department of Interprofessional Health Sciences and Health Administration in the School of Health and Medical Sciences (SHMS), Seton Hall University.
- Since inception, partnered with multiple community organizations on grants involving MHA students from Seton Hall University.
- Volunteer Director: Dr. Anne M. Hewitt and Contributing Faculty, Dr. Nalin Johri who are both full-time faculty for the Master of Healthcare Administration degree program.

Please visit SCCPH at <http://www.shu.edu/interprofessional-health-sciences-administration/seton-center-community-population-health.cfm>.

About Healthy Communities Institute

The Healthy Communities Institute (HCI) offers a web-based dashboard system that allows data to be easily visualized and comprehended by its users. The web portal allows community stakeholders to understand the variety of data, and to be able to take concrete action and improve target areas of interest. HCI has over 100 implementations of its dashboard for clients in 35+ states. The HCI mission is to improve the health, environmental sustainability, and economic vitality of cities, counties, and communities worldwide. The company is rooted in work started in 2002 in concert with the Healthy Cities Movement at the University of California at Berkeley. HCI staff are experts in managing and presenting data with extensive experience in data visualization and data mapping. HCI has recently become part of the Xerox company. For additional information, please visit the Healthy Communities Institute at <www.HealthyCommunitiesInstitute.com>.

Service Area: Select zip codes in Middlesex, Union, and Somerset counties in New Jersey

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The service area of JFKMC and JRI includes Middlesex County, New Jersey. While some residents of surrounding counties, primarily in a few zip code areas in Union County and one

in Somerset County, utilize JFKMC and JRI services, this assessment and subsequent interventions will present primary data for Middlesex County residents, who make up > 65% of JFKMC and JRI patients. All available data for the Union County/Somerset County sub population residents are also presented in the report. Note: this service area coverage is for both the JFK Medical Center and the Johnson Rehabilitation Institute.

Both licensed hospitals are located at the same physical location in Edison, New Jersey. The primary service area (PSA) is defined as zip codes which provide 65% of the market share and are provided in the table below. JFKMC and/or JRI's PSA covers 21 of 36 zip codes in Middlesex county, eight of 26 zip codes in Union county, and one zip code in Somerset county. JFKMC and JRI PSA's overlap in 50% (15 zip codes) of the 30 zip codes in their combined PSAs, 43% (13) are only JRI's PSA with the remaining 7% (2) being exclusively JFKMC's PSA.

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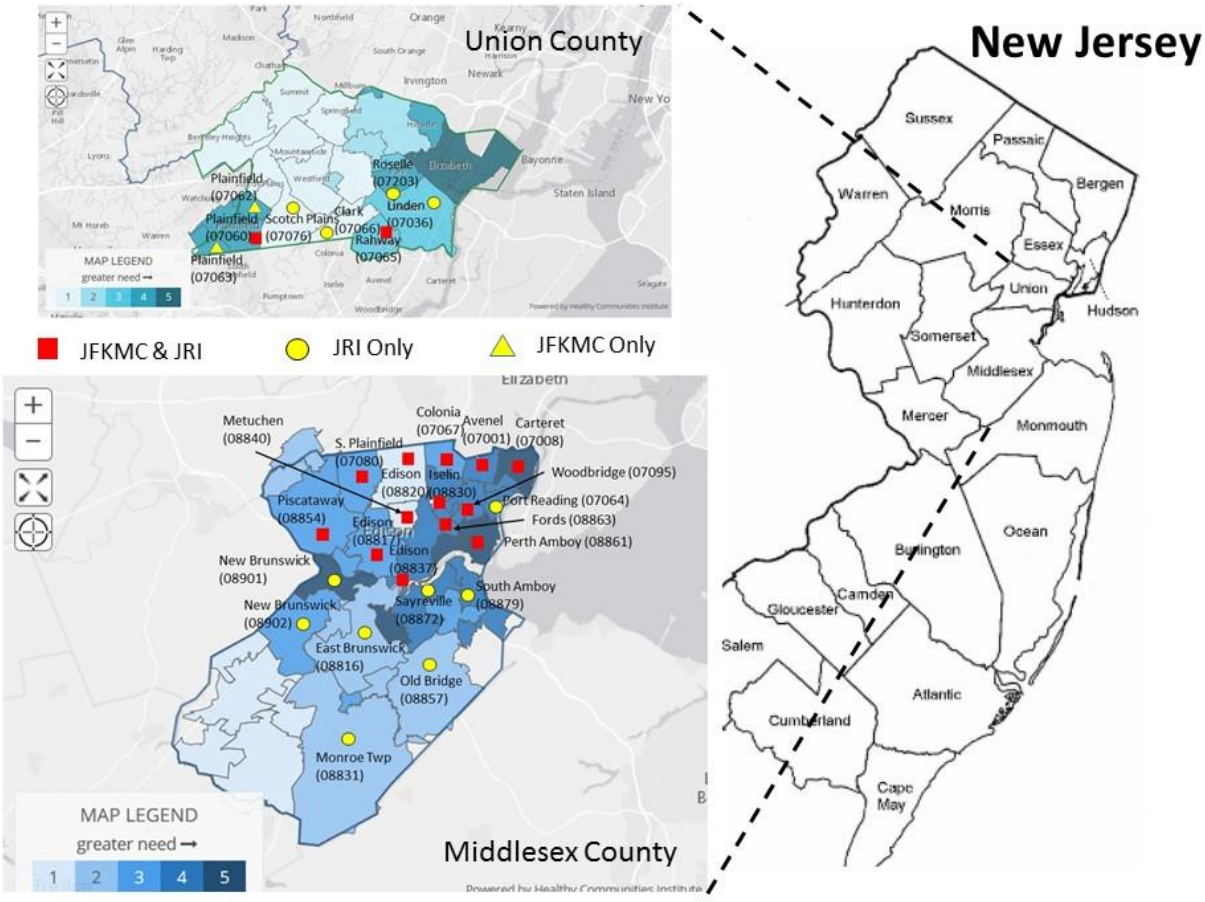


Demographics

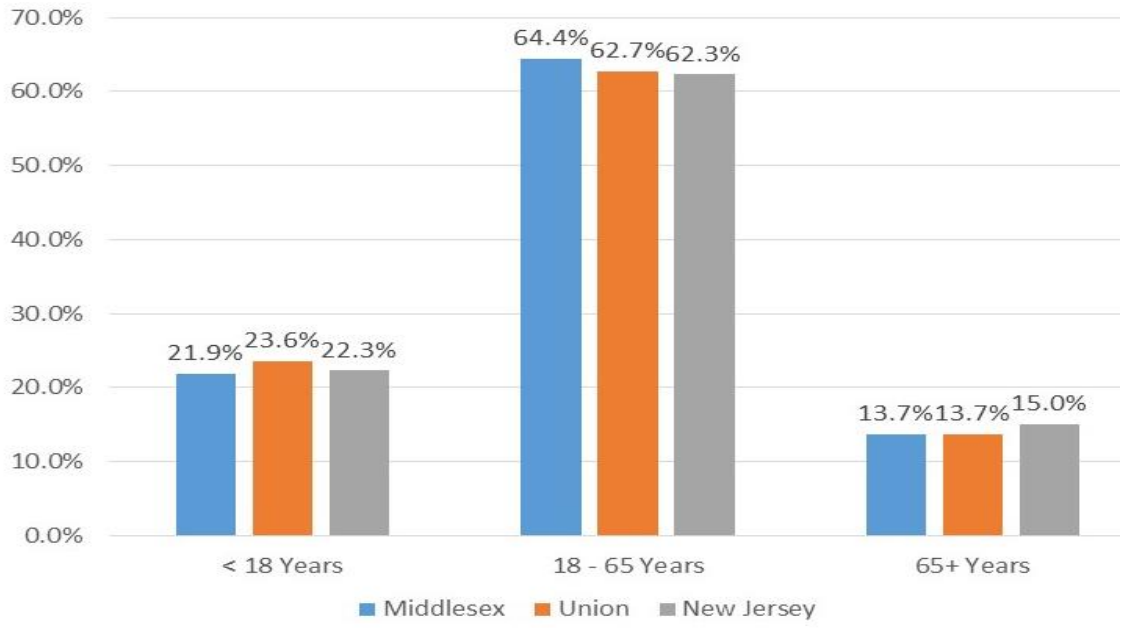
Population

An estimated 840,900 people lived in Middlesex County in 2015, and the population density is much higher (2,621.0 people per square mile) than New Jersey (1,195.5 people per square mile). The primary service area focuses on Edison, Metuchen, Iselin, Woodbridge, and Plainfield.

Age

Overall, Middlesex County residents are slightly younger compared to the state average. While the proportion of residents below 18 years of age is approximately equal to the state average, both Union (13.7%) and Middlesex county (13.7%) have similar percentages of residents over the age of 65.

Figure 3: Population by Age, 2015



Origin and Race/Ethnicity

A significant percentage of Union county (30.9%) residents identify as Hispanic or Latino, as compared to the state average (19.7%.) At least 42% of Middlesex and 42.6 % of Union county residents speak a language other than English at home, versus 30.3% statewide.

Figure 4: Ethnicity and Origin, 2015

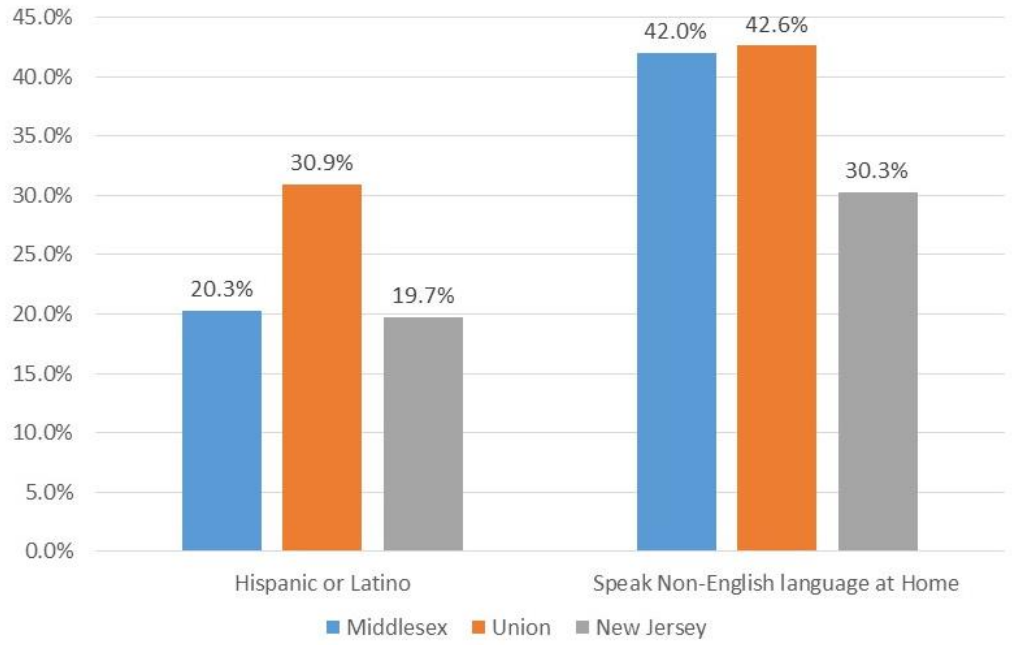
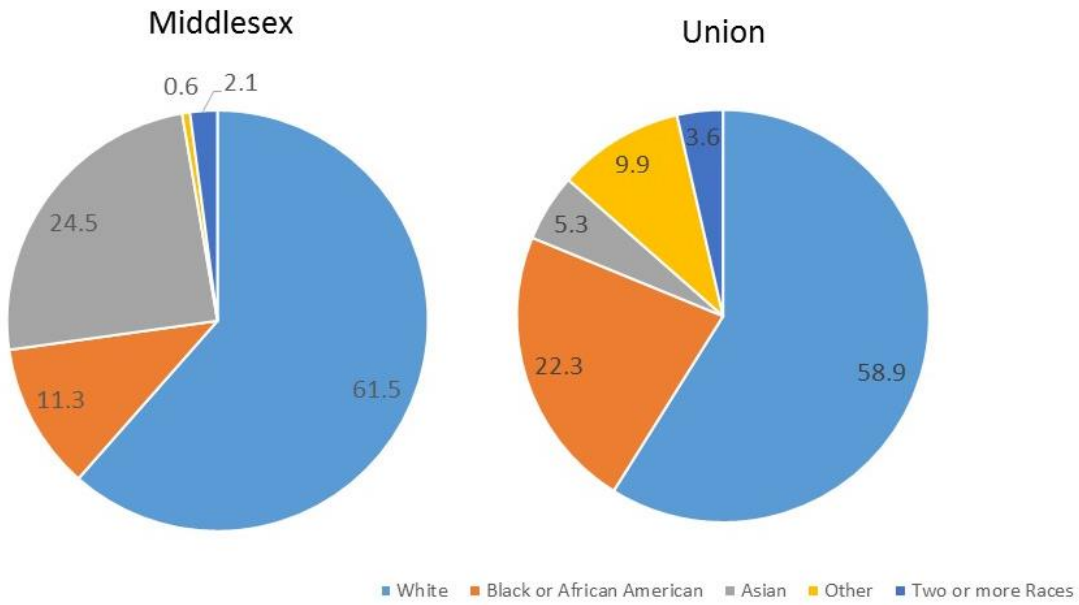


Figure 5: Population by Race, 2015



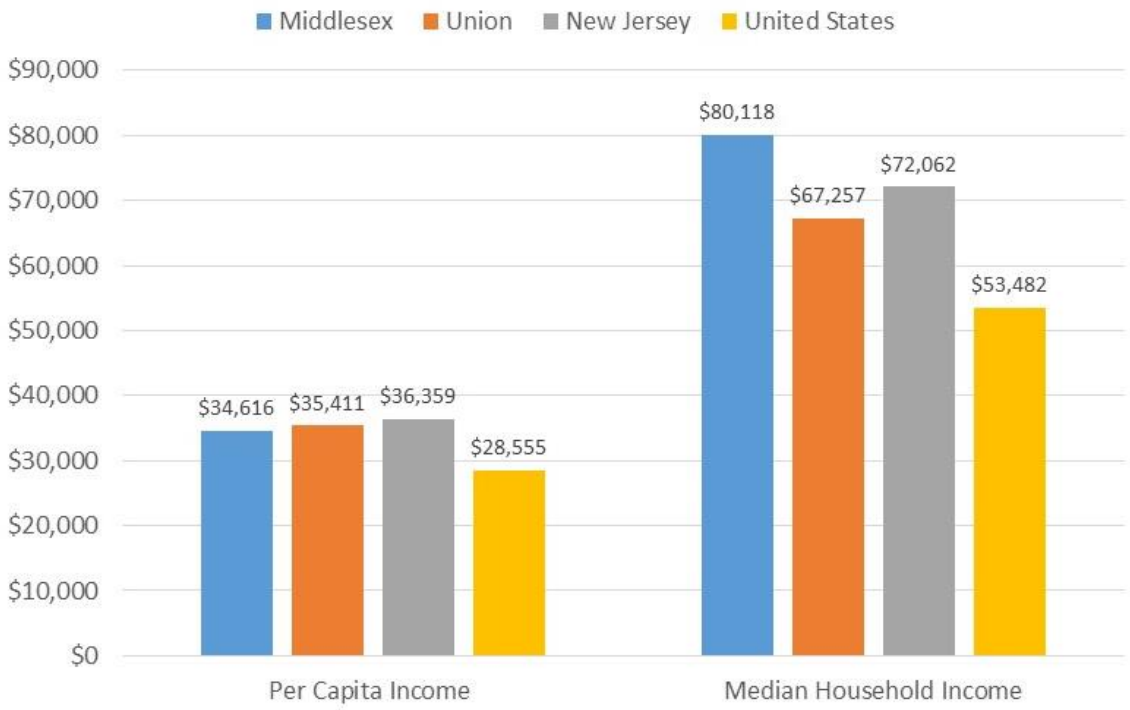
Among people reporting a single race, both counties have a similar proportion of residents who identified as White (61.5%, 58.92%) as compared to the New Jersey average (72.6%). The majority of non-White residents in Middlesex are Asian (24.5%), and in Union are Black/African American (22.26%).

Economy

Income

While per capita income is lower in Middlesex county as compared to state average, median household income in Middlesex county ($80,118) is higher and in Union county ($67, 257) lower compared to the state average ($72,062).

Figure 6: Income Levels, 2010-2014



Poverty

The percent of families in poverty in New Jersey is 8.5%. A lower percent of Middlesex County families (6.1%) live in poverty compared to Union County (8.8%). The average household income for Black/Africa American in Union is $64,726, compared to median household income in Middlesex of $80,118.

Figure 7: Percent of Families Living Below Poverty Line, 2010-2014

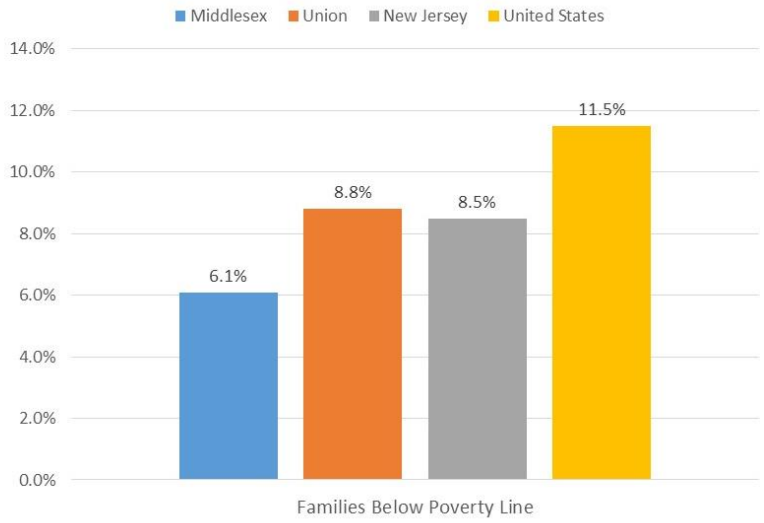
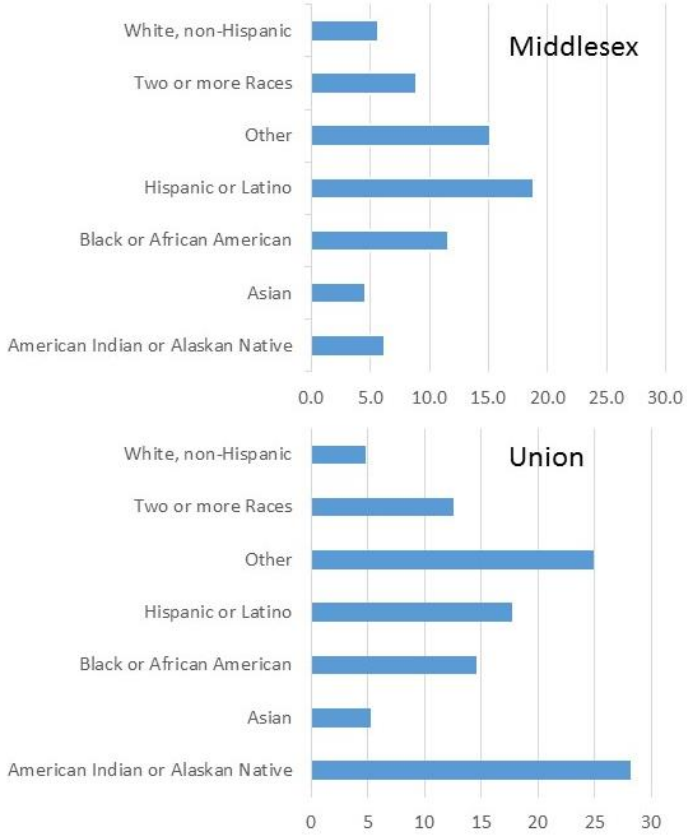


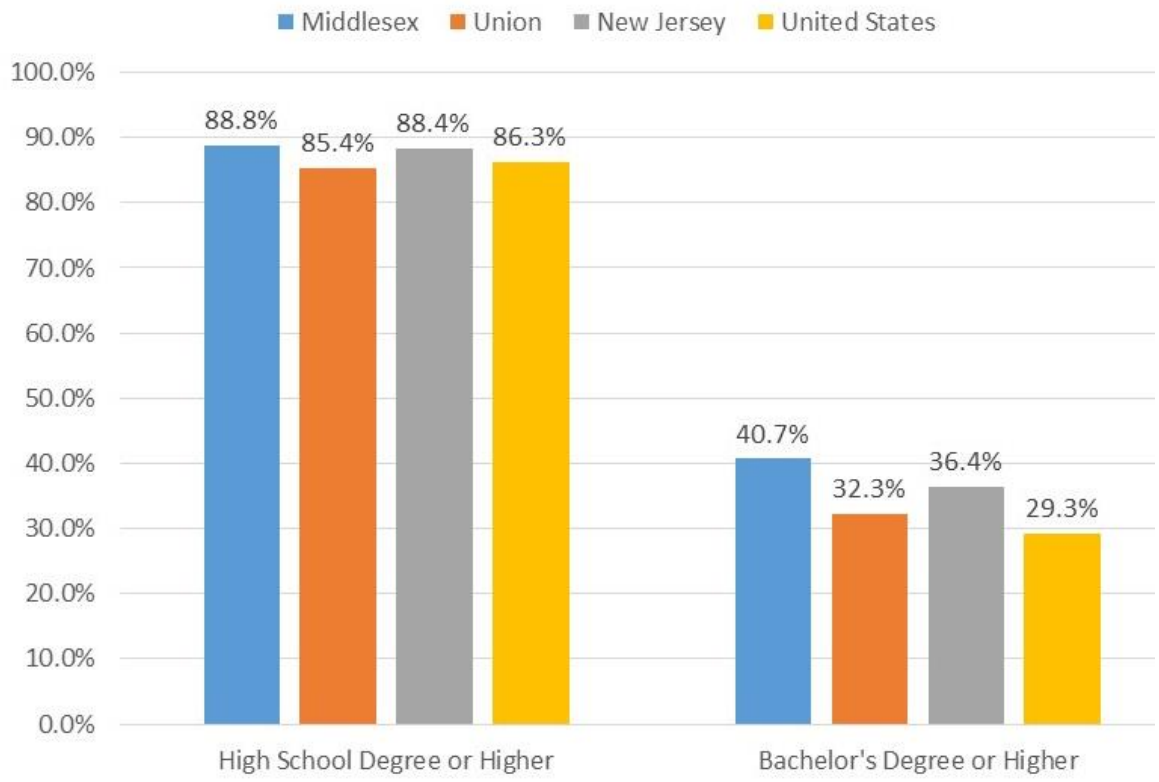
Figure 8: Percent of Population Living Below Poverty Line by Race/Ethnicity, 2010-2014



Education

Findings indicate that 88.8% of peoples age 25+ or older are high school graduates or higher in Middlesex County. For Union County, 14% of peoples over 25+ had less than high school graduation, which is slightly less than Middlesex County and state benchmarks.

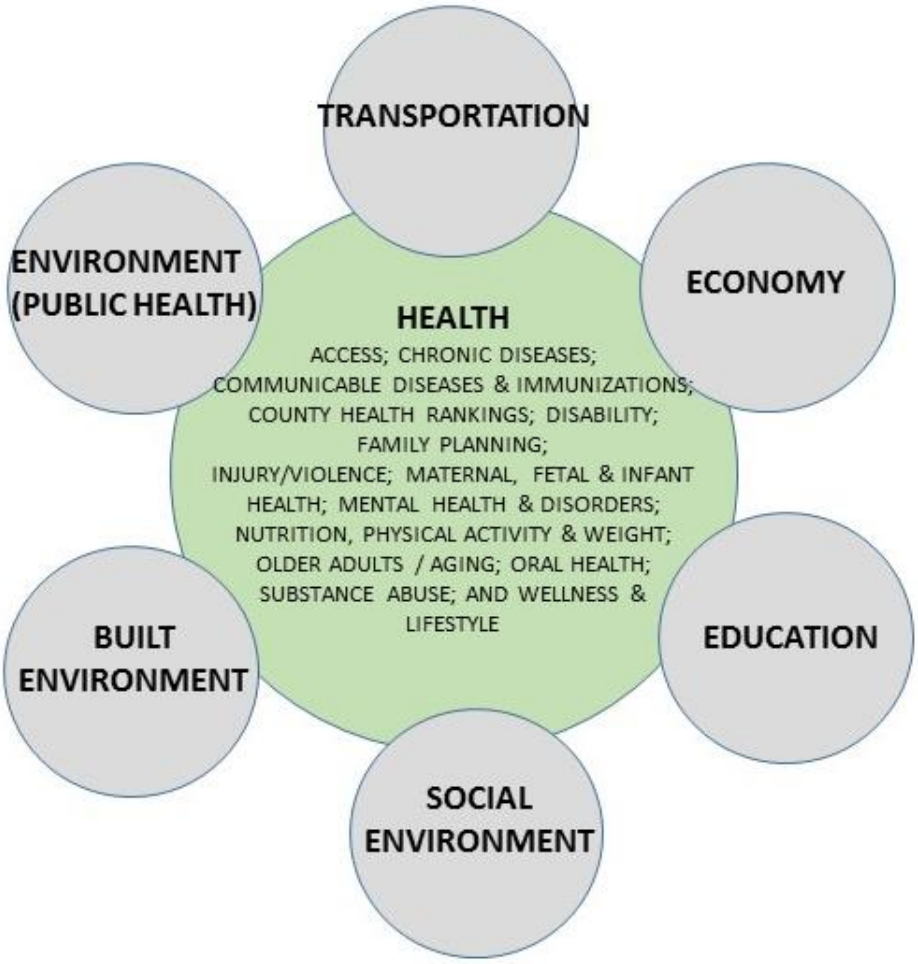
Figure 9: Educational Attainment Among People 25+, 2010-2014



Methodology

JFKMC and JRI remain committed to their vital role in caring for the health of our community. As part of the CHNA process, JFKMC and JRI contracted with the Seton Center for Community and Population Health (SCCPH) to conduct a rigorous CHNA process that produced an accurate and representative snapshot for primary service areas and reflected the voice of the community via a tailored survey. SCCPH collaborated with the Healthy Communities Institute (HCI) to develop a web-based platform, which included 132 health and quality of life indicators for any community or county.

Figure 10: Intersection of Health and Other Sectors



The complete CHNA process involved the collection of primary and secondary data, and the application of triangulation, a technique that uses multiple outcomes to accurately measure community health needs. The figure here presents the SCCPH approach to the CHNA process, which complies with the primary IRS requirements for the CHNA report.

Figure 11: Approach to Community Health Needs Assessment

The IRS requirements serve as a framework for the entire CHNA and Community Health Implementation Plan (CHIP) process.

Figure 12: IRS Requirements for Completing Community Health Needs Assessment

IRS Requirements*

Conducting CHNA

- Define community
- Assess health needs
- Solicit inputs from community stakeholders and experts in public health
- Document a written CHNA report adopted by authorizing body
- Make CHNA report widely available to the public

In assessing needs – identify needs; prioritize them; and identify resources available to address them

* (Community Health Needs Assessment (CHNA) to meet 501 (r) 3 requirements Federal Register Vol. 79 No. 250 dated Dec. 31, 2014)

Primary Data Collection

Using a comprehensive review of background materials, including but not limited to past reports, evaluations, data, and strategic implementation outcomes, the SCCPH developed a detailed plan for primary data collection. This activity involved outreach and consultation with community representatives, municipal organizations, health agencies, and other interested stakeholders, both external and internal to JFKMC and JRI. This plan ensured adequate representation and engagement. (See Appendix C for Community Organizations and Participants). The SCCPH completed a primary data strategy, which included:

- A personalized/tailored JFK CHNA questionnaire
- Community-based focus groups, and
- Key informant interviews

In addition, SCCPH representatives attended several Central New Jersey Coalition meetings and other planning events to obtain contextual evidence.

Based on best practice models identified by the Association for Community Health Improvement's *Community Health Assessment Toolkit*, SCCPH developed a 23 item JFKMC and JRI CHNA survey. Survey items included basic population profile questions, health status updates, assessment of community health needs and challenges, and a prioritization of potential community health issues. Respondents were also given several opportunities to share their perspectives and primary health concerns.

The surveys were distributed during the Summer of 2016 via email, web links, and paper copies within representative service area locations. JFKMC and JRI advertised the availability through the website, printed media (JFKMC and JRI newsletter) and accessibility via an e-survey.

Table 6: Completed JFK CHNA Surveys, 2016

Location Surveys Distributed	Survey Distribution / Completion Dates	Total # of Surveys
Hands Of Hope & Middlesex County Faith-Health Initiative Conference	June 18th & June 20th	15
Edison Family Day	June 12th	18
Lincoln Technical Institute	June 28th	61
Plainfield Health Connections Program	July 6th	28
Focus Group Collection	July 28th, 29th, & August 2nd	7
Family Medical Center	July 12th	390
Edison Senior Services	July 14th	90
Radiation Oncology Department, Outpatient Waiting Room, & Volunteer Services	August 10th	109
Metuchen Library	July 9th	5
Individuals (Online)		22
TOTAL		745

The JFK CHNA questionnaires were also available in additional languages (Spanish, Mandarin, and Gujarati). All responses were kept strictly confidential and data analyzed in the aggregate. (See Appendix A for a copy of the JFK CHNA Survey).

SCCPH conducted three targeted focus groups during the Summer of 2016 to obtain comments and suggestions from interested and knowledgeable community officials and representatives. The first focus group included municipal representatives from the JFKMC and JRI's primary service area including public health and environmental directors and other local and county representatives. While the second focus group engaged interested individuals from various local community organizations and the third focus group consisted of JFKMC and JRI employees who were invited to attend and contribute their perspectives on the community health needs of their patients and consumers. A final focus group was conducted with representative from the Plainfield, NJ community. SCCPH also completed a personal interview with the JFKMC and JRI community outreach coordinator. Other key informants were identified using recommendations from JFKMC and JRI senior staff and community leaders. These activities ensured that all data were grounded in the realities of the communities that JFKMC and JRI serves.

Secondary Data Collection

Secondary data was obtained from the HCI web-based platform which offered a portal to obtain real-time data and analysis. The HCI platform provides information on 132 community health indicators. The HCI database includes relevant data at the county level from a variety of sources, such as the County Health Rankings, BRFSS, NJ State Health, US Census Data and CDC Wonder databases. Census tract and zip code data are offered, if available, for a particular indicator. SCCPH also added primary data from the JFK questionnaires to the HCI platform for additional comparisons. Zip code hospital usage data was obtained from New Solutions, Inc. and integrated with the standard HCI data to ensure custom and valid analysis and reporting.

Secondary Data Analysis

Secondary data used for this assessment was collected and analyzed with the JFKMC and JRI/SCCPH community dashboard (http://jfkmc.org/community-health-needs-assess), a web-based community health data platform developed by Healthy Communities Institute and SCCPH. The community dashboard brings non-biased data, local resources and a wealth of information to one accessible, user-friendly location. It includes a comprehensive dashboard of over 132 community indicators covering over 20 topics in the areas of health, determinants of health, and quality of life. The data is primarily derived from state and national public secondary data sources.

Table 7: Comparison of Select Health and Social Indicators, HCI Platform

Indicator	Middlesex (MX)	MX - NJ	Union (UN)	UN - NJ	NJ	U.S	HP 2020
Primary care provider rate / 100,000 (2013)	95	✓	69	✗	86	--	--
Age-adjusted death rate due to breast cancer / 100,000 (2013)	22.6	✓	24.4	✗	23.4	21.5	20.7
Mammography screening (Medicare population) (2013)	61%	=	59%	✗	61%	--	--
Adults (20+) with diabetes (2013)	9.8%	✗	7.8%	✓	9.3%	--	--
Diabetes (Medicare population) (2014)	34%	✗	32.2%	✗	31.8%	26.7%	--
Adults (20+) who are obese (2013)	25%	✓	24.7%	✓	25.6%	--	30.5%
Adults (20+) who are sedentary (2013)	23.9%	✗	22.7%	✓	22.9%	--	32.6%
Babies with low birth weight (2013)	8.1%	✓	8.4%	✗	8.3%	8.0%	7.8%
Adults with Health Insurance (2014)	85.9%	✓	79.9%	✗	84.6 %	83.7%	100%
Persons with disability in poverty (2014)	11.8%	✓	17.8%	✓	21.4 %	28.2%	--
Heart failure: Medicare Population (2014)	18.3%	✗	18.3%	✗	16.5 %	13.7%	--
HIV/AIDS Prevalence Rate / 100,000 (2014)	257.8	✓	531.3	✗	427.8	--	--
Tuberculosis incidence / 100,000 (2015)	6.3	✗	4.4	✗	3.7	3.0	1.0
Mental Health Provider rate / 100,000 (2015)	157	✗	169	✗	175	--	--
Alzheimer's or Dementia: Medicare Population (2014)	10.8%	✓	11.3%	=	11.3 %	10.0%	--
Alcohol-impaired driving deaths (2014)	28.6%	✗	30.5%	✗	26.2 %	--	--
Linguistic isolation (2014)	8.8%	✗	12.2%	✗	7.2%	4.5%	--

(Source: HCI Platform)

Please note that the most recent period of measure was used for all secondary data presented in this report (as publicly available in July, 2016).

For ease of interpretation and analysis, indicator data is visually represented as a green-yellow-red gauge showing how the community is faring against four distinct benchmarking values:

- Healthy People 2020
- United States benchmark
- State benchmark
- County benchmark

Healthy People 2020 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative and were selected as the comparison point of choice. If no HP 2020 value was available, the comparison analysis followed this progression: US benchmark, State benchmark and County benchmark.

An indicator represented by a needle pointing to the green section signifies that the community value is in the better performing half (or top 50th percentile) of all, yellow signifies that the value is between the bottom 25th and 50th percentile, and red signifies that the value is in the worst performing quartile (or bottom 25th percentile) of all.

Figure 13: Indicator Gauge and Available Comparisons

Indicators were categorized into 21 topic area, which were further classified as a quality of life or health topic.

Table 8: Quality of Life and Health Topic Areas

Quality of Life	Health	Health
Economy	*Access to Health Services*	*County Health Rankings*
Education	*Chronic Diseases:*	*Disability*
Social Environment	• Cancer	*Family Planning*
Built Environment	• Diabetes	*Injury & Violence Prevention*
Environment	• Heart Disease & Stroke	*Maternal, Fetal & Infant*
Transportation and Transportation Safety	• Respiratory Diseases	*Mental Health/Disorders*
	• Other Diseases	*Nutrition, Physical Activity & Weight*
	Communicable Diseases:	*Older Adults and Aging*
	• STD	*Oral Health*
	• HIV/AIDs	*Substance Abuse & Tobacco*
	• Influenza	*Wellness and Lifestyle*
	• Tuberculosis	

SCCPH adopted a data-for-decision-making approach to this CHNA. In order to make the available data actionable, the HCI Dashboard was used in conjunction with primary data to identify priority health needs. A detailed process is described in the Results/Findings section. The data from this CHNA can be made available in electronic format through the web-based portal of the HCI platform. This portal includes a variety of linkages to social media. In addition, paper formats of the key highlights from this CHNA will be developed for further dissemination.

Significant CHNA FINDINGS

Using extensive data available from both primary (JFK CHNA Survey, Focus Groups, Key Interviews) and secondary data sources (HCI and New Solutions, Inc.) a comprehensive analysis was completed and summarized.

Primary Data Results

Findings from the JFKMC and JRI CHNA survey, along with summary information from the four focus groups and key informant surveys, provide significant community input for the CHNA process. Contributions from each group are briefly presented. Additional information can be found in the Appendices.

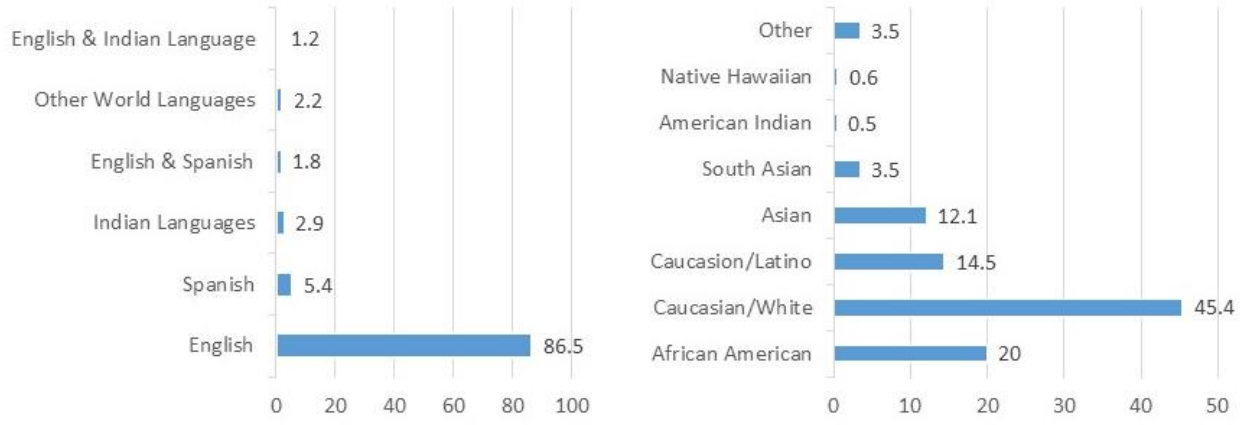
JFK Survey Results

JFKMC and JRI received 745 completed surveys for analysis. Community respondents provided significant input to the CHNA process. A brief participant profile is provided.

- N = 745 completed questionnaires
- 70% Female, Mean age = 48.5
- 52% previously admitted to JFK Medical Center; 6% to Johnson Rehab. Inst.
- 64% Middlesex, 15% Union, 3% Somerset
- 80% rated their overall health as "*good", "very good" or "excellent"*
- 76% of the respondents indicated receiving routine care in physician's office
- 93% were able to visit a doctor when needed

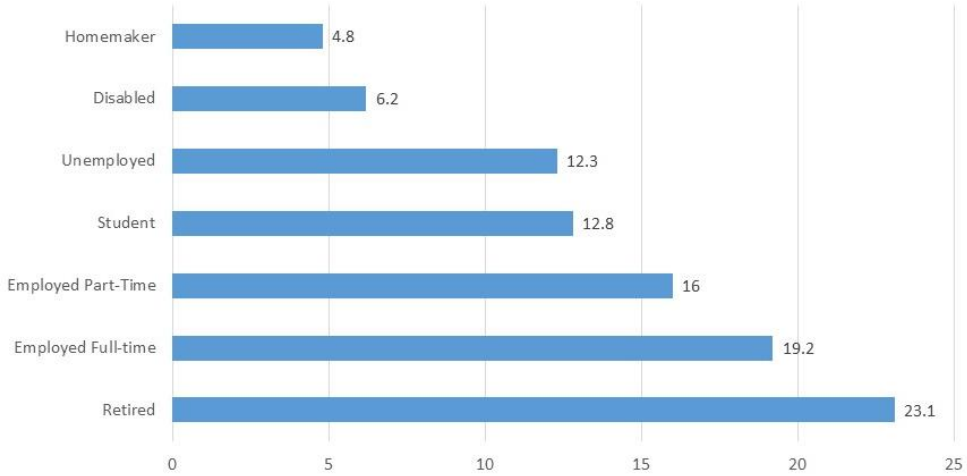
The majority of respondents spoke English, but more than 50% identified themselves as from a minority group.

Figure 14: Language and Race Profile of Respondents, JFK CHNA, 2016



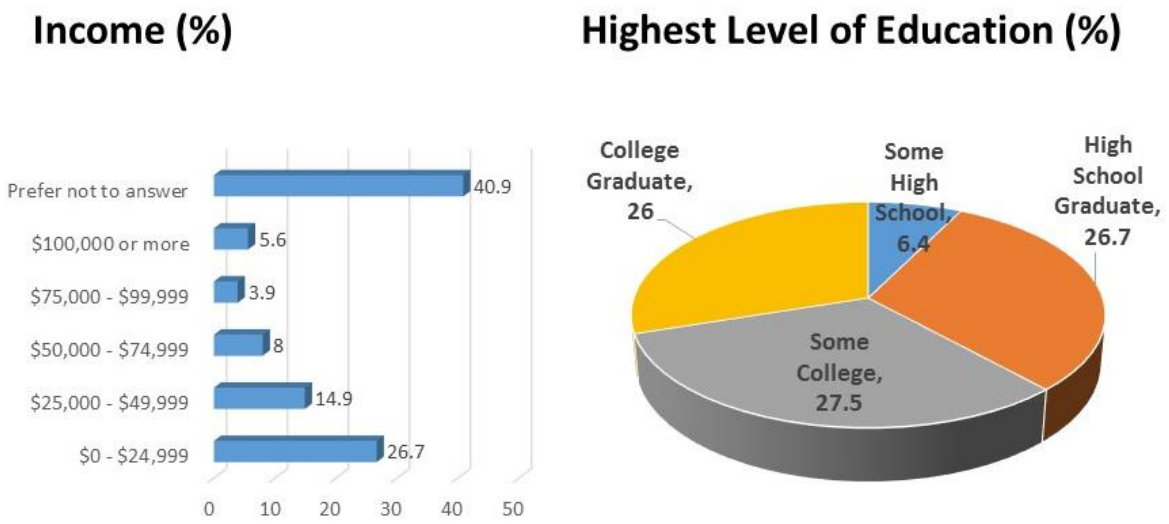
A population pyramid presenting percent (%) employed shows the largest group as retired, followed by fully and part-employed individuals.

Figure 15: Employment Status of Respondents, JFK CHNA, 2016



A significant number of individuals preferred not to share income level, but at least one-quarter of those reporting indicated making less than $25,000. In contrast to that information, over 50% of the participants indicated having some college education or were college graduates.

Figure 16: Income and Level of Education of Respondents, JFK CHNA, 2016



The second section of the CHNA survey questionnaire focused on identifying the community's top health challenges, healthy behaviors, and community health needs.

JFKMC and JRI consumers were asked to select their top health challenges from a list of 16 choices.

Results show that the top nine indicators mentioned are all chronic diseases and several were addressed by the 2013 Community Health Implementation Plan.

Table 9: Prioritized Health Challenges Faced by Respondents, JFK CHNA, 2016

Prioritized Health Challenges
Overweight / Obesity
Joint pain / Back pain
High blood pressure
Arthritis
Diabetes
Asthma
Heart disease
Mental health issues
Cancer

JFKMC and JRI respondents indicated they attempted to practice positive health behaviors and utilized preventive procedures in the past 12 months when available.

Table 10: Health Behavior of Respondents, JFK CHNA, 2016

Statement	Yes
I exercise at least 3 times per week	48.2
I eat at least five servings of fruits and vegetables every day	45.4
I eat fast food more than once per week	24.8
I smoke cigarettes	9.3
I chew tobacco	0.3
I use illegal drugs	1.3
I abuse or overuse prescription drugs	0.5
I consume more than four alcoholic drinks (if female) or five (if male) per day	1.6
I use sunscreen or protective clothing for planned time in the sun	54.2
I receive a flu shot each year	57.3
I have access to a wellness program through my employer	11.7

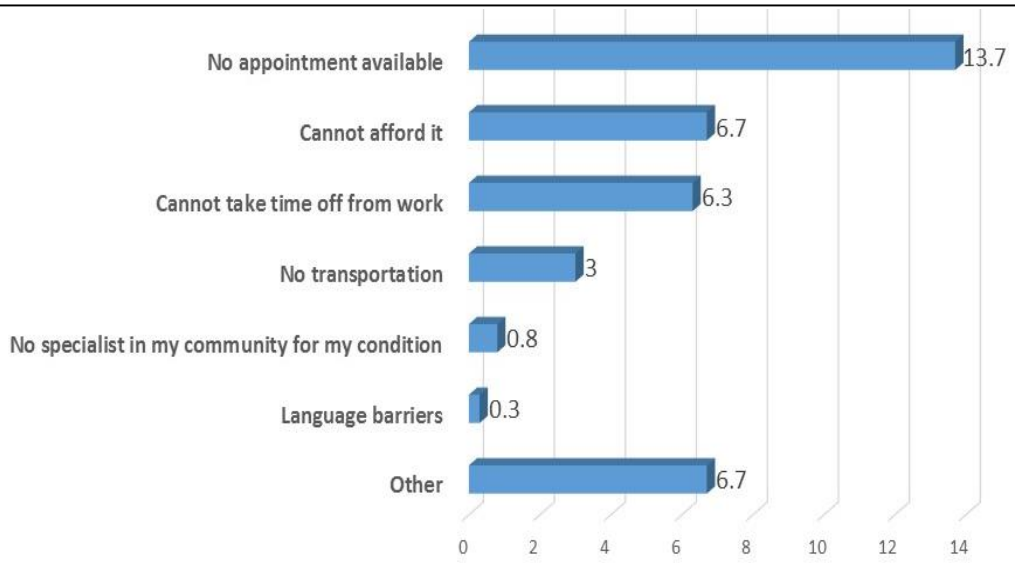
Results show wide variation in the type and frequency of healthy behaviors within the participant group. Findings suggest additional opportunities for screening activities. A significant number reported eating healthy food weekly, and a smaller number than the national average reported smoking.

Table 11: Health Screening and Prevention by Respondents, JFK CHNA, 2016

Preventive Procedure	Yes (%)
Blood pressure check	71.3
Physical exam	63.9
Flu shot	53.8
Dental cleaning / x-ray	52.3
Vision screening	52.5
Cholesterol screening	45.5
Pap smear (if woman 21 - 65)	59.8
Mammogram (if woman 45+)	68.0
Hearing screening	20.9
Cardiovascular screening	22.4
Colon/rectal exam	14.9
Bone density test	13.7
Skin cancer screening	13.2
Prostrate cancer screening (if man 40+)	31.8

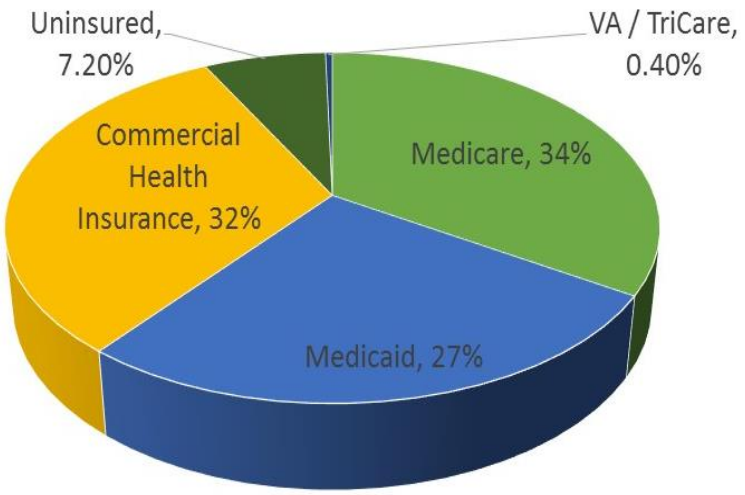
The survey also sought to identify potential reasons for barriers to a healthy lifestyle. Insurance coverage and reasons for not being able to visit a doctor when needed were identified.

Figure 17: Barriers to Seeking Care, JFK CHNA, 2016



Only a small percentage of participants reported being uninsured, but approximately 14% indicated they had difficulties in obtaining appointments with their doctor when needed.

Figure 18: Health Insurance Coverage of Respondents, JFK CHNA, 2016



The CHNA survey also requested community residents to share their perceptions related to community health needs. Community residents provided responses to:

- prioritize potential community health issues,
- identify the greatest community health concerns and
- identify the greatest strengths for JFKMC and JRI.

The following table and figures summarize the survey findings for these three main issues.

Table 12: Community Health Issues Prioritized by Respondents, JFK CHNA, 2016

Rank	Prioritized Community Health Issue
1	Nutrition – Access, Availability, Weight Control
2	Wellness and Lifestyle Activity
3	Oral Health Availability
3	Respiratory Disease – COPD / Asthma
5	Healthy Environment
6	Diabetes
7	Prevention Programs – Smoking Cessation
8	Older Adults – Aging Alone / Alzheimer's
8	Family Planning
10	Cancer
11	Heart Disease and Stroke
12	Access to Quality Health Services
12	Maternal Child Health – Low Birth Weight
14	Mental Health
15	Substance Abuse and Misuse
16	Communicable Diseases – HIV/AIDS

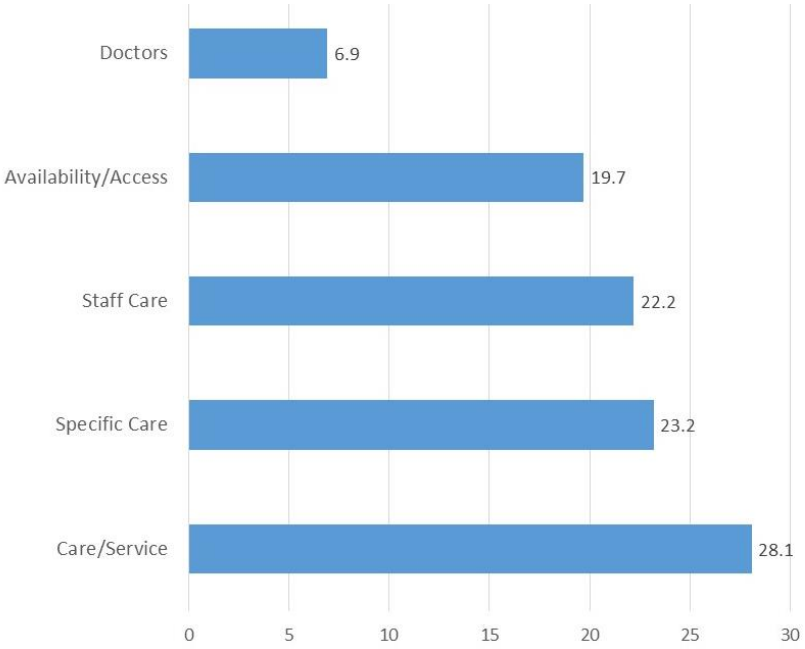
The top 16 identified community health issues highlight common chronic diseases and related risk factor behaviors. Other important priority areas included: aging-related issues, substance abuse/misuse, and HIV/AIDs.

Respondents indicated a concern for specific types of care and access to care when needed.

Participants also provided suggestions and recommendations for improving community health, with a third of the respondents sharing suggestions related to disease specific service delivery.

When asked to identify the greatest community strengths for JFKMC and JRI, 215 community participants provided a diverse list of significant health benefits.

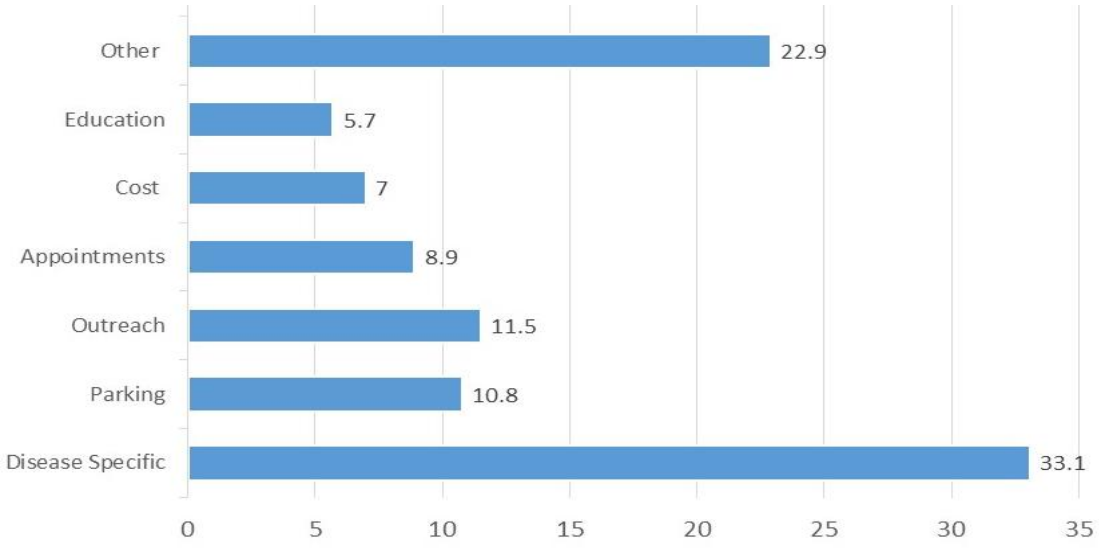
Figure 19: Greatest Community Strength of JFK Reported by Respondents, JFK CHNA, 2016



These positive findings show strong support for all types of care (general, disease-specific, and staff care) as well as positive references to JFK physicians.

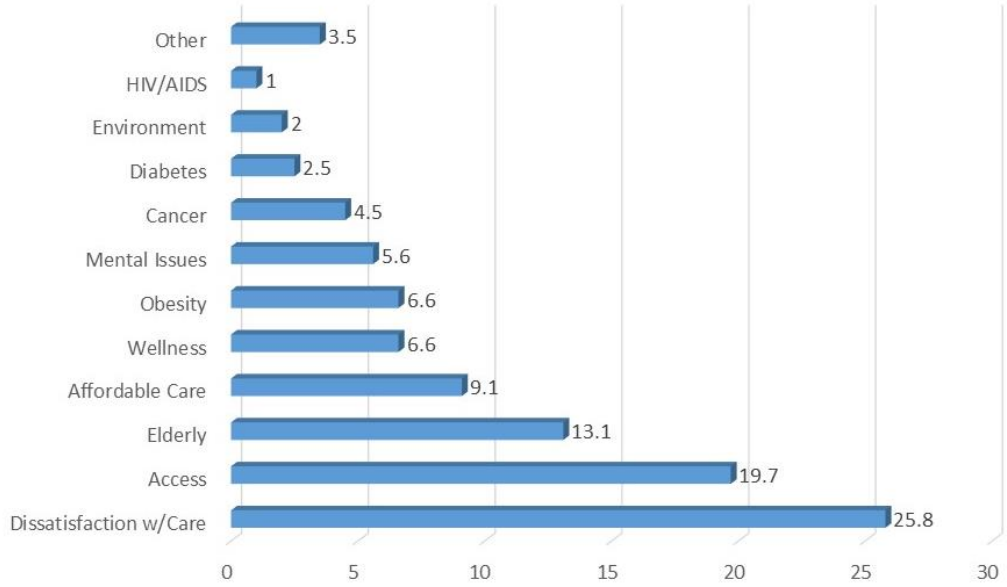
Survey respondents were also asked to indicate their greatest community health concern for JFK. Feedback included comments from 229 individuals.

Figure 20: Greatest Community Health Concern for JFK Reported by Respondents, JFK CHNA, 2016



Survey respondents often hold differing perceptions of a community hospital. In Figure 21, approximately 26% indicated a level of dissatisfaction with care. However, the previous figure (Figure 19) shows 74% of community residents indicating satisfaction with various types of care. Individual perceptions of healthcare experiences often explain the variation apparent in CHNA survey items. This conclusion is validated with the very small percentages (<10%) for nine (9) of the twelve (12) concerns listed.

Figure 21: Suggestions for Improving Community Health Provided by Respondents, JFK CHNA, 2016



Over one- third of the respondents shared suggestions related to disease specific service delivery. This finding indicates an important focus on improving care quality.

JFKMC 2013 PRIORITY AREAS REVIEW

The JFKMC 2013 Community Health Needs Assessment process resulted in the identification of 20 community health needs areas that were further categorized as:

- Core competency: Needs related to the area of expertise and services provided by JFKMC.
- Specialized community assets: Needs related to the provision of services that JFKMC does not offer today or where other organizations are better positioned or have specialized expertise.
- Environmental (external): Needs that are not central to the JFKMC mission or where JFKMC has limited ability to influence actions.

These categorizations were based on JFKMC's strategic plan, community partnerships, and local opportunities to address major health needs within the primary service area. The following table shows the prioritized need and its categorization as part of the Implementation strategy process.

Table 13: Prioritized and Categorized Community Health Needs, JFK CHNA, 2013

Core Competency	Specialized Community Assets	Environmental Issues (External)
Emergency Care Services (2)	Mental Health Services (1)	Services for Low Income (4)
Weight Control Program (5)	Substance Abuse Services (3)	Violent Crime Rate (8)
Physical Activity Programs (7)	Reproductive Services for Youth (6)	Inadequate Social Support (9)
Mammography Screening (15)	Excessive Drinking (12)	Fast Food Restaurants (10)
Diabetic Screening (19)	Sexually Transmitted Infections (13)	Unemployment Rate (11)
Low Birthweight (20)		Daily Fine Particulate Matter (14)
		Cancer Incidence (16)
		Children in Single Parent Home (17)
		Population in Poor/Fair Health (18)

Each year, a complete CHNA-Implementation Strategy Update was completed. Please see the appendix for the 2015 Implementation Strategy Update Report. The report shows significant progress (using metric indicators) for all priority need areas with several implementation strategies completed. Of the 60 CHIP strategies identified, 18 (30%) strategies were totally completed and the rest in advanced stages of progress.

In addition, JFKMC partnered with Seton Hall University to have six Master of Healthcare Administration (MHA) students complete a progress report on each of the Core Competency areas. The MHA graduate students completed an in-depth review of past and current initiatives for each of the six areas, including a review of the following indicators:

1) Weight Control: Adults 20+ who are obese, Adults 20+ who are sedentary, Health Behaviors Ranking, Food Security Rate, and Child Food Security Rate
2) Mammography Screenings: Mammography Screenings-Medicare Population, Breast Cancer Incidence Rate, and Age-Adjusted Death Rate due to Breast Cancer

3) Emergency Care Services: Non-Physician Primary Care Provider Rate, Primary Care Provider Rate, and Preventable Hospital Stays
4) Low Birth Weight: Babies with Low Birth Weight, Babies with Very Low Birth Weight, Mothers who received Early Prenatal Care, Mothers who Received No Prenatal Care, Preterm Births, and Very Preterm Births
5) Physical Activity: Access to Exercise Opportunities and Recreation and Fitness Facilities
6) Diabetes Screening: Adults 20+ with Diabetes, Age-Adjusted Death Rate due to Diabetes, Diabetes: Medicare Population, and Diabetic Screening: Medicare Population

Students also met with JFKMC and JRI executives and staff to gain internal perspectives and to collect supporting data. Findings show strong support for all six priority areas, including: implementation of new programs and enhanced outreach resulting in healthier outcomes for JFKMC and JRI consumers. Results from the findings were presented to the President/CEO Raymond Fredericks during May, 2016 by all the student interns. The presentations are available by contacting The Seton Center of Community and Population Health at Anne.Hewitt@shu.edu .

In 2016, the JFK CHNA survey also asked community stakeholders to provide feedback on JFKMC and JRI's progress on the 2013 six priority CHNA areas.

Table 14: Rating by Respondents of Improvements in CHNA 2013 Priorities, JFK CHNA, 2016

	Much Improved	***Improved***	***Not Improved***	***Missing***
Emergency Care Services	42.1% 212	37.1% 187	20.8% 105	*32.3%* *241.0*
Weight Control Programs	15.4% 74	41.0% 197	43.5% 209	*35.6%* *265.0*
Physical Activity Programs	18.5% 89	38.9% 187	42.6% 205	*35.4%* *264.0*
Mammography Screening	27.8% 135	35.2% 171	37.0% 180	*34.8%* *259.0*
Diabetes Screening	22.2% 105	37.9% 179	39.8% 188	*36.6%* *273.0*
Low Birth weight	15.8% 71	32.9% 148	51.3% 231	*39.6%* *295.0*

Approximately one-third of the survey respondents did not respond to this survey item, however those who did strongly felt that all six priority areas had either been much improved or improved in the last three years. The priority area with the least improvement was for Low

Birth Weight. (Additional information on 2013 Key Priority Indicators is found in the Appendices).

JFK Focus Group Outcomes

SCCPH conducted four focus groups during August/ September, 2016. Invited participants represented local and state municipal groups, interested community stakeholders and JFKMC and JRI employees. Invitation letters were sent to all designated community participants. All focus groups were held at JFKMC and JRI headquarters in Edison, New Jersey except for the Plainfield Municipal focus group session. See the Appendices for list of participants/organizations. Each focus group followed a pre-set list of questions in order to ensure continuity and validity across each focus group session. Focus groups were recorded and transcribed. Major themes were identified and collated. Findings are presented by group.

Focus group members introduced themselves and then responded to these core set of questions. These included:

- How well do JFKMC and JRI serve the community? Are there any weaknesses?
- Are there community health services that JFK should continue to expand?
- Are there opportunities for the JFKMC and JRI to better meet the community's health needs?

Figure 22: Focus Groups for Community Inputs, JFK CHNA, 2016

Each focus group lasted a minimum of one and half hours. SCCPH facilitators encouraged participants to expand on comments and proposed solutions. All participants were engaged and provided clear recommendations based on their perceptions of community healthcare problems. In addition to tape recording, the JFK-MHA student intern took notes and a flipchart

was used to help collate ideas and solutions. All focus group members were encouraged to complete the JFKMC and JRI questionnaire if they had not already done so. While the discussion focused on many issues, several themes were apparent across the different groups.

Table 15: Community Health Needs Identified Across Focus Groups, JFK CHNA, 2016

Community Health Needs	Municipal / Government	Community	Hospital
Continuity of Care (Transportation)	☑	☑	☑
Chronic Diseases	☑	☑	
Mental / Behavioral Health / Substance Abuse	☑	☑	☑ *
Language and Culture	☑	☑	
Knowledge Sharing / Engagement	☑	☑	☑
Access to Care		☑	☑
Community Outreach		☑	
Caregiver Support		☑	☑
Safety / Security / Trust		☑	

* Specifically opioid and other drug abuse

All participating stakeholders offered opinions and context for community health needs. The community stakeholder group provided several major issues and requested further attention from JFKMC and JRI. Additional information is available in Appendix.

Table 16: Recommendations Across Focus Groups, JFK CHNA, 2016

Recommendations	Municipal / Government	Community	Hospital
Expand Community Outreach	☑	☑	☑
Collaboration / Partnership	☑	☑	
Continuity of Care		☑	☑
Culture of Acceptance / Advocacy	☑	☑	
Specialized Programs for Youth	☑	☑	
Information Sharing			☑
Access		☑	

Clearly, all focus groups recommended expansion of community outreach. At least two out of three groups reached consensus on the following topic areas:

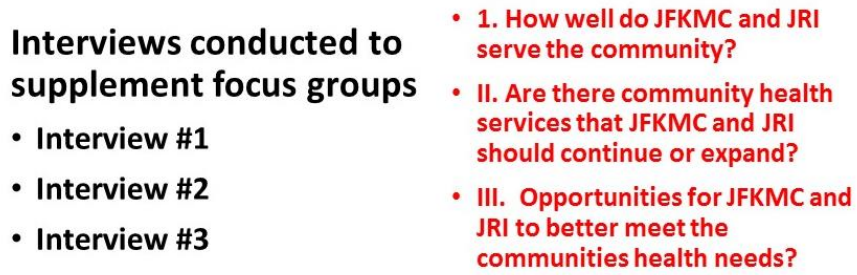
- Collaboration/ Partnership
- Continuity of Care
- Culture of Acceptance/Advocacy
- Specialized programs for youth

Only two topics did not reach consensus: information sharing and access to care.

Key Informant Findings

The key informants included a local public health officer, an executive manager from Johnson Rehabilitation Institute and a JFKMC and JRI representative. Together, their input helped provide additional detail and context for understanding the community stakeholders and their relationship to JFKMC and JRI.

Figure 23: Key Informant Interviews for Community Inputs, JFK CHNA, 2016



Key informant interviews provided significant detail on previously indicated areas of community health needs. Details included a clarification of risk factors, issues related to continuity and delivery of care and a description of the most vulnerable populations and the barriers they encounter. The key informants provide several relevant recommendations along with proposed activities to support positive outcomes. All key informants highlighted the need for true partnership and engagement with community leaders and health organizations.

Table 17: Recommendations Across Key Informant Interviews, JFK CHNA, 2016

Recommendations	interview #1	interview #2	interview #3
Cultural competency	☑	☑	
Expand services	☑	☑	☑
Partnership for community outreach and screening	☑	☑	☑
Address parking issue through satellite facilities		☑	
Advocate for healthy nutrition	☑		
Health literacy	☑		☑

Using the findings from the JFK-CHNA survey questionnaire, focus groups and key informant interviews provided a clear representation of the community's voice and their perception of current health needs and health status.

Secondary Data Results

Using the custom designed reports from the HCI platform, SCCPH identified important data outcomes for comparison via the dashboard indicators. Given the complex amount of data available, only significant findings are reported by category. Additional information is available at < http://jfkmc.org/community-health-needs-assess >.

Community Dashboard Comparison

Of primary importance was the summary of selected health and health status indicators that did not meet any of the comparison benchmarks. All indicators were reviewed for comparisons (where appropriate) to HP 2020, US benchmark, or the NJ benchmark. Data for both Middlesex and Union counties were assessed. Summary slides from the HCI platform show only seventeen (17) primary areas of interest where there was a discrepancy between county data and one of the benchmark indicators.

Table 18: Comparison of Select Health and Social Indicators, HCI Platform

Indicator	Middlesex (MX)	MX - NJ	Union (UN)	UN - NJ	NJ	U.S	HP 2020
Primary care provider rate / 100,000 (2013)	95	✓	69	✗	86	--	--
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Mammography screening (Medicare population) (2013)	61%	=	59%	✗	61%	--	--
Adults (20+) with diabetes (2013)	9.8%	✗	7.8%	✓	9.3%	--	--
Diabetes (Medicare population) (2014)	34%	✗	32.2%	✗	31.8%	26.7%	--
Adults (20+) who are obese (2013)	25%	✓	24.7%	✓	25.6%	--	30.5%
Adults (20+) who are sedentary (2013)	23.9%	✗	22.7%	✓	22.9%	--	32.6%
Babies with low birth weight (2013)	8.1%	✓	8.4%	✗	8.3%	8.0%	7.8%
Adults with Health Insurance (2014)	85.9%	✓	79.9%	✗	84.6 %	83.7%	100%
Persons with disability in poverty (2014)	11.8%	✓	17.8%	✓	21.4 %	28.2%	--
Heart failure: Medicare Population (2014)	18.3%	✗	18.3%	✗	16.5 %	13.7%	--
HIV/AIDS Prevalence Rate / 100,000 (2014)	257.8	✓	531.3	✗	427.8	--	--
Tuberculosis incidence / 100,000 (2015)	6.3	✗	4.4	✗	3.7	3.0	1.0
Mental Health Provider rate / 100,000 (2015)	157	✗	169	✗	175	--	--
Alzheimer's or Dementia: Medicare Population (2014)	10.8%	✓	11.3%	=	11.3 %	10.0%	--
Alcohol-impaired driving deaths (2014)	28.6%	✗	30.5%	✗	26.2 %	--	--
Linguistic isolation (2014)	8.8%	✗	12.2%	✗	7.2%	4.5%	--

(Source: HCI Platform)

The combined primary and secondary data analysis revealed 17 indicators of major health concerns for the JFKMC and JRI primary service area using the HCI dashboard. A wide range of indicators were identified focusing on access to healthcare, prevalence of specific diseases, rates of healthy behaviors, and other quality of life issues.

As presented in the table, comparisons are shown for both Middlesex and Union counties. They represent they primary discrepancies between current health status indicators and the benchmark indicators: New Jersey, United States and Healthy People 2020. Both counties were below benchmark comparisons for:

- Diabetes - % of Medicare population
- Heart Failure - % of Medicare population
- Tuberculosis – Incidence per 100,000
- Mental Health – Provider rate per 100,000
- Alcohol impaired Driving Deaths - % per 100,000
- Linguistic isolation - % comparison

In addition to the combined primary and secondary analysis findings, JFK also reviewed three additional reports to further clarify CHNA findings. Analysis was completed using the CHI platform to assess these additional categories of interest:

- SocioNeeds Index
- Health Disparities and
- Demographic Issues.

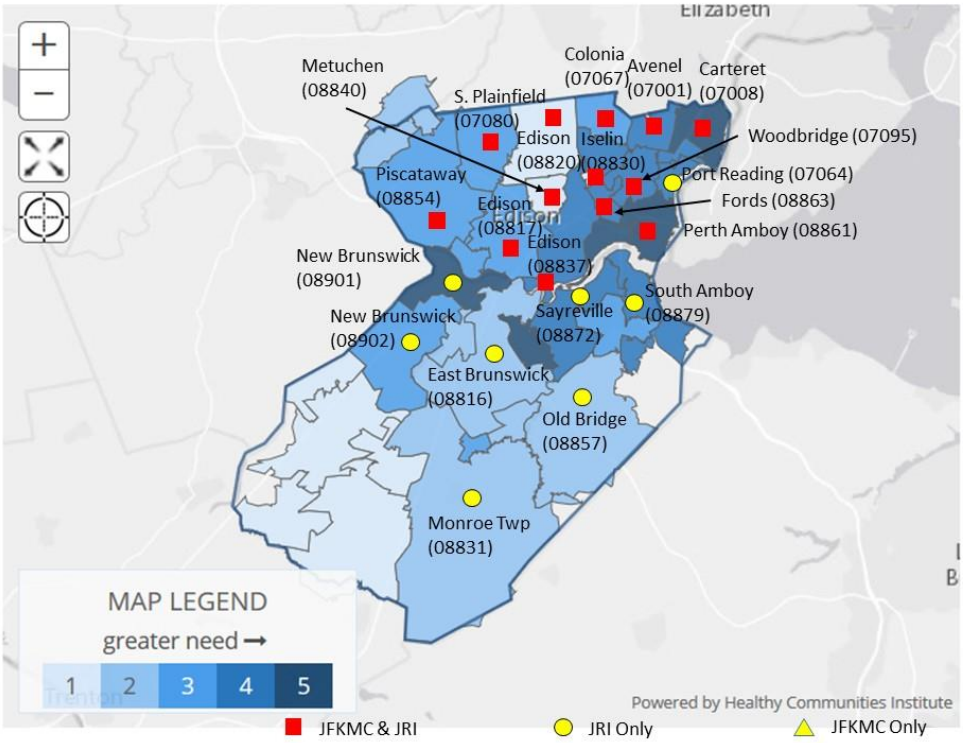
Findings from these reports are presented below

SocioNeeds Index

The 2016 SocioNeeds Index, created by Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes. All zip codes, counties, and county equivalents in the United States are given an Index Value from 0 (low need) to 100 (high need). To help you find the areas of highest need in your community, the selected locations are ranked from 1 (low need) to 5 (high need) based on their Index Value.

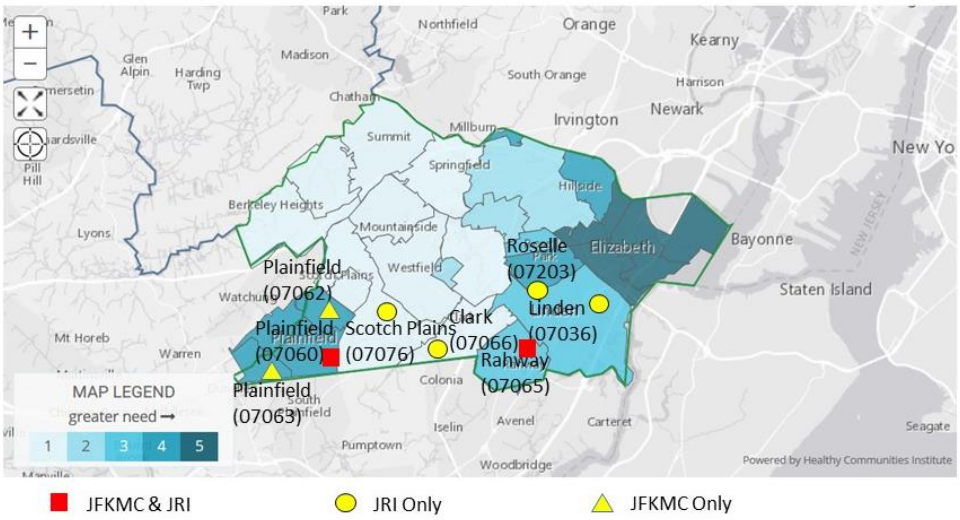
For Middlesex County, 39% of the zip code areas are classified as either a high or a very high socioeconomic need areas. In JFK's Primary Service Area, 52% of zip codes were classified as either a high or a very high socioeconomic need areas.

Figure 24: Social Needs Index, JFK Primary Service Area, Middlesex County, HCI



For Union County, 38% of the zip code areas were classified as high or very high socioeconomic need areas. In JFK's Primary Service Area, 50% of zip codes were classified as high or very high socioeconomic need areas.

Figure 25: Social Needs Index, JFK Primary Service Area, Union County, HCI Platform



Health Disparities

The Health Disparities Dashboard facilitates analysis and comparison of all 132 indicators by age, gender, and race data, wherever available. http://jfkmc.org/community-health-needs-assess

Demographic Issues

The Demographics Dashboard provides information on a variety of population, economy, infrastructure, and transportation issues for the county as compared to New Jersey. http://jfkmc.org/community-health-needs-assess

Prioritization of Community Health Needs Process

Step 1: Identification of Community Health Needs and Triangulation Ranking

Primary and secondary data were evaluated to identify the significant community health needs of JFKMC and JRI's service area. These needs span the following topic areas and are often inter-connected, which supports the use of triangulation of both primary and secondary data and the inclusion of direct community input. First, this table lists all the 29 primary community health needs identified by the community. Second, it presents a ranking based on a review of all the various data sources and a detailed rating system based on scoring system weighted to highlight the greatest need for all 29 identified health needs.

The final prioritization process relied on the triangulation of both primary and secondary data and the inclusion of direct community input. The rating criteria included: (a) core relationship to mission (b) continuation of 2013 priority (c) significant disparity with benchmark comparisons (d) identified as top health concern via the JFKMC and JRI-CHNA questionnaire findings and (e) appropriate for both JFKMC and JRI populations. The following matrix displays a detailed rating system based on scoring system weighted to highlight the greatest need.

Table 19: Prioritization of Community Health Needs, JFK CHNA, 2016

Community Health Issue	Disparity - HP2020 or US or NJ	Top Health Concern (Respondent)	Ranking of Community Issues	Greatest Perceived Community Concern	Focus Group	Interview	**Overall Score**
Transportation and Parking	1		1	3	3	3	**11**
Diabetes	2	2	2	1	2	1	**10**
Mental / Behavioral Health	2	1	1	2	3		**9**
Obesity	0	3	3	2		1	**9**
Wellness / Prevention		3	3	2			**8**
Cardiac / Heart Disease	2	1	1		2	1	**7**
Access	1		1	3	2		**7**
Cancer	1	1	2	2			**6**
COPD		2	3				**5**
Older Adults	0		2	3			**5**
Affordability	1			3		1	**5**
Vulnerable Population	1				1	3	**5**
Health Environment			3	1			**4**
Substance Abuse / Opioids	2		1				**3**
Weight Control	0		3				**3**
Oral Health			3				**3**
Rehab (Joint / Back Pain)		3					**3**
HIV/AIDS	1		1	1			**3**
Knowledge Sharing					3		**3**
Arthritis		2					**2**
Low Birth Weight	1		1				**2**
Caregiver Support					2		**2**
Language / Culture					2		**2**
Lingusitics	2						**2**
Physical Activity	1						**1**
Rehab Access			1				**1**
TB	1						**1**
Health Literacy						1	**1**
Emergency Care							

Notes:

Disparity in comparison to HP2020 or US or NJ value (0 - no disparity, 1 - in MX or Union, 2 in MX AND Union)
Top Health Concern for Respondent CHNA Survey - 3 if in top third, 2 if in middle third, 1 if in bottom third
Ranking of Community Health CHNA Survey - 3 if in top third, 2 if in middle third, 1 if in bottom third
Greatest Perceived Comm. Health CHNA Survey - 3 if in top third, 2 if in middle third, 1 if in bottom third
Focus Group - 3 - in all focus groups, 2 in two focus groups, 1 in one focus group
Interview - 3 in all interviews, 2, in two interview, 1 in one interview

Step 2: Prioritization of Community Health Needs Using Mission Criteria

The final prioritization process is based on recognizing the important role of JFK's mission and the ability to impact community health needs. The mission rating criteria included: (a) core

relationship to mission (b) continuation of a 2013 priority (c) significant disparity with benchmark comparisons (d) identified as top health concern via the JFKMC and JRI-CHNA questionnaire findings and (e) appropriate for both JFKMC and JRI populations. All 29 of the health needs identified by the community (See Table 20) are categorized and prioritized by the above mission rating criteria.

Based on the systematic delineation and rating of community health needs, the final selection of Priority Needs for JFKMC and JRI are presented:

Table 20: Prioritized and Categorized Community Health Needs

	Core to MISSION		**SHARED PARTNERSHIP**		**ENVIRONMENTAL / COMPLEX**
C1	Parking – issue indicated by community ranking, perceived concern, focus groups and key informant interviews	P1	Mental/Behavioral health - mental health Provider rate	E1	Transportation – issue indicated by community ranking, perceived concern, focus groups and key informant interviews
C2	Community outreach (community presence and engagement with other organizations)	P2	Obesity rates (percentage for Adults (20+))	E2	Access to care – availability of care for all populations (primary care provider rate)
C3	Diabetes (rate in Medicare population)	P3	Substance abuse (% alcohol impaired driving deaths, opioid use - community survey)	E3	Affordability of care for uninsured or under insured (% adults with health insurance)
C4	Access and availability of Community Wellness Events	P4	HIV/AIDS (prevalence rate)	E4	Vulnerable population - wheelchair bound / disabled appropriate facilities (% with disability in poverty)
C5	Cardiac/Heart disease - % of Medicare population	P5	Knowledge sharing – indicated by focus groups as communication gap	E5	Healthy environment (lead, unsafe drinking water, and food safety)
C6	Cancer (age-adjusted death rate – breast cancer, Mammography screening in Medicare population)	P6	Arthritis – top health concern from community survey	E6	Linguistic isolation (% non-English speaking households)
C7	COPD – top health concern from community survey	P7	Caregiver support – identified as lacking by focus groups	E7	Health literacy (limited ability to understand basic health knowledge)

	Core to MISSION		SHARED PARTNERSHIP		ENVIRONMENTAL / COMPLEX
C8	Older adults – % of Medicare population with Alzheimer's/Dementia	P8	Physical activity – adults (20+) who are sedentary		
C9	Weight control for adults (20+) who are sedentary	P9	Tuberculosis rates – incidence rates in community population		
C10	Oral health – survey ranking of community issues				
C11	Rehabilitative care – survey ranking of community issues				
C12	Prenatal care - % of babies with low birth weight				
C13	Caregiver burnout/stress – training/relief - identified by focus groups				
C14	Language / Culture – sensitivity to differences in service delivery				

Step 3: Final Prioritization of Community Health Needs by Strategic Focus

The original 29 identified community health needs were first ranked by community relevance and importance, and secondly by using JFK mission criteria. The final prioritization step involved additional JFK strategic criteria: (a) relationship to existing programs, (b) the ability to make an impact within a reasonable time frame, (c) the financial and human resources required, and (d) whether there would be a measurable outcome to gauge improvement. The process also included a review of other community resources that might also be better suited to provide needed services or who were also providing similar services. (These organizations are listed in detail in Appendix E). These criteria were used to select the top community health needs priorities that align JFKMC and JRI's commitment to the community. The following JFK–CHNA Population Health Matrix shows the final community health needs priority areas placed under the three population health focus areas.

To further align the community health needs assessment process with JFKMC and JRI's commitment to the community, the following JFK–CHNA Population Health Matrix is presented.

Table 21: Population Health and Prioritized Community Health Needs

POPULATION HEALTH FOCUS #1: HEALTH PROMOTION and WELLNESS for all Populations
Goal: To improve access to primary care, and deliver preventive care opportunities for all JFK service area populations. "Highlight Health Promotion and Wellness initiatives".
Community Outreach/Awareness/Physician Availability
Physical Activity/Weight Control
POPULATION HEALTH FOCUS #2: DISEASE MANAGEMENT for all Populations
Goal: Implement targeted initiatives for at-risk populations that reflect a strategy of "Right Care, Right Place, Right Time".
Diabetes
Cancer/Mammography Screening
Cardiac/Heart Disease
POPULATION HEALTH FOCUS #3: CONTINUITY of CARE for Vulnerable Populations
Goal: Focus on maintaining and facilitating the continuity of care especially for vulnerable populations. "Make Every Health Issue a Priority".
Emergency Care
Prenatal Care
Rehabilitative Care

This analysis permitted JFKMC and JRI to also review additional needs and to identify available resources that would help address needed resources given some of the identified issues are outside the mission of JFKMC and JRI.

Identified Resources for Other Significant Health Needs

Located within the JFKMC and JRI service area, several community hospitals and medical centers also provide needed healthcare services. Primary acute care providers include: RWJ University Hospital, Saint Peter's University Hospital, Raritan Bay Medical Center, and Princeton Healthcare System. Together, these four healthcare providers provide an important resource for addressing community health needs. Also available are several examples of municipal entities that cover cities (Edison, New Brunswick, Metuchen) and multiple township/boroughs (Franklin, Milltown, Old Bridge, Perth Amboy) and others that cover resident health needs. Municipal resources also include local health departments and departments of Public Safety and Health, boards of social services and planning and various other wellness committees. In addition, many health coalitions also serve the JFK geographic area including the Middlesex County Wellness Coalition, Middlesex County Mayor's Council, Community Health Consortium for Central Jersey, Regional Disease Coalition, and the Central Jersey Health Consortium.

Finally, of particular note is the State of New Jersey's Department of Health's main population health initiative, NJHealth, which sponsors and funds major health promotion and disease prevention activities in collaboration with healthcare providers.

(See Appendices for an additional list of Community Health Resources. Note: List is not inclusive).

Conclusion

The JFKMC and JRI community health needs assessment process utilized a comprehensive set of primary and secondary data indicators to identify the health needs and quality of life the primary service population located in Middlesex, Union, and Somerset counties located in New Jersey. Primary data was obtained from 745 CHNA surveys completed by residents in addition to findings from local focus groups and key informants who represented the broad interests of the community. The prioritization of the identified health needs will guide the community health improvement efforts for both the JFK Medical Center and the Johnson Rehabilitation Institute. From this process, JFKMC and JRI will be outlining how they plan to address the most significant health needs as identified by the community in their Implementation Strategy.

APPENDIX A

Community Health Needs Assessment Survey

1) How would YOU describe your overall health?

❑ Excellent ❑Very Good ❑Good
❑Fair ❑Poor

2) Where do YOU go to for routine healthcare?

❑Physician's Office ❑Urgent Care Clinic
❑Health Department ❑Clinic in grocery / or drug store
❑Emergency Room ❑I do NOT receive routine healthcare
❑Other (Please list) _____

3) Are you able to visit a doctor when needed?

❑Yes ❑No

4) If you have NOT been able to visit a doctor when needed, please indicate the reason:

❑No appointment available ❑Language barriers / could not communicate
❑Cannot afford it ❑No transportation
❑Cannot take time off from work ❑No specialist in my community for my condition
❑Other (Please list) _____

5) What type of healthcare coverage do you have?

❑Medicare
❑Medicaid
❑Commercial Health Insurance (Aetna, Cigna, Horizon Blue Cross)

❑Other [ ]

6) Please select the TOP 3 Health Challenges that you face. Select only the top 3, the rest just list as Not as Important.

	Top Health Challenge	2nd Important Health Challenge	3rd Important Health Challenge	Not as Important
Asthma	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑
Cancer	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
Overweight / Obesity	❑	❑	❑	❑
Lung Disease / COPD	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
HIV / AIDS	❑	❑	❑	❑
Stroke	❑	❑	❑	❑
Heart disease	❑	❑	❑	❑
Joint pain / back pain	❑	❑	❑	❑
Mental health issue	❑	❑	❑	❑
Alcohol overuse	❑	❑	❑	❑
Drug addiction	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑
I don't have any health challenges	❑	❑	❑	❑
Other (Please list) [ ]	❑	❑	❑	❑

7) Please choose ALL statements below that apply to YOU.

	Yes	No
I exercise at least 3 times per week.	❑	❑
I eat at least 5 servings of fruits and vegetables each day.	❑	❑
I eat fast food more than once per week.	❑	❑
I smoke cigarettes.	❑	❑
I chew tobacco.	❑	❑
I use illegal drugs.	❑	❑
I abuse or overuse prescription drugs.	❑	❑
I consume more than 4 alcoholic drinks (if female) or 5 (if male) per day.	❑	❑
I use sunscreen or protective clothing for planned time in the sun.	❑	❑

I receive a flu shot each year.	❑	❑
I have access to a wellness program through my employer.	❑	❑
None of the above apply to me.	❑	❑

8) Which of the following preventative procedures have you had in the past 12 months?

	Yes	No
Monogram (if woman)	❑	❑
Pap smear (if woman)	❑	❑
Prostate cancer screening (if man)	❑	❑
Flu shot	❑	❑
Colon / rectal exam	❑	❑
Blood pressure check	❑	❑
Skin cancer screening	❑	❑
Cholesterol screening	❑	❑
Vision screening	❑	❑
Hearing screening	❑	❑
Cardiovascular screening	❑	❑
Bone density test	❑	❑
Dental cleaning / x-rays	❑	❑
Physical exam	❑	❑
None of the above	❑	❑

9) Please help us prioritize by importance all of these potential community health issues.

	Most Important	Important	Not Important
Access to Quality Health Services	❑	❑	❑
Cancer	❑	❑	❑
Diabetes	❑	❑	❑
Health Prevention Programs (Smoking Cessation)	❑	❑	❑
Heart Disease and Stroke	❑	❑	❑
Respiratory Disease (COPD / Asthma)	❑	❑	❑
Communicable Disease - HIV / AIDS	❑	❑	❑
Family - Family Planning	❑	❑	❑
Healthy Environment	❑	❑	❑
Maternal / Child Health - Low Birth weight	❑	❑	❑
Mental Health	❑	❑	❑
Nutrition- Access, Availability, Weight Control	❑	❑	❑

Older Adults- Aging Alone / Alzheimer's	❑	❑	❑
Oral Health - Availability	❑	❑	❑
Substance Abuse and Misuses - Alcohol / Drugs/ Poisoning	❑	❑	❑
Wellness and Lifestyle Opportunities - Activity	❑	❑	❑
Other (Please list)	❑	❑	❑

10) What did YOU see as the greatest community health concern for JFK?

11) What do YOU see as the greatest community strength for JFK?

12) Below is the list of prioritized JFK Health Needs from 2013. Please indicate your current rating.

	Much Improved	Improved	Not Improved
Emergency Care Services	❑	❑	❑
Weight Control Programs	❑	❑	❑
Physical Activity Programs	❑	❑	❑
Mammography Screening	❑	❑	❑
Diabetes Screening	❑	❑	❑
Low Birth weight	❑	❑	❑

13) How you ever been admitted to a JFK Medical Center hospital?

❑JFK Medical Center ❑JFK Robert Wood Johnson Jr. Rehabilitation Institute

14) What is your gender?

❑Female ❑Male

15) What is your county of Residence?

❑Middlesex ❑Union ❑Somerset ❑Other

16) What is your 5 digit zip code? (Example 08818)

17) What is your age? (Example 32)

18) What is your preferred language?

19) What is your race?

- ❑African American / Black
- ❑Caucasian / White
- ❑Caucasian / Latino
- ❑Asian
- ❑South Asian
- ❑American Indian / Alaska Native
- ❑Native Hawaiian / Pacific Islander
- ❑Other (Please list)

20) What is your current employment status?

- ❑Employed full-time
- ❑Employed part-time
- ❑Student
- ❑Homemaker
- ❑Unemployed
- ❑Disabled
- ❑Retired

21) What is your household income?

- ❑$0 - $24,999
- ❑$25,000 - $49,000
- ❑$50,000 - $74,000

Data Summary for: *JFK - Community Health Needs Assessment Survey #7039*

Number of responses:

- 745 valid response(s)

1. How would YOU describe your overall health?

	N	*Percent*
Excellent	105	14.1%
Very good	209	28.1%
Good	284	38.1%
Fair	110	14.8%
Poor	24	3.2%

Note: This is a multi-choice element so the percentages may add up to more than 100%

2. Where do YOU go for routine healthcare?

	N	*Percent*
Physician's Office	568	76.2%
Health Department	26	3.5%
Emergency Room	18	2.4%
Urgent Care Clinic	27	3.6%
Clinic in grocery/or drug store	2	0.3%
I do NOT receive routine healthcare	29	3.9%
Other (Please list)	70	9.4%

Note: This is a multi-choice element so the percentages may add up to more than 100%

Frequency	Text
31	JFK FAMILY MEDICINE CENTER
7	JFK MEDICAL CENTER
4	JFK
3	JFK FAMILY MEDICAL PRACTICE
2	FAMILY PRACTICE
2	JFK FAMILY MEDICINE PRACTICE
2	JFK Family Practice
1	AVENAL ISLIC MEDICAL

1	CARDIOLOGIST
1	HOSPITAL
1	JFK FAMILT MEDICINE PRACTICE
1	JFK FAMILY CARE
1	JFK FAMILY MEDICINE
1	JFK FAMILY PRACTICE CENTER
1	LLMD
1	NEVER BEEN TO ONE
1	Plainfield Health Center
1	RUTGERS UBJC
1	Satelitte JFK Plainfield Health Center
1	V.A.
1	V.A. East Orange
1	VA HOSPITAL
1	whichever is necessary

3. Are you able to visit a doctor when needed?

	N	*Percent*	
Yes	691	92.8%	
No	40	5.4%	

Note: This is a multi-choice element so the percentages may add up to more than 100%

4. If you have NOT been able to visit a doctor when needed, please indicate the reason:

	N	*Percent*	
No appointment available	102	13.7%	
Cannot afford it	50	6.7%	
Cannot take time off from work	47	6.3%	
Language barriers/could not communicate	2	0.3%	
No transportation	22	3.0%	
No specialist in my community for my condition	6	0.8%	
Other: Please list	50	6.7%	

Note: This is a multi-choice element so the percentages may add up to more than 100%

Frequency	Text
7	N/A

4	No insurance
2	NONE
2	WHEEL CHAIR BOUND
1	AVAILABILITY OF SCHEDULE
1	CANNOT TAKE OFF FROM SCHOOL
1	car broken
1	DIDN´T HAVE INSURANCE PREVIOUSLY
1	DIDN´T NEED TO SEE A DOCTOR
1	DIFFICULTY FINDING & MAKING APPOINTMENTS
1	DO NOT ACCEPT INSURANCE
1	Do not have insurance.
1	FAMILY MEMBERS PROVIDE ME HELP
1	FULL TIME FATHER
1	I DON´T NEED AN APPOINTMENT
1	I´VE BEEN HELPED.
1	INSURANCE - ¨OUT OF NETWORK¨
1	Insurance limitations
1	JFK
1	limited ins. doctors
1	MY HEALTH IS GOOD - DO NOT NEED TO SEE A DOCTOR
1	No call back.
1	NO COMPLAINTS
1	NO REASON
1	NO SPECIALIST WILL ACCEPT MEDICAID
1	NOAPPOINTMENT NEEDED
1	OFFICE CLOSED FOR HOILDAY WEEKEND - BACKUP DOCTOR CALLED ME ONCE BUT THEN DIDN´T HEAR FROM HER AGAIN
1	TOO MANY APPOINTMENTS TO MAKE & KEEP MY 3 KIDS.
1	WAIT - HOPEFULLY IT GOES AWAY
1	WHEN IT IS CLOSED
1	WHEN THE OFFICE IS CLOSED ON THE WEEKEND

5. What type of healthcare coverage do you have?

	N	*Percent*	
Medicare	242	32.5%	

Medicaid	225 30.2%	
Commercial Health Insurance (Examples: Aetna, Cigna, Horizon Blue Cross, etc.)	279 37.4%	
Other (please list)	132 17.7%	

Note: This is a multi-choice element so the percentages may add up to more than 100%

Frequency	Text
42	Uninsured
8	CHARITY CARE
3	AARP supplement
3	AARP united health care
3	NJ FAMILY CARE
3	UNITED HEALTH
3	UNITED HEALTHCARE
2	AARP
2	AMERIGROUP
2	HORIZON
2	NJ HORIZON
2	OBAMA CARE
2	Qualcare
1	AARP HEALTHCARE
1	AARP MEDICARE COMPLETE
1	AETNA- BETTER HEALTH
1	AMERI HEALTH
1	american progressive
1	AMERIHEALTH 65
1	ANTHEM BCBS
1	BASIC OCCUPATIONAL COVERAGE
1	BCBS SUPPLEMENTAL
1	Blue Cross Blue Shield
1	Blue Cross GHI
1	CASH PAYMENT
1	CHARITY
1	CHILD CARE
1	FAMILY CARE

1	GEHA
1	GHA
1	horizon blue cross
1	horizon blue cross blue shield
1	HORIZON NJ HEALTH
1	JFK FAMILY CENTER
1	MAGNACARE
1	NJ FAMILY CARE / UNITED
1	NJ HEALTH
1	NJ HEALTH CARE
1	NONE
1	NYSHIP
1	OBAMACARE
1	OSCAR HEALTH INSURANCE
1	private insurance through work
1	QUAL CARE
1	SECINDARY INSURANCE
1	SECONDARY
1	SUPPLEMENT
1	supplemental: united health care
1	TRICARE
1	tricare for life
1	UNINSURED & VA VETERANS
1	UNITED AMERICIAN
1	UNITED HEALTH CARE
1	UNITED HEALTH CARE AARP
1	UNITED HEALTH- SUPPLEMENT
1	UNITED HEALTHCARE & BCBS OF MICHIGAN
1	UNITED HEALTHCARE / SUPPLEMENT
1	UNITED HEALTHCARE PLAN - AARP PLAN F
1	UNITED HEALTHCARE VIA AT&T
1	US Healthcare
1	V.A.

6. Please select the TOP 3 Health Challenges that you face. Select only the top 3, the rest just list as Not as Important

	Top Health Challenge	*2nd Important Health Challenge*	*3rd Important Health Challenge*	*Not as Important*
Asthma	4.8% 36	3.6% 27	1.9% 14	75.4% 562
Arthritis	8.2% 61	4.6% 34	3.8% 28	71.3% 531
Cancer	5.8% 43	2.7% 20	0.8% 6	77.2% 575
Diabetes	12.1% 90	2.1% 16	2.7% 20	69.1% 515
Overweight/Obesity	16.2% 121	5.8% 43	4.0% 30	61.7% 460
Lung Disease/COPD	2.6% 19	1.2% 9	1.2% 9	80.5% 600
High blood pressure	16.2% 121	6.0% 45	3.6% 27	63.2% 471
HIV/AIDS	0.8% 6	0.4% 3	0.1% 1	83.9% 625
Stroke	2.3% 17	0.9% 7	0.3% 2	82.0% 611
Heart disease	5.5% 41	2.4% 18	1.9% 14	76.5% 570
Joint pain/ back pain	15.0% 112	7.2% 54	3.9% 29	63.0% 469
Mental health issues	4.4% 33	2.0% 15	1.9% 14	77.6% 578
Alcohol overuse	0.9% 7	0.4% 3	0.3% 2	83.4% 621
Drug addiction	0.8% 6	0.5% 4	0.1% 1	83.6% 623
Tuberculosis	0.3% 2	0.4% 3	0.3% 2	83.8% 624
I do not have any health challenges	15.7% 117	1.5% 11	1.2% 9	11.0% 82
Other (please list)	8.2% 61	1.6% 12	1.1% 8	1.1% 8

Note: These are multi-choice questions so the percentages may add up to more than 100%

Frequency	Text
4	CHOLESTEROL
3	EPILEPSY
3	lupus
3	MIGRAINES
2	High cholesterol
2	ULCERATIVE COLITIS
1	ABDOMEN PAIN
1	Allergies
1	ALLERGY
1	ANEMIA
1	ANXIETY
1	ASSBERGERS
1	BLINDNESS
1	cholesterol problem
1	CHOLESTEROL, TAKE CRESTOR - UNDER CONTROL
1	COLITIS
1	diastasis recti
1	DIZZY
1	DUT / ULCERATIVE, COLITIS
1	each problem under control with meds
1	EATING HEALTHY
1	EMPHUSENA
1	EPILAPSY
1	eye problems - allergy
1	FAINTING, TMJ DISORDER
1	FIBROMYALBIA
1	FIBROMYGALGIA
1	GRAVE DISEASE
1	GRAVES DISEASE, HERNIA
1	HEPA B

1	HIGH LIVER ENZIMES & LEG PAINS (CRAMPS)
1	HYPOTHYROID
1	Infertility
1	kidney
1	KIDNEY STONES
1	M5
1	Ménière´s disease
1	MIGRANES
1	MILD VERTIGO
1	MULTI-HANDICAPPED
1	N/A
1	neurofibromatosis
1	NEUROLOGY / BRAIN
1	NEUROPATHY PAIN
1	OSTEOPORSIS
1	OSTEPOROSIS
1	overactive bladder
1	PARKINSONS
1	PCOS
1	pelvic
1	PMS
1	POLYP
1	PREGNANCY
1	PROSTATE
1	RIGHT HAND PAIN DUE TO SCAR TISSUE.
1	SEIZURE
1	Smoking
1	STRESS
1	THYROID
1	THYROID DISEASE
1	THYROID PAINS
1	Thyroid/PCOS
1	trach
1	ULCER / COLLITIS
1	vein problem in leg

1	VERTIGO, MENIERELS, TIMTIO
1	WALKING
1	weakness

7. Please choose ALL statements below that apply to YOU.

	YES	*NO*
I exercise at least 3 times per week.	48.2% 359	49.9% 372
I eat at least 5 servings of fruits and vegetables each day.	45.4% 338	52.8% 393
I eat fast food more than once per week.	24.8% 185	72.9% 543
I smoke cigarettes.	9.3% 69	88.1% 656
I chew tobacco.	0.3% 2	97.0% 723
I use illegal drugs	1.3% 10	95.8% 714
I abuse or overuse prescription drugs.	0.5% 4	96.6% 720
I consume more than 4 alcoholic drinks (if female) or 5 (if male) per day.	1.6% 12	95.7% 713
I use sunscreen or protective clothing for planned time in the sun.	54.2% 404	43.5% 324
I receive a flu shot each year.	57.3% 427	41.3% 308
I have access to a wellness program through my employer.	11.7% 87	83.4% 621
None of the above apply to me.	1.5% 11	3.6% 27

Note: These are multi-choice questions so the percentages may add up to more than 100%

Click here to see a list of '*Other*' items.

8. Which of the following preventive procedures have you had in the past 12 months?

	YES	*NO*
Mammogram (if woman)	30.3% 226	42.7% 318
Pap smear (if woman)	36.0% 268	36.1% 269
Prostate cancer screening (if man)	4.4% 33	19.7% 147
Flu shot	53.8% 401	43.4% 323
Colon/rectal exam	14.9% 111	79.5% 592
Blood pressure check	71.3% 531	25.6% 191
Blood sugar check	2.3% 17	3.6% 27
Skin cancer screening	13.2% 98	81.6% 608
Cholesterol screening	45.5% 339	50.6% 377
Vision screening	52.5% 391	44.0% 328
Hearing screening	20.9% 156	74.2% 553
Cardiovascular screening	22.4% 167	72.3% 539
Bone density test	13.7% 102	80.8% 602
Dental cleaning/x-rays	52.3% 390	44.3% 330
Physical exam	63.9% 476	32.6% 243
None of the above	4.2% 31	2.0% 15

Note: These are multi-choice questions so the percentages may add up to more than 100%

9. Please help us prioritize by importance all of these potential community health issues.

	Most Important	*Important*	*Not Important*	*Missing*
Access to Quality Health Services	58.6% 426	15.7% 114	25.7% 187	*2.4%* *18.0*
Cancer	41.5% 299	24.9% 179	33.6% 242	*3.4%* *25.0*
Diabetes	39.2% 283	27.7% 200	33.1% 239	*3.1%* *23.0*
Health Prevention Programs (Smoking Cessation)	20.4% 147	29.9% 215	49.7% 357	*3.5%* *26.0*
Heart Disease and Stroke	40.4% 291	23.3% 168	36.3% 262	*3.2%* *24.0*
Respiratory Disease (COPD/Asthma)	27.4% 197	29.9% 215	42.6% 306	*3.6%* *27.0*
Communicable Disease - HIV/AIDS	24.1% 173	25.1% 180	50.8% 365	*3.6%* *27.0*
Family - Family Planning	19.3% 138	29.5% 211	51.2% 366	*4.0%* *30.0*
Healthy Environment	30.1% 216	29.5% 212	40.4% 290	*3.6%* *27.0*
Maternal/ Child Health - Low Birthweight	23.2% 166	26.4% 189	50.5% 362	*3.8%* *28.0*
Mental Health	36.8% 265	23.0% 166	40.2% 290	*3.2%* *24.0*
Nutrition - Access, Availability, Weight Control	31.6% 228	31.2% 225	37.2% 268	*3.2%* *24.0*
Older Adults - Aging Alone/ Alzheimer's	31.1% 224	26.7% 192	42.2% 304	*3.4%* *25.0*
Oral Health - Availability	31.7% 227	29.5% 211	38.8% 278	*3.9%* *29.0*
Substance Abuse and Misuses - Alcohol/ Drugs/ Poisoning	22.6% 162	26.1% 187	51.3% 368	*3.8%* *28.0*
Wellness and Lifestyle Activity	26.2% 187	33.7% 240	40.1% 286	*4.3%* *32.0*
Other	21.7% 5	21.7% 5	56.5% 13	*96.9%* *722.0*

Percentages in the table are valid percent.

10. What do YOU see as the greatest community health concern for JFK Medical Center?*

This element has 229 text response(s).

*Contact SCCPH for a copy of this information. Anne.Hewitt@shu.edu

11. What do YOU see as the greatest community strength for the JFK Medical Center?*
This element has 215 text response(s).

*Contact SCCPH for a copy of this information. Anne.Hewitt@shu.edu

12. During 2013, JFK Medical Center completed its first Community Health Needs Assessment and identified 6 main health priorities. Please indicate if you think we have IMPROVED health in these 6 areas over the last 3 years.

	Much Improved	*Improved*	*Not Improved*	*Missing*
Emergency Care Services	42.1% 212	37.1% 187	20.8% 105	*32.3%* *241.0*
Weight Control Programs	15.4% 74	41.0% 197	43.5% 209	*35.6%* *265.0*
Physical Activity Programs	18.5% 89	38.9% 187	42.6% 205	*35.4%* *264.0*
Mammography Screening	27.8% 135	35.2% 171	37.0% 180	*34.8%* *259.0*
Diabetes Screening	22.2% 105	37.9% 179	39.8% 188	*36.6%* *273.0*
Low Birth weight	15.8% 71	32.9% 148	51.3% 231	*39.6%* *295.0*

Percentages in the table are valid percent.

13. Have you ever been admitted to a JFK Medical Center hospital?

	N	*Percent*	
JFK Medical Center	384	51.5%	
JFK Robert Wood Johnson Jr. Rehabilitation Institute	46	6.2%	

Note: This is a multi-choice element so the percentages may add up to more than 100%

14. What is your gender?

	N	*Percent*	
Female	524	70.3%	
Male	142	19.1%	

Other	0	0.0%	

Note: This is a multi-choice element so the percentages may add up to more than 100%

15. What is your county of Residence?

	N	*Percent*	
Middlesex	477	64.0%	
Union	110	14.8%	
Somerset	25	3.4%	
Other	54	7.2%	

Note: This is a multi-choice element so the percentages may add up to more than 100%

16. What is your 5 digit zip code (Example 08818)

This element has 646 numeric responses.

17. What is your age? (Example - 32)
This element has 642 numeric response(s)

Mean:	48.5109

18. What is your preferred language?*
This element has 651 text response(s).

*Contact SCCPH for a copy of this information. Anne.Hewitt@shu.edu

19. What is your race?

	N	*Percent*	
African American/Black	133	17.9%	
Caucasian/White	300	40.3%	
Caucasian/Latino	90	12.1%	
Asian	79	10.6%	
South Asian	22	3.0%	
American Indian/ Alaska Native	5	0.7%	
Native Hawaiian/ Pacific Islander	4	0.5%	
Other - Please list	25	3.4%	

Note: This is a multi-choice element so the percentages may add up to more than 100%

Frequency	Text
3	Hispanic
2	Mixed
2	SOUTH AMERICAN
1	COLORED / ITALIAN
1	INDIAN
1	JEWISHA SHERAZI
1	LIBERIAN AFRICAN
1	MALLATO
1	MIDDLE EAST
1	not necessary
1	PREFER NOTTOANSEUER
1	PUERTO RICAN / HAITIAN
1	TWO OR MORE
1	WEST INDIAN
1	White Hispanic

20. What is your current employment status?

	N	*Percent*	
Employed full-time?	143	19.2%	
Employed part-time	119	16.0%	
Student	95	12.8%	
Homemaker	36	4.8%	
Unemployed	92	12.3%	
Disabled	46	6.2%	
Retired	172	23.1%	

Note: This is a multi-choice element so the percentages may add up to more than 100%

21. What is your household income range?

	N	*Percent*	*Valid Percent*	
$0-$24,999	191	25.6%	26.7%	
$25,000-$49,999	107	14.4%	14.9%	
$50,000-$74,999	57	7.7%	8.0%	
$75,000- $99,999	28	3.8%	3.9%	

$100,000 or more	40	5.4%	5.6%	
Prefer not to answer	293	39.3%	40.9%	
Missing	*29*	*3.9%*		

22. What is the highest level of education you have completed?

	N	*Percent*	
Some high school	48	6.4%	
High school graduate	199	26.7%	
Some college	205	27.5%	
College graduate	194	26.0%	

Note: This is a multi-choice element so the percentages may add up to more than 100%

23. What could JFK Medical Center do to better meet the health needs of our community?*

This element has 201 text response(s).

*Contact SCCPH for a copy of this information. Anne.Hewitt@shu.edu

APPENDIX B

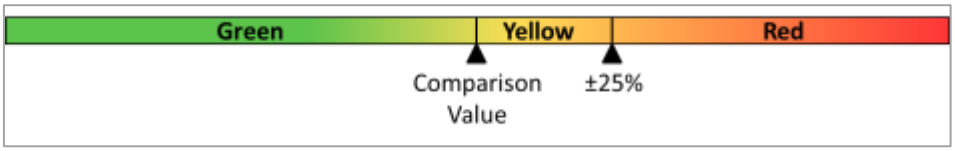
Secondary Data Analysis Protocol

SCORING METHOD (Standard Example)

Indicators are categorized into 21 topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the state and national comparisons of all indicators within the topic. Each indicator is assigned a number of points according to its comparisons. A comparison in the red portion of the gauge accumulates 2 points, yellow accumulates 1 point, and green accumulates 0 points.

Education Indicator	Illinois Comparison Gauge	Illinois Comparison Points	National Comparison Gauge	National Comparison Points	Total Points
High School Graduation		2			2
People 25+ with a Bachelor's Degree or Higher		1		1	2
People 25+ with a High School Degree or Higher		1		0	1
Student-to-Teacher Ratio		2		2	4

If a county distribution is not available and the value must be compared to a state or national value, the comparison is considered green if better than the comparison, red if worse by more than 25% of the comparison value, and yellow if in-between.



If there is no US county distribution or US value available for comparison, a comparison to a Healthy People 2020 target is substituted in for a national comparison if a target that matches the indicator definition exists. Because this comparison is to a target rather than a measured value, the maximum number of points accumulated by this type of comparison is one (if target is not met).

The sum of all points within the topic is divided by the possible number of points to calculate the score. The score has a range of 0-1, where a higher score indicates greater need according to secondary data.

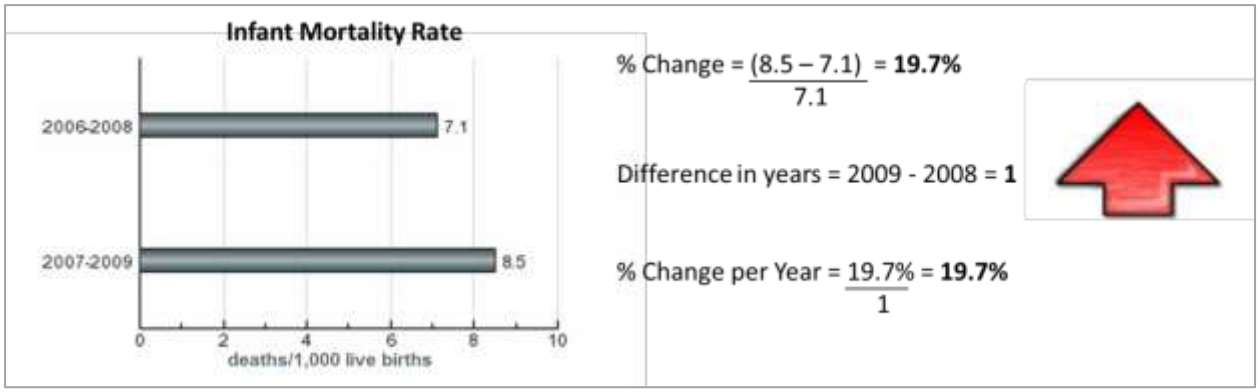
Education Indicator	State Comparison Points	National Comparison Points	Total Points	Possible Points
High School Graduation	2		2	2
People 25+ with a Bachelor's Degree or Higher	1	1	2	4
People 25+ with a High School Degree or Higher	1	0	1	4
Student-to-Teacher Ratio	2	2	4	4
Total for Topic	**6**	**3**	**9**	**14**

(9 points / 14 possible) = 0.64

TREND

A comparison of the most recent value to a previous value allows for the identification of poor trends in Vermilion County. If the confidence intervals of the two values overlap, the change over time is not considered statistically significant. For indicators with no available confidence intervals, the magnitude of the trend was utilized to identify poor trends. If an indicator value worsened by at least 5% per year, the trend is highlighted as being poor.

In this example, the indicator worsened by 19.7% per year, and therefore meets the cutoff to be highlighted as a poor trend:



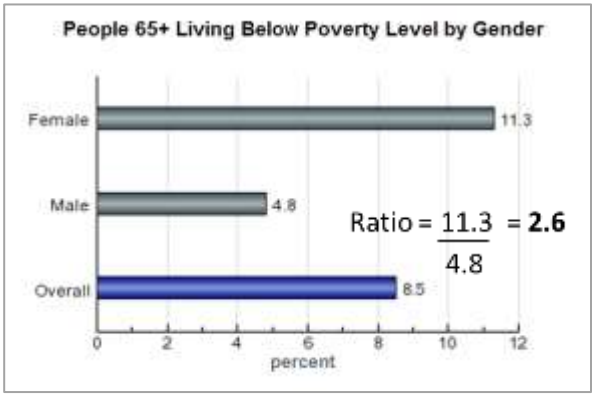
HEALTHY PEOPLE 2020

Healthy People 2020 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. If a Healthy People 2020 goal matches an indicator definition, findings note if Vermilion County has not met the target.

DISPARITIES

To identify indicators with the largest disparities by age, gender, or race/ethnicity, ratios were calculated between the highest and lowest sub-population values. Indicators with a disparity ratio of two or higher are highlighted as having a large disparity. The availability of sub-population data varies by source and indicator.

For this indicator, the disparity by gender would be highlighted in findings because the ratio between gender-specific values is greater than two.



DATA SOURCES AND INDICATORS

This table lists all indicators by topic area, with the most recent value for any County and comparison findings. All geographic comparisons are made to a distribution of county values, unless noted by an asterisk (*), which indicates a comparison to a state or national value. If data was not available for a comparison the cell is left blank. HP2020 targets are noted as met or not met. Trends and disparities are only noted if they met the cutoffs previously described.

APPENDIX C

Organizations Providing Community Input

JFK Community Health Needs Assessment – Partners / Events Attended

1. Focus Group Attendees:

Municipal Stakeholders:

Edison Senior Services, Edison Health Department, Middlesex County Office of Planning, Borough of Metuchen Business Administrator, South Plainfield Mayor's Wellness Committee, Middlesex County Regional Chronic Disease Coordinator, Middlesex County Health Educators, and Middlesex County Interns.

Edison Stakeholders:

Edison Greenways Group Inc. and YMCA of Metuchen, Edison, and Woodbridge

Hospital Departments:

Volunteer Services, Quality & Accreditation, Diagnostic Imaging, Neuroscience, Endocrinology , C.C.U., JFK @ Home , Rehabilitation, Center For Behavioral Health, Fitness, Admitting, , Nuclear Medicine, Materials Management, Accounts Payable, Bariatric Surgery, Nursing, Health Information Services, MRI Center, Nursing Administration, Hospitality Services, Diagnostic Imagining , Case Management, Social Work , and Breast Surgery Associates.

Plainfield Stakeholders:

Plainfield Health Coalition

2. Survey Distribution:

Edison Senior Services, Lincoln Technical Institute Iselin Campus (LPN Nursing Students), Plainfield Health Connections Program (Run through JFK Health) , JFK Health Family Medicine Center, Radiation Oncology Department, JFK Medical Center Outpatient Waiting Room, JFK Health Volunteer Services,

3. Health Fairs/ Meetings Attended:

Hands of Hope, Edison Family Day, Metuchen Library, the BAPS Temple Health Fair, Middlesex County Faith Health Initiative Conference, Community Health Consortium for Central Jersey, Middlesex County Wellness Council

4. Key Informant Interviews:

JFK Johnson Rehabilitation Institute – Rehabilitation Client Services Manager, Municipal Health Officer

APPENDIX D – Authors

Authors:

Seton Center for Community and Population Health.
Anne M. Hewitt, Ph.D., Director

The Seton Center for Community and Population Health (SCCPH) was established in 2004 as an academic resource for collaboration, learning and research to enhance the quality of life for individuals and communities in need. The center is located in the Department of Interprofessional Health Sciences and Health Administration in the School of Health and Medical Sciences and provides technical assistance to community health agencies focused on improving the health status of New Jersey residents.

The center follows a partnership approach that facilitates linkages with community stakeholders, healthcare providers and graduate students. Since its inception, the center has collaborated with eight different community agencies and involved graduate students from the Master of Healthcare Administration (M.H.A.) and other health-related SHU graduate programs. The Center has successfully developed and completed strategic plans, marketing frameworks, agency needs assessments, and commmunity program evaluations. The SCCPH serves as an academic link and resource to local and regional non-profit, health service agencies.

Anne M. Hewitt, Ph.D.

Anne M. Hewitt, PhD is Program Director for the Masters in Healthcare Administration (MHA) and Associate Professor at Seton Hall University. Dr. Hewitt also serves as Director of the Seton Center for Community and Population Health. She received a dissertation grant from the American Lung Association while completing her PHD from Temple University, and has been awarded additional grants from federal and state agencies and national non-profit foundations. She was previously selected as a RWJ Foundation Community-Campus Health Fellow She has numerous publications, participates as a peer reviewer for several health journals, and serves on state nonprofit and public health advisory boards. Dr. Hewitt also provides expert commentary on health issues via social and traditional communication channels. Her research interests focus on community health needs assessments, population health models and health professions education including online pedagogy. She is a member of Upsilon Phi Delta, Kappa Omicron Phi, and Sigma Beta Delta honor societies.

Nalin Johri, Ph.D., MPH

Nalin Johri, Ph.D., MPH is Assistant Professor in the Masters in Healthcare Administration program/ Dept. of Interprofessional Health Sciences and Healthcare Administration/ School of Health and Medical Sciences at Seton Hall University and teaches several courses, including Research Methods, Healthcare Economics, Healthcare Policy, Financial Management and Strategic Planning and Marketing. Dr. Johri's work experience includes program development, monitoring and evaluation experience on maternal and child health and nutrition and prevention of mother-to-child transmission of HIV and spans over 10 years with NGOs such as CARE and EngenderHealth, Francois-Xavier Bagnoud Center at the University of Medicine and Dentistry of New Jersey as well as consulting with UNICEF and until April 2013 he was the Impact Evaluation Advisor for USAID's Palestinian Health Sector Reform Project.

APPENDIX E

Community Resources

The following resources available to Middlesex and Union county residents were identified by key informants during interviews or by the decision-making team during the prioritization process.

Population Health Focus #1 – Health Promotion and Wellness for All Populations
CATCH (Coordinated Approach to Child Health)
Chamber of Commerce (Service Area Representatives
Edison Greenways Group
Faith-Based (St. James Episcopal, St. Paul's Evangelical Lutheran, Holy Redeemer, BAPS (Indian Hindu Temple) Congregation Beth-El, First Chinese Baptist Church of Edison, Community Presbyterian Church of Edison, (selected examples)
Muhlenberg School of Nursing
Plainfield Health Coalition
Plainfield Connections Programs/ Local Health School Liaisons
Sustainable Jersey for Schools
YMCA(s) of Metuchen, Edison and Woodbridge

Population Health Focus #2 – Disease Management for All Populations
Bright Star (Home Healthcare Services)
Community Surgical
Horizon Blue Cross Blue Shield
Instacare (In-home Healthcare, personal senior care)
Ocean Healthcare (Serves all areas of care)
VNA of Central Jersey

Population Health Focus #3 – Continuity of Care for Vulnerable Populations
Division of Family Health Services
Edison Senior Citizens
Edison Job Corps
Hands of Hope
Hartwyck at Edison Estates/Oak Tree
Iris House
Meals on Wheels (Metuchen, Edison, Woodbridge
Metuchen Library
New Jersey Division of Vocational Rehabilitation
Metuchen Library
Ontime Transport
Puerto Rican Action Board
Rutgers NJ- SNAP
South Plainfield Senior Center
Special Child and Early Intervention Services