# University Hospital

# Community Health Needs Assessment

# FY 2014

Prepared by

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Newark New Jersey is the State's largest city.  In striving to identify and address Newark's most pressing health care needs and to position University Hospital (UH) to optimally address them, a Community Health Needs Assessment was developed.  It is evident that the residents of Newark and surrounding areas face challenges unlike most other cities in the state of New Jersey.

This report, an assessment of our area's healthcare profile, includes review of public health data, analysis of claims data, patient needs information from care providers, data obtained by means of focus groups, and a community needs assessment completed by the Greater Newark Health Care Coalition. Relevant factors that limit access to healthcare include socio-economic variations, adequacy of health insurance coverage, and language. Poverty, high mortality and morbidity rates, barriers to accessing healthcare and homelessness are some of the key indicators of a community that is clearly in crisis. These findings are not new as the problems have existed in Newark for some time.

University Hospital has cared for the indigent, sick, and injured since 1882 and in 2013 is the largest provider of charity care in the state.  This needs assessment underscores the importance of strengthening collaboration with physicians, community agencies, political leaders, public health, religious leaders as well as other organizations so that improvement can be realized.

Key demographic facts impacting UH's Community Health Needs Assessment:

➢ Race & Ethnicity
  •Newark is predominantly comprised of ethnic/racial minorities (over half are African American and one third are Hispanic/Latino)
  •Approximately 30% of Newark's population is foreign born compared to 20% of New Jersey's population and 12% nationally. Of the 30%, 10% are naturalized citizens. The status of the remaining 20% is unknown, but can have significant implications on access to and payment for care.
  •Those that are not US citizens may be hesitant to seek care until conditions become acute for fear of discovery.

➢ Language
  •Almost one quarter of Newark residents indicated that they did not speak English very well. This percentage is nearly double that of statewide statistics

➢ Barriers to Preventive/Primary Care
  •Lack of health insurance coverage
  •Transportation problems
  •Inability to get an appointment due to lack of availability of providers
  •Lack of a telephone
  •Language barriers
  •Cost of care
  •Waiting time to see a provider

➢ Prenatal Care
  •56% of the women in Newark receive prenatal care compared to 75.8% statewide, and 83.9% nationally.

➢ Mortality Rates - Specifically related to heart disease, cancer and HIV
  •The rank of 19 for mortality and morbidity is striking and alarming as only two other counties have such poor outcomes/factors as Essex County.
  • Diseases of the Heart have the highest mortality rate in Essex County and Cancer is the second highest.

➢ Poverty/Median Household Income
  •Residents within the Newark zip codes have the lowest Median Household Incomes compared to the rest of the state. Main sources of income in Essex county are welfare, food stamps, Medicaid and Temporary Assistance for Needy Families.

➢ Unemployment
  •Trends from multiple sources demonstrate that Newark is consistently higher than state and national statistics for unemployment. As of September 2010, Newark's unemployment rate was 14.7% compared to a national average of 9.2%.
➢ Homelessness
  •2010 census of the homeless population indicates that almost 4,000 adults and children are homeless in Essex County with almost 90% of the sheltered and unsheltered homeless staying in the City of Newark.

It is well documented that there are many social and economic issues that plague the residents of Newark, many of which are beyond any one organization's control. What is within our grasp is the ability to form collaborative relationships with appropriate providers, organizations and the community in an effort to better meet the healthcare needs that have been identified through the Community Health Needs Assessment. The fact that many people in Newark are not connected to primary care is recognized as a major barrier to a healthier population. A high priority is to improve access to primary care and, when healthcare services are needed, to provide easy access to high quality, cost effective healthcare services.

UH Administration met to review and discuss the findings of the 2013 Community Health Needs Assessment. These results were validated through feedback solicited from our Patient Advisory Council; documented trends experienced by UH; and external resources, such as the Greater Newark Healthcare Coalition, and the Newark Department of Child and Family Well Being.

A grid was developed to prioritize the community needs, to identify those within the current scope of UH, and to identify key focus areas for 2013.  Plans were developed to address the top three initiatives.  These plans were reviewed and approved by the Board.

# UH 2013 Key Findings

| Health Care Need Category | Gap / Comments: | GNHCC Ranking | UH Ranking Top 5 | Population | Address Need Yes/No | If no, reason why. |
|---|---|---|---|---|---|---|
| 1. Heart Disease | Age adjusted mortality rate in Essex County is higher than Healthy People (HP) 2020 target. Rate of cardiovascular disease, heart attack, and diabetes among Newark residents is almost twice as high as Essex County Essex county residents repot higher cholesterol levels at a rate of three times higher than the HP 2020 target | 4 | 2 | All | YES | |
| 2. Cancer | Age adjusted rates for cancer deaths in Essex County are higher than Healthy People (HP) 2020 target. Mortality rates among blacks in Essex County were significantly higher than the rate county-wide The percent of women who had a pap smear in the last 3 years was 11.7% points below the HP 2020 target | 7 | | All | YES | |
| 3. Septicemia and Diabetes | Mortality rates for septicemia and diabetes were significantly higher in Essex County than statewide Blacks had significantly higher mortality rates than residents county-wide | 2 | | All | YES | |
| 4. Years of Potential Life Lost | Essex County residents had a higher rate of premature deaths than residents statewide and far worse than the county health ranking national benchmark | - | | All | Indirectly | |
| 5. Maternal and Child Health | Infant mortality rates are higher than the state The rates of low birth weight infants are higher than HP 2020 target and the state average The percentage of Essex County women receiving 1$^{st}$ trimester care is 8.6% points below HP 2020 target The percentage of women receiving no prenatal care is significantly higher than the statewide rate Teen births (15-19) are nearly double the county health ranking benchmark Primary C-section rates are significantly higher than the statewide rate | - | 5 | All infants<br><br>Females – OB/GYN | YES | |
| 6. Health and Behavioral Health Status and Prevention (see below) | Essex County residents report significantly more mentally and physically unhealthy days than the county health ranking benchmark Immunizations for flu & pneumonia are respectively 27.5% and 35.2% points lower than HP 2020 target Essex County adults reporting any physical activity in the last month is 7% point below the benchmark (Newark 10% below) | 1, 5, 9 | | All | See below | |
| Prevention Services | Prostate screenings | - | 1 | Males | YES | |
| | Screening Mammograms | | | All | YES | |
| | Pap Smears/GYN Exams | | | Females | YES | |
| | Colonoscopies | | | All; age approp. | YES | |
| | Eye Exams | | | All | YES | |
| | Blood Pressure Checks | | | All | YES | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Diabetes Screening | | | All | YES | |
| | | Immunizations | | | All | YES | |
| 7. | Substance Abuse and Mental Health | Tobacco use is 2.8% points higher than the HP 2020 target<br>Excessive drinking is reported 6% points higher than county health ranking benchmark<br>Admission rates for heroin / other opiods, cocaine, and other drugs are significantly higher than statewide rates | 1, 10 | 3 | All<br>Age approp. | Partially | |
| 8. | High Risk Sexual Behaviors | STD rates are significantly higher than the state rate<br>HIV / AIDS prevalence in Newark is twice the county rate (three times the state rate) | - | | All<br>Age approp. | YES | |
| 9. | Health Care Access | Lack of Primary Care Physicians (Essex County 99.7 / 100,000 versus the State 158.5 / 100,000)<br>19.1% of adults 18-64 report being without insurance coverage<br>Essex County ranks 3rd statewide in ED utilization<br>Adult ED visits for outpatient conditions in Essex County were significantly higher than statewide<br>Transportation to medical appointments<br>Delayed access due to provider shortages<br>Charity Care / Uninsured population<br>Cultural Diversity<br>Language<br>Literacy | 3, 6 | 1 | All<br>Low income<br>Immigrants | YES | |
| 10. | Physical Environment | Number of unhealthy are quality days is significantly higher than the county health ranking rate benchmark<br>The percentage of Essex County children with high blood lead levels is significantly higher than statewide<br>Ready access to fast food and liquor; limited access to recreation | 5, 8 | | All | Indirectly | Preventive services; patient education<br>Pediatrics – referred to RU – NJMS or community pediatrician |
| 11. | Social and Economic Factors | The percentage of Newark families receiving public assistance is two times the national average and three times that of NJ<br>16.5% of Essex County residents did not complete HS | - | | All | NO | Increased focus on financial counseling to ensure patients are enrolled in any applicable programs |
| 12. | Violence & Injury Prevention | Violent crime rate is two times the state rate and ten times the national benchmark<br>The homicide rate is three times the state rate | - | | All | YES | |

**2013 UH - Community Health Needs Implementation Strategy**

**Priority 1:** Health Care Access / Preventive Services

**Problem:** Patients present to the ED for treatment with conditions that can be treated in an outpatient setting; patients present for treatment with a higher acuity/severity level due to the delay in seeking care

| Strategy/Program | Long Term Goal | Target Population | Key Performance Indicators | Target 2014 | Responsible Party(ies) | Baseline FY13 | Status at close FY14 |
|---|---|---|---|---|---|---|---|
| **Patient navigators** | 20% reduction in ED visits for ambulatory conditions | Patients with frequent ED visits | Reduction in visits to the ED for frequent users | 10% reduction from baseline | ED and Primary Care Practice Managers | Average 589 patients w/> 4 ED visits in the last 365 days each month | |
| **Walk-in / next day primary care appointments** | 10% increase in post ED DC walk-in appointments | Patients with frequent ED visits | Reduction in visits to the ED for frequent users | 5% increase in ED / DC appointments | ED and Primary Care Practice Managers | Implementation pending; target Fall 2013 | |
| **Expand open access scheduling** | Routine new patient appointment within 5 work days | Primary care | Reduction in the time for a new appointment | Reduction from 12 days to 7 days | Primary care medical and administrative leaders | Average 12 days for resident clinic and 10 days IM | |
| **Increase charity care / decrease self-pay** | Increase percentage of patients screened for charity care. | Uninsured Low income | Number of patients processed | 100% of patients screened for charity care and/ or other programs | Director of Admitting and Financial Counseling | Baseline pending | |
| **Increase PCP providers** | Increase number of pcp providers / increase panels | Primary care | Increase number of sessions | 20% increase in sessions | CMO | 35 sessions / 3.9 providers | |

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| Strategy/Program | Long Term Goal | Target Population | Key Performance Indicators | Target 2014 | Responsible Party(ies) | Baseline FY13 | Status at close FY14 |
|---|---|---|---|---|---|---|---|
| **Community Outreach and education** | Make our services known and accessible and build trust with community leaders particularly the clergy | All Residents | Number of health fairs and community events that we participate in | Increase 5% over FY13 community events | Manager, Community Outreach | Baseline pending | |
| **Patient as active healthcare team member** | Increase patient involvement in healthcare decisions | All | Documented evidence of patient's involvement in decision-making | TBD | Providers Quality Assurance | Baseline pending chart audit | |

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**2013 UH -** Community Health Needs Implementation Strategy

**Priority 2:** Heart Disease

**Problem:** Readmissions for heart disease exceeds standards and improved self-management is needed to help maintain health

| Strategy/Program | Long Term Goal | Target Population | Key Performance Indicators | Target 2014 | Responsible Party | Baseline FY13 | Status at close FY14 |
|---|---|---|---|---|---|---|---|
| Patient navigators / care coordinators | 20% reduction in readmissions | CHF | Reduction in readmission for all causes. | 10% reduction from FY 2013 | Inpatient and Cardiac Clinic Practice Managers | 26.8% | |
| Increase patient education / self-management | 20% increase in patients w/"perfect" teach-back | CHF | Increase in retention of information based upon teach-back | 10% increase "perfect" scores | Inpatient and Cardiac Clinic Practice Managers | New metric | |
| Improve medication reconciliation | 20% increase in medication reconciliation | CHF | Increase in documented compliance with medication reconciliation | 10% improvement over 2013 | Providers Quality staff | UH: 78% Ambulatory: 72.8% | |

**2013 UH -** Community Health Needs Implementation Strategy

Priority 3: **Substance Abuse**

Problem: **Patients present to the ED and/or are admitted and their substance abuse issues may be identified; however, treatment options are not well developed resulting in frequent use of the ED and readmissions.**

| Strategy / Program | Long Term Goal | Target Population | Key Performance Indicators | Target 2014 | Responsible Party(ies) | Baseline FY13 | Status at close FY14 |
|---|---|---|---|---|---|---|---|
| **Patient navigators / substance abuse counselors** | 20% reduction in readmissions | Substance abuse | Reduction in readmission for all causes. | 5% reduction from FY 2013 | Inpatient and Outpatient Practice Managers | To be determined | |
| **Implement Screening Brief Intervention and Referral to Treatment Process** | 100% of patients screened for substance abuse | All adult patients | Increase in the percentage of patients screened | 80% of patients screened | Nurse Manager and Substance Abuse Counselors | New metric and process | |
| **Implement Substance Abuse Clinic** | 100% of eligible patients are referred for care (high risk) | Substance abuse | Percentage of eligible patients referred and participating in care. | Initiate ambulatory program | COS for Psychiatry

ACS Medical Director | Proposed new service | |

Next Steps:

- These results will serve as a guide for planning and implementation of healthcare initiatives that will allow UH to best serve the emerging needs of Newark;
- Conduct outreach and provide services in a culturally sensitive manner in conjunction with the health care professionals already serving the community;
- Collaborate with community partners to expand and promote primary care treatment of the uninsured / underinsured using the medical home model;
- Increase information sharing with our community on how to access services and what services are available;
- Expand community outreach efforts through education regarding health concerns through community based events and health fairs in order to promote sound health practices among Newark residents;
- Expand our heart program to identify high risk patients and provide them with affordable screenings as well as ongoing care;
- Initiate a drug screening program and brief intervention and treatment.

References:

GNHCC Greater Newark Healthcare Coalition Public Health Symposium, January 29, 2012.  Results for Essex County presented by New Solution, Inc.

2010 US Census. www.census.gov