CHILTON HOSPITAL

Community Health Needs Assessment

Final Summary Report

March 2013

HOLLERAN

COMMUNITY HEALTH NEEDS ASSESSMENT

FINAL SUMMARY REPORT

TABLE OF CONTENTS

COMMUNITY HEALTH NEEDS ASSESSMENT

FINAL SUMMARY REPORT

I. COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

EXECUTIVE SUMMARY

Chilton Hospital led a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in their hospital service area in New Jersey beginning in 2012. Chilton Hospital partnered with the Community Health Alliance of North Central (CHANCe) New Jersey to complete the assessment. The purpose of the assessment was to gather information about local health needs and health behaviors. It also served as a continuation of previous Community Health Needs Assessments conducted by Chilton Hospital as part of its' mission and vision to meet the needs of the community. The assessment examined a variety of indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease).

The completion of the CHNA enabled Chilton Hospital and its partners to take an in-depth look at its greater community. The findings from the assessment were utilized by Chilton Hospital to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. Chilton Hospital is committed to the people it serves and the communities they live in. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

Research Components

- Secondary Statistical Data Profile of Chilton Hospital's service area
- Household Telephone Survey with 783 community residents
- Focus Group Discussions with 54 community residents
- Morris County Prioritization Session

Key Areas of Opportunity

- Physical Activity and Nutrition
- Access to Care
- Mental Health and Well-Being
- Substance Use and Abuse

HOSPITAL & COMMUNITY PROFILE

Hospital Overview

Chilton Hospital is a not-for-profit health care facility that serves residents of more than 33 communities in Morris, Passaic, Essex, Bergen, and Sussex Counties in New Jersey. It was founded in 1954 as the result of a land donation by Forrest S. Chilton II, MD and his wife, Elizabeth, RN, in memory of their son who died serving in World War II. Chilton Hospital started as a 50-bed facility and is now a 260-bed facility with approximately 1,400 employees and more than 630 physicians from 60 medical specialties. It serves more than 160,000 patients annually. The mission of Chilton Hospital is to "Promote wellness and provide compassionate care and healing." It is a member of the American Hospital Association and New Jersey Hospital Association.

Chilton Hospital recently expanded its services through the Chilton Health Network. The Chilton Health Network is comprised of seven sites, in addition to Chilton Hospital, that offer health care services and providers throughout Northwestern New Jersey. The network sites and their respective services include:

- The Collins Pavilion
  - The Breast Center, Chilton Cancer Center, colorectal surgery, gynecology/ urogynecology, oncology/hematology, pediatrics, and podiatry/foot and ankle
- Chilton Lab
  - Blood work, blood glucose testing, body fluid analysis, and therapeutic drug monitoring
- Chilton Physical Therapy
  - Physical therapy, occupational therapy, hand therapy, speech language pathology, and massage therapy
- Chilton Occupational Health
  - Corporate wellness, travel medicine program, drug testing, and pre-employment exams
- Chilton at Hewitt Plaza
  - Chilton Lab, obstetrics and gynecology, and orthopedics
- Butler Internal Medicine
  - Internal medicine/Family medicine
- Family Health & Wellness
  - Pediatrics and Internal medicine

Community Overview

Chilton Hospital defined their current service area based on an analysis of the geographic area where individuals utilizing their health services reside. Chilton Hospital's total service area is considered to be Northwestern New Jersey, including Morris, Passaic, Essex, Bergen, and Sussex Counties. It is a relatively large service area with a population of approximately 309,000 residents. However, Chilton Hospital further defined the geographic area they serve by primary service area (PSA) and secondary service area (SSA). The PSA is the area from which Chilton Hospital draws the majority of its patients. It comprises most of Passaic and Morris Counties and has a population of approximately 192,000 residents. The SSA includes portions of all four counties served by Chilton Hospital and has a population of approximately 118,000 residents. The conclusions drawn from the various research components represent the total service area.

METHODOLOGY

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document:

- Quantitative Data:
  - A **Secondary Statistical Data Profile** depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates and other health statistics for Chilton Hospital's service area was compiled.
  - A **Household Telephone Survey** was conducted with 783 randomly-selected community residents. The survey was modeled after the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) which assesses health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

- Qualitative Data:
  - Four **Focus Groups** were held with 54 community members in March 2013.

Chilton Hospital contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Chilton Hospital's contract with Holleran is a continuation of their partnership over past years to improve community health. Holleran has over 20 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

1) Collected and interpreted Secondary Data
2) Conducted, analyzed, and interpreted data from Household Telephone Survey
3) Conducted focus groups with community members
4) Facilitated a prioritization and implementation planning session

Community engagement and feedback were an integral part of the CHNA process. Chilton Hospital sought community input through focus groups with community members and inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community served by Chilton Hospital including medically underserved, low income, and minority populations.

Following the completion of the CHNA research, Chilton Hospital prioritized community health issues and developed an implementation plan to address prioritized community needs. A description of the priority issues is included on page 42 and a detailed scorecard of how these issues were selected is included in Appendix E.

II. SECONDARY DATA PROFILE OVERVIEW

BACKGROUND

One of the initial undertakings of the CHNA was to create a "Secondary Data Profile." Data that is obtained from existing resources is considered "secondary." Demographic and health indicator statistics were gathered and integrated into a report to portray the current health status of Chilton Hospital's service area.

Quantitative data was collected from reputable sources including the U.S. Census Bureau, Centers for Disease Control and Prevention, National Cancer Institute, and New Jersey Department of Health and Senior Services. Data sources are listed throughout the report and a full reference list is included in Appendix A. The most recent data available was used wherever possible. When available, state and national comparisons were also provided as benchmarks.

The profile details data covering the following areas:

- Population Statistics
- Household Statistics
- Income/Employment Statistics
- Education Statistics
- Mortality Statistics
- Birth Statistics
- Sexually Transmitted Illness Statistics
- Substance Abuse Statistics
- Mental Health Statistics
- Cancer Statistics
- Crime Statistics

KEY FINDINGS

This section serves as a summary of the key takeaways from the secondary data profile. A full report of all of the statistics is available through Chilton Hospital.

Demographic Statistics

According to U.S. Census Bureau (2010) estimates, the total population in Chilton Hospital's service area is 309,440. Nearly 89% of residents identify as White and only 2.0% of residents identify as Black/African American compared to 13.7% in New Jersey and 12.6% nationally. Approximately 8.2% of residents identify as Hispanic or Latino compared to 17.7% in New Jersey and 16.3% in the nation. The primary language spoken in the total service area is English; only 19.2% of residents speak a language other than English at home. The population is slightly older with a median age of 41.7 compared to 39.0 in New Jersey and 37.2 in the nation (U.S. Census Bureau, 2010).

Table 1. Overall Population (2010)

	U.S.	New Jersey	Total Service Area	Primary Service Area	Secondary Service Area
Population	308,745,538	8,791,894	309,440	191,599	117,841
Population Change ('00 – '10)	9.7%	4.5%	3.9%	2.8%	5.8%
Median Age	37.2	39.0	41.7	42.9	40.2
% 65 Yrs. and Over	13.0%	13.5%	14.7%	15.6%	13.0%

Source: U.S. Census Bureau, 2010

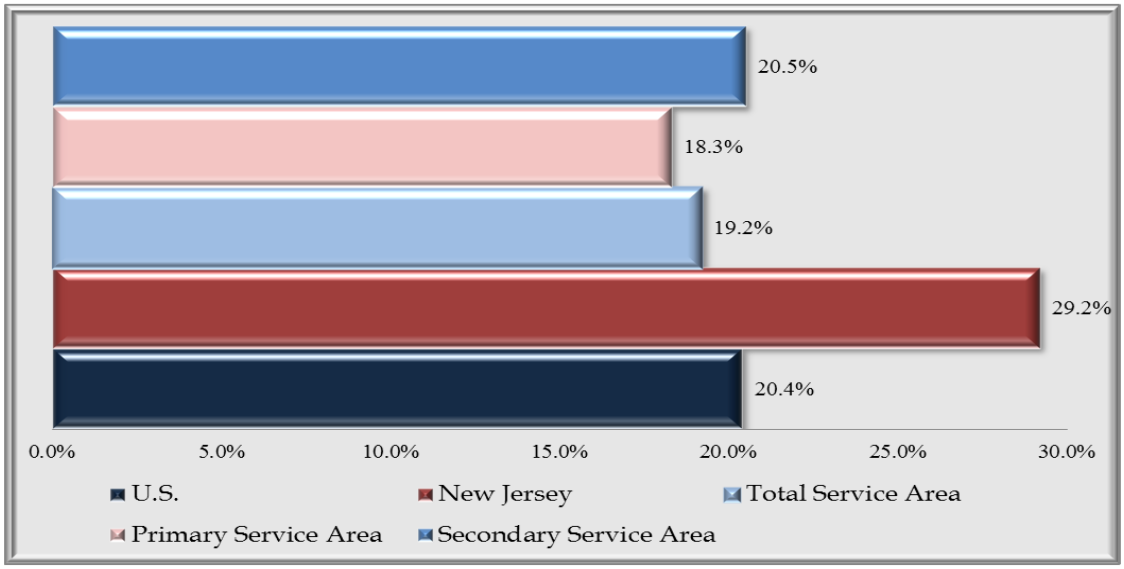


Figure 1. Percentage of population speaking a language other than English, 2010
Source: U.S. Census Bureau, ACS estimates

The total service area is comprised primarily of family households (73.2%) in comparison to New Jersey (69.3%) and the nation (66.4%). Family households are defined as more than one person living together, either as relations or as a married couple. Residents are also more likely to live in owner-occupied units (81.2%) in comparison to New Jersey (65.4%) and the Nation (65.1%). The median value for owner-occupied units is $447,793, which is notably higher than the median value across the state and the nation (U.S. Census Bureau, 2010).

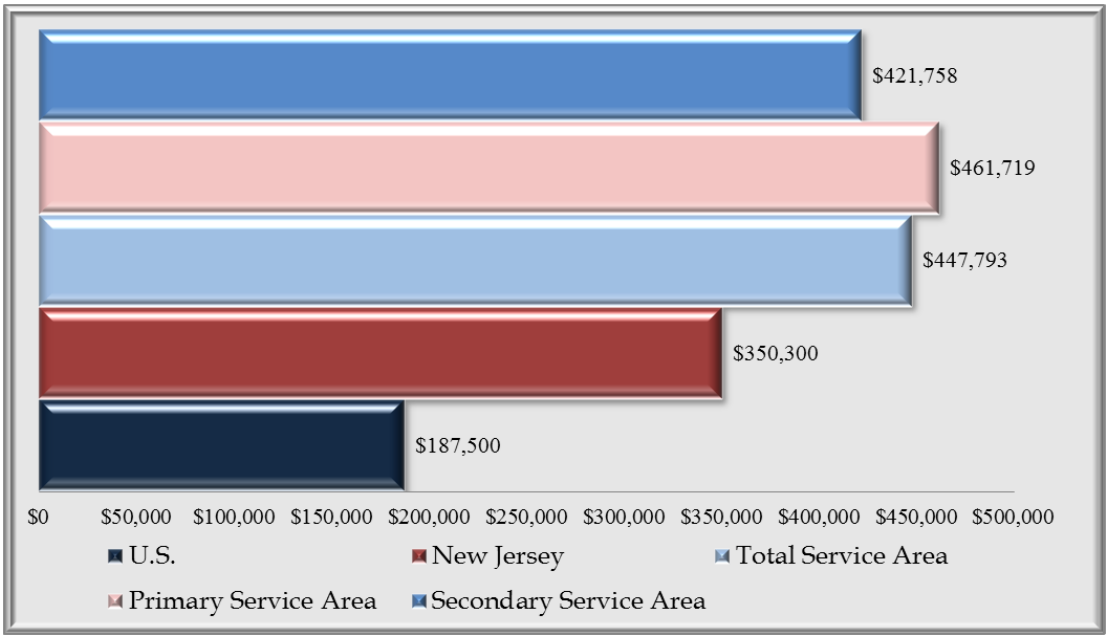


Figure 2. Median value for owner-occupied unit, 2010
Source: U.S. Census Bureau, ACS estimates

The median income for households and families in the Chilton Hospital service area ($92,779 and $107,853 respectively) is higher than in New Jersey and the nation. In addition, the percentage of families and individuals living in poverty in the past 12 months is lower for all reported categories than in the state and the nation (U.S. Census Bureau, 2010).

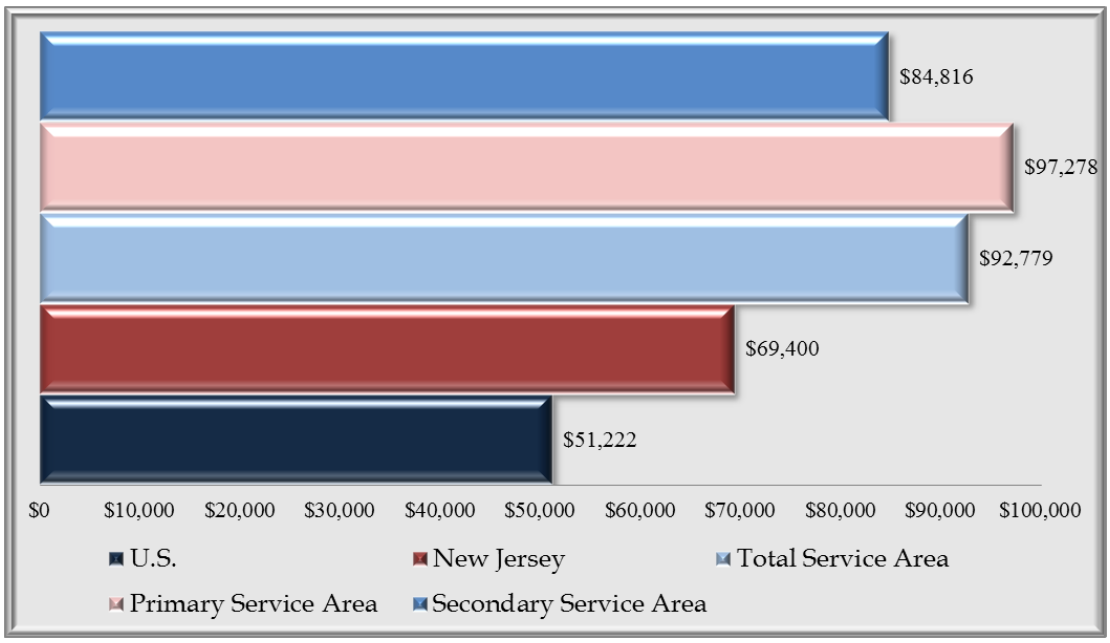


Figure 3. Median household income, 2010
Source: U.S. Census Bureau, ACS estimates

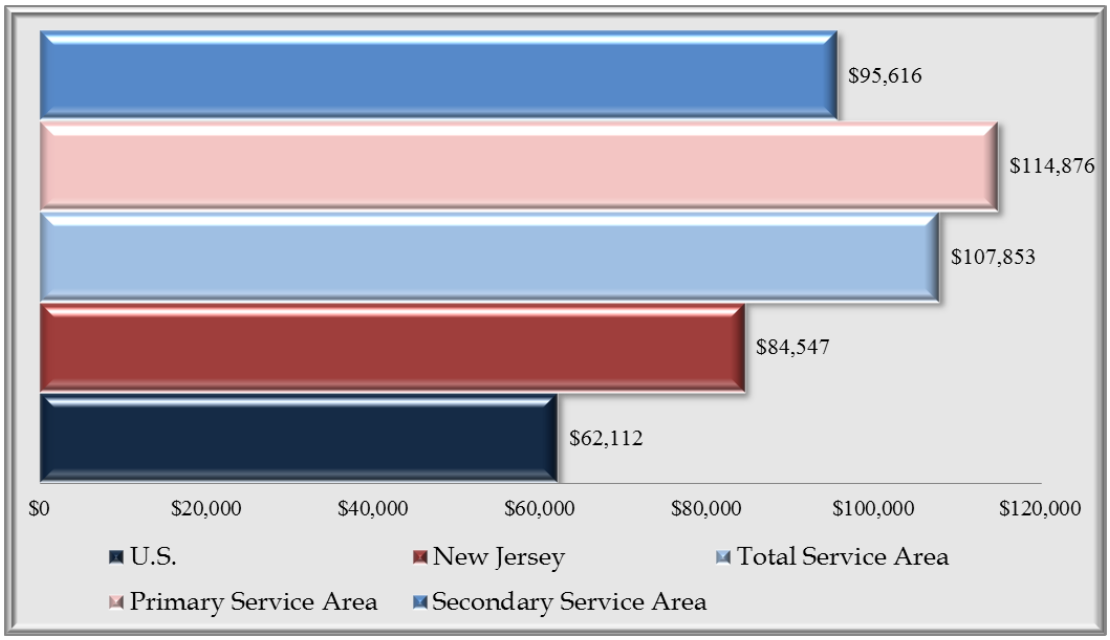


Figure 4. Median family income, 2010
Source: U.S. Census Bureau, ACS estimates

Table 2. Poverty Status of Families and People in the Past 12 Months (2010)

	U.S.	New Jersey	Total Service Area	Primary Service Area	Secondary Service Area
Families	10.5%	7.0%	2.6%	2.1%	3.5%
With related children under 18 years	16.5%	10.9%	3.8%	3.1%	4.9%
Families with female householder, no husband present	29.2%	21.8%	10.6%	8.9%	13.4%
With related children under 18 years	38.1%	30.9%	15.9%	14.5%	18.1%
18 years and over	12.5%	8.3%	3.9%	3.1%	5.1%
65 years and over	9.4%	7.7%	4.7%	4.3%	5.3%

Source: U.S. Census Bureau, ACS estimates

According to the U.S. Census Bureau (2010), the unemployment rate for the total area served by Chilton Hospital (6.9%) is below the state (8.8%) and the nation (9%). Of the residents who are employed, the majority work in management, business, science, or arts and are private wage and salary workers.

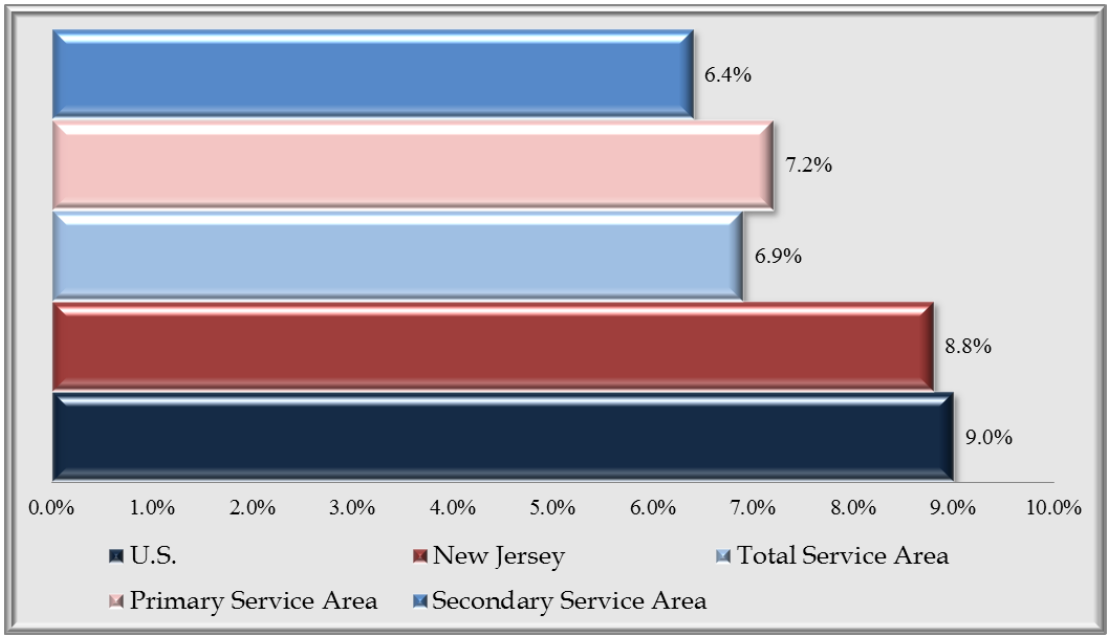


Figure 5. Unemployment rate for civilian labor force, 2010
Source: U.S. Census Bureau, ACS estimates

Education is an important social determinant of health. Studies have shown that individuals who are less educated tend to have poorer health outcomes. Both high school and higher education graduation rates are higher in the area served by Chilton Hospital (91.9% and 38.9% respectively) than in New Jersey (87.6% and 34.9% respectively) and the Nation (85.3% and 28.0% respectively) (U.S. Census Bureau, 2010).

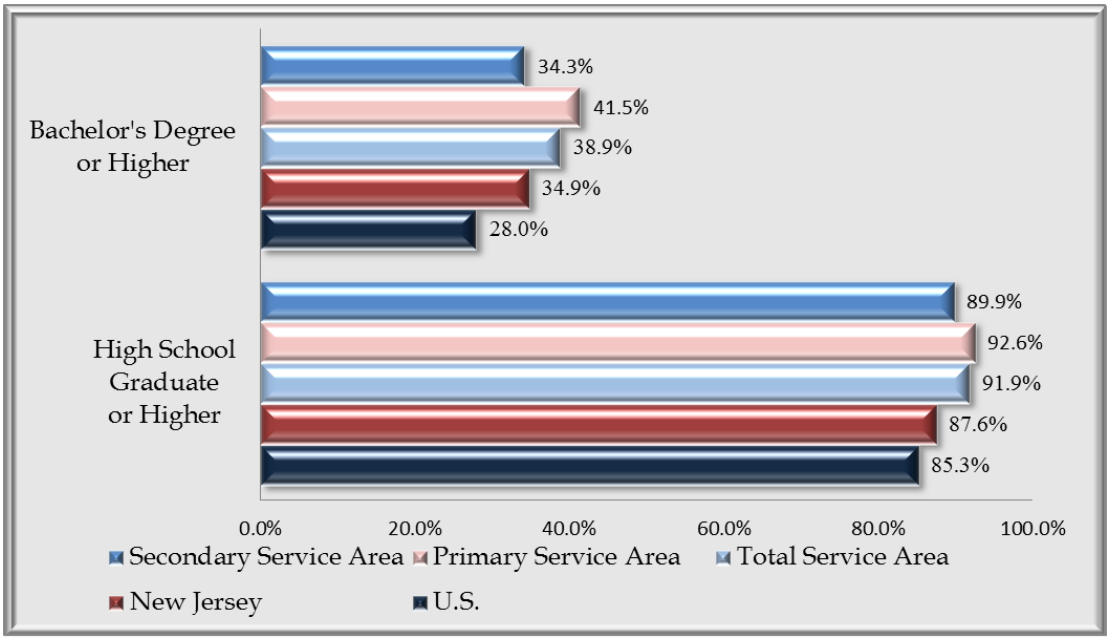


Figure 6. Educational attainment, 2010
Source: U.S. Census Bureau, ACS estimates

Health Status Indicators

Mortality Rates

The overall crude mortality rate for the Chilton Hospital service area is 815.7 per 100,000. This is higher than the mortality rate for New Jersey (798.2 per 100,000) and the nation (803.6 per 100,000). A contributing factor to the overall mortality rate may be the higher median age of the population. The table below details the percentage of deaths due to the top 10 leading causes of death in the United States. As shown in the table, the only cause of death that has a higher percentage in the Chilton Hospital service area than in New Jersey and the nation is septicemia. However, diseases of the heart and malignant neoplasms (cancer) are still cause for concern as they are the leading causes of death in the area (New Jersey Department of Health and Senior Services, 2007 & CDC, 2007).

Table 3. Top 10 Leading Causes of Death, All Ages (2007)

	U.S.	New Jersey	Total Service Area	Primary Service Area	Secondary Service Area
The following are the top 10 leading causes of death in ranking order of the United States.					
Diseases of heart	25.4%	27.1%	23.3%	27.1%	25.8%
Malignant neoplasms (Cancer)	23.2%	24.6%	22.3%	25.3%	27.5%
Cerebrovascular disease (Stroke)	5.6%	5.0%	4.6%	5.0%	5.8%
Chronic lower respiratory diseases	5.3%	4.3%	5.0%	6.0%	5.1%
Accidents (Unintentional injuries)	5.1%	3.4%	2.2%	2.1%	2.9%
Alzheimer's disease	3.1%	2.6%	2.6%	3.1%	2.3%
Diabetes Mellitus	2.9%	3.4%	3.0%	2.8%	4.4%
Influenza and pneumonia	2.2%	1.9%	1.6%	1.7%	1.5%
Nephritis, nephrotic syndrome and nephrosis	1.9%	2.4%	1.5%	1.7%	2.1%
Septicemia	1.4%	2.5%	3.2%	3.3%	3.0%

Sources: Center for Disease Control and Prevention, 2007
New Jersey Department of Health and Senior Services, 2007

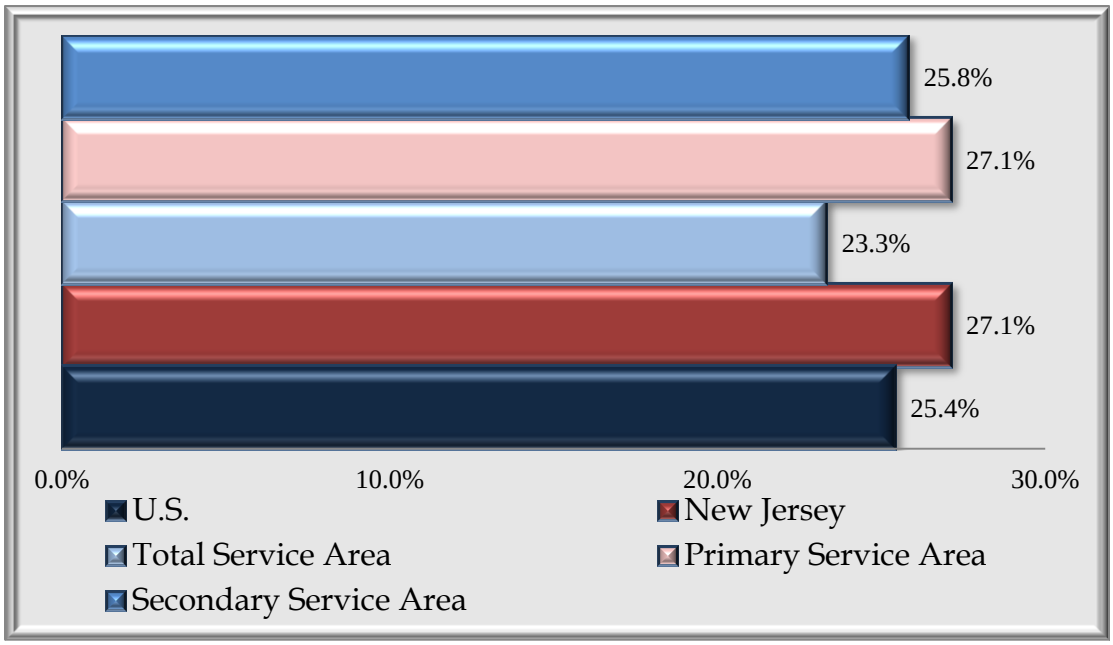


Figure 7. Percentage of deaths due to diseases of the heart, 2007
Sources: Center for Disease Control and Prevention &
New Jersey Department of Health and Senior Services, 2007

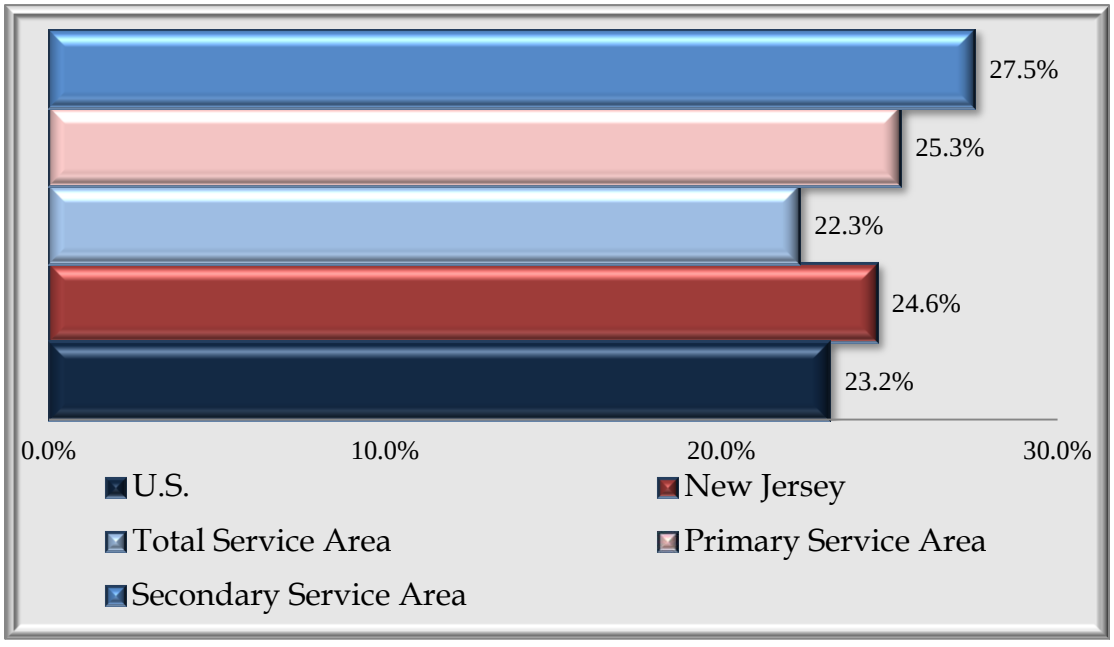


Figure 8. Percentage of deaths due to malignant neoplasms (cancer), 2007
Sources: Center for Disease Control and Prevention &
New Jersey Department of Health and Senior Services, 2007

Maternal & Infant Health

Overall, there are fewer births in the area served by Chilton Hospital. The birth rate per 1,000 is 9.6 compared to 13 in New Jersey and 14 in the nation. In particular, the birth rate for Black/African American mothers (0.2) is notably lower compared to New Jersey (14.4) and the nation (16.6). Of the births that do occur, fewer are to teenage mothers aged 15 to 19 years (2%). The majority of births are to women aged 25 to 39 years (85.7%). In addition, a higher percentage of mothers receive prenatal care in the first trimester (87.1%) compared to mothers across New Jersey (75.6%) and the nation (71%) (New Jersey Department of Health and Senior Services, 2008 & CDC, 2008).

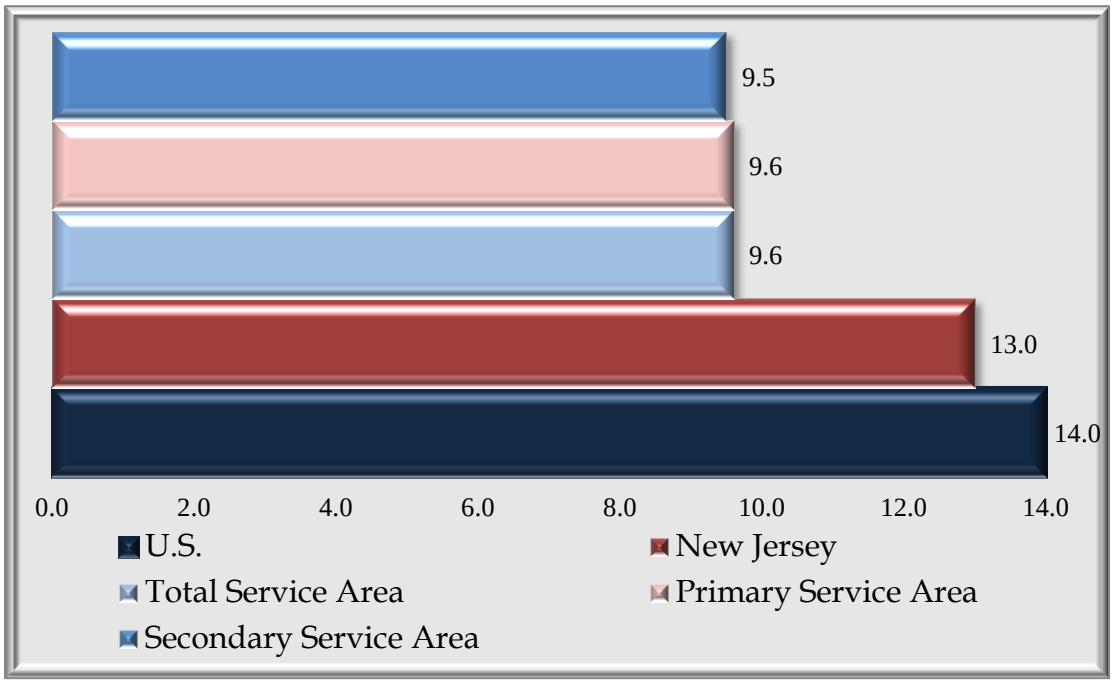


Figure 9. Live birth rate per 1,000, 2007
Sources: Center for Disease Control and Prevention &
New Jersey Department of Health and Senior Services, 2008

The infant mortality rate per 1,000 live births is lower in Chilton Hospital's total service area (1.9) than in New Jersey (5.1) and the nation (6.8). Only six infant deaths occurred in the service area in 2007 (New Jersey Department of Health and Senior Services, 2007 & CDC, 2007). Related to infant mortality is birth weight. Overall, the percentage of infants born with low birth weight in Chilton Hospital's service area (8.2%) is consistent with New Jersey (8.1%) and the nation (8.2%). However, the percentage of White infants born with low birth weight (7.9%) is slightly higher than what is seen in New Jersey (7.3%) and the nation (7.2%) and the percentage of Black/African American infants born with low birth weight (7.6%) is lower than what is seen in New Jersey (13%) and the nation (13.7%) (New Jersey Department of Health and Senior Services, 2008 & CDC, 2008).

Sexually Transmitted Illnesses

Overall, the rates for sexually transmitted illnesses are lower in the Chilton Hospital service area than in New Jersey and the nation. The chlamydia rate per 100,000 is 93.4 compared to 297.3 in New Jersey and 426in the nation. The gonorrhea rate per 100,000 is 10.3 compared to 66.8 in New Jersey and 100.8 in the nation. The New Jersey Department of Health reports that only five cases of syphilis (congenital, primary and secondary, early latent, and late latent) occurred in 2010 (New Jersey Department of Health and Senior Services, 2010 & CDC, 2010).

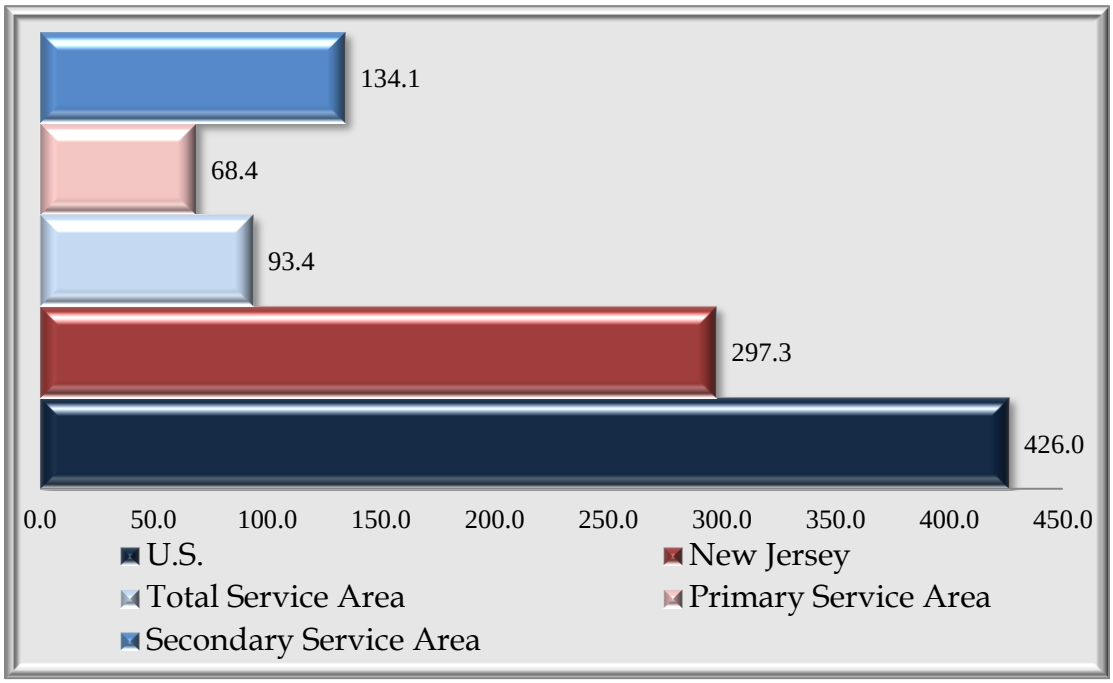


Figure 10. Chlamydia rates per 100,000, 2010
Sources: Center for Disease Control and Prevention &
New Jersey Department of Health and Senior Services, 2008

Substance Abuse Statistics

According to the New Jersey Department of Human Services, drug and alcohol admissions total 2,116 in the Chilton Hospital service area. The most common admissions are due to alcohol (41.4%) and heroin and other opiates (39.4%). The alcohol admission rate is similar to the national rate (41.6%), but higher than the New Jersey rate (34%). However, the national rate includes admissions due to alcohol and alcohol with a secondary drug and may be inflated as a result. Admissions due to drugs other than heroin and other opiates, cocaine, and marijuana are also higher in the area served by Chilton Hospital (8.6%) than in New Jersey (3%) (New Jersey Department of Human Services, 2010 & Substance Abuse & Mental Health Services Administration, 2009).

Mental Health Statistics

Suicide rate is considered an indicator of the mental health status of an area. The suicide rate per 100,000 in the Chilton Hospital service area is 4.9 compared to 6.8 in New Jersey and 11.5 in the nation. This is a positive finding, but it should not be considered an all-encompassing indication of the mental health status of the Chilton Hospital service area. Additional indicators from the household telephone survey and focus groups should be considered for a more comprehensive understanding (New Jersey Department of Health and Senior Services, 2008 & CDC, 2007).

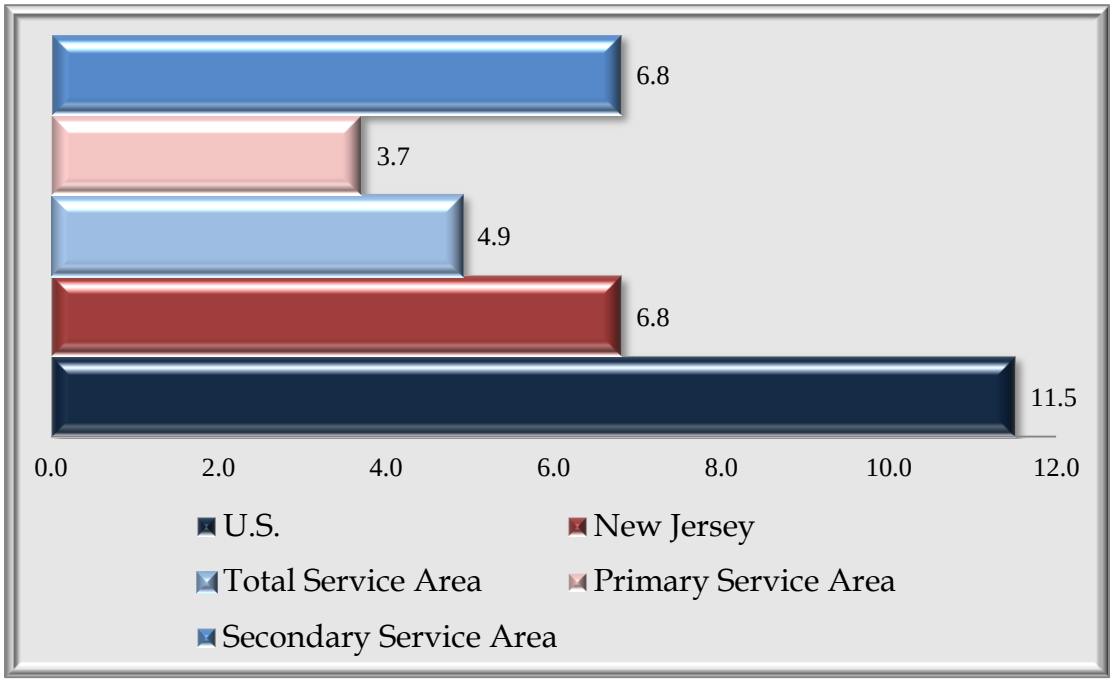


Figure 11. Suicide rates per 100,000, 2010
Sources: Center for Disease Control and Prevention &
New Jersey Department of Health and Senior Services, 2007

Cancer Statistics

Cancer is the second leading cause of death in the Chilton Hospital service area. The mortality rate for all cancer sites is higher in the service area (212.2) than in New Jersey (196.3) and the nation (186.6) (New Jersey Department of Health and Senior Services, 2007 & CDC, 2007).

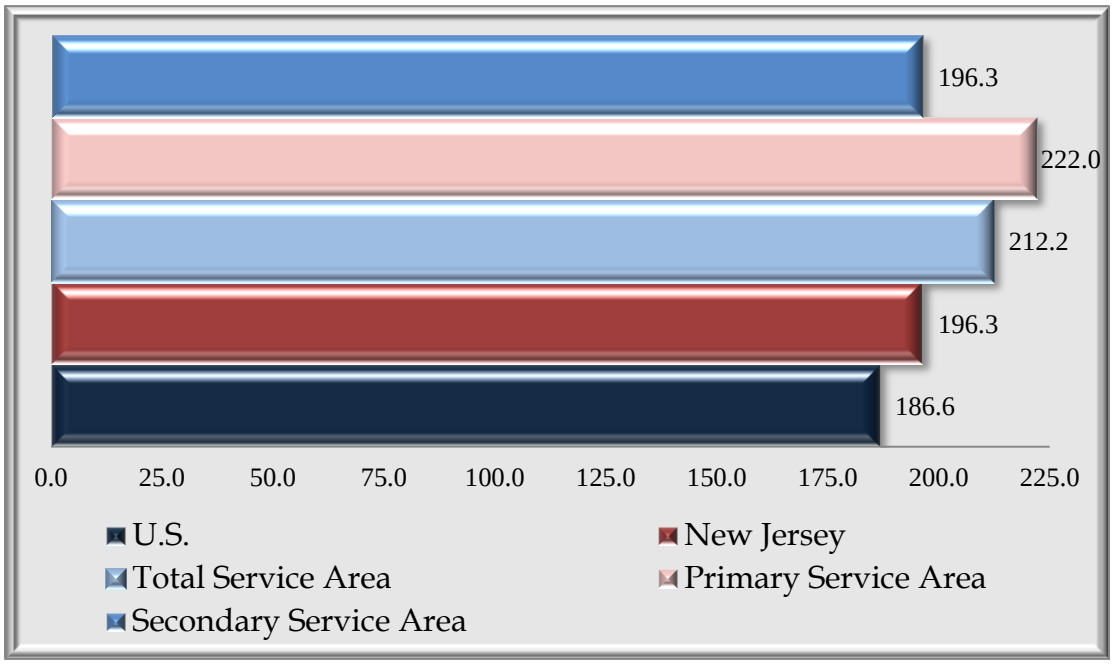


Figure 12. Cancer mortality rates for all sites per 100,000, 2010
Sources: Center for Disease Control and Prevention &
New Jersey Department of Health and Senior Services, 2007

Specifically, mortality rates due to breast and colon, rectum, and anus cancer are higher in the Chilton Hospital service area than in New Jersey and the nation. On a positive note, mortality rates due to trachea, lung, and bronchus and prostate cancer are lower than in New Jersey and the nation (New Jersey Department of Health and Senior Services, 2007 & CDC, 2007).

Table 4. Cancer Mortality by Site (2007)

	U.S.		New Jersey		Total Service Area		Primary Service Area		Secondary Service Area	
	n	Rate	n	Rate	n	Rate	n	Rate	n	Rate
Breast	40,970	13.6	1,421	16.4	58	18.7	30	15.6	28	23.8
Colon, rectum and anus	53,586	17.8	1,766	20.4	83	26.8	56	29.1	27	23.0
Trachea, lung and bronchus	158,760	52.6	4,388	50.8	147	47.4	96	49.9	51	43.4
Prostate	29,093	9.6	837	9.7	25	8.1	18	9.5	7	5.9

Sources: Center for Disease Control and Prevention, 2007 & NJ Department of Health and Senior
New Jersey Department of Health and Senior Services, 2007

Secondary Service Area

The focus of the summary is the total area served by Chilton Hospital; however, it is worth noting the disparities that exist within the secondary service area. The secondary service area is similar to the primary service area in that it fares better than New Jersey and the nation for almost all social determinants of health and health indicators. However, the secondary service area consistently fares worse than the primary service area, and this is not evident when solely reviewing the total service area.

A review of the demographic statistics reveals that the secondary service area has lower median household and family incomes, higher poverty rates, lower median home values, and lower educational attainment. A review of health indicators finds similar trends in maternal and infant health, sexually transmitted illnesses, and suicide rates. The percentage of infants who are born with low birth weight is higher in the secondary service area (10.6%) than in the primary service area (6.7%), New Jersey (8.1%) and the nation (8.2%). This is true of White infants as well. The percentage of infants born to teenage mothers is also slightly higher in the secondary service area (2.9%) than in the primary service area (1.5%).

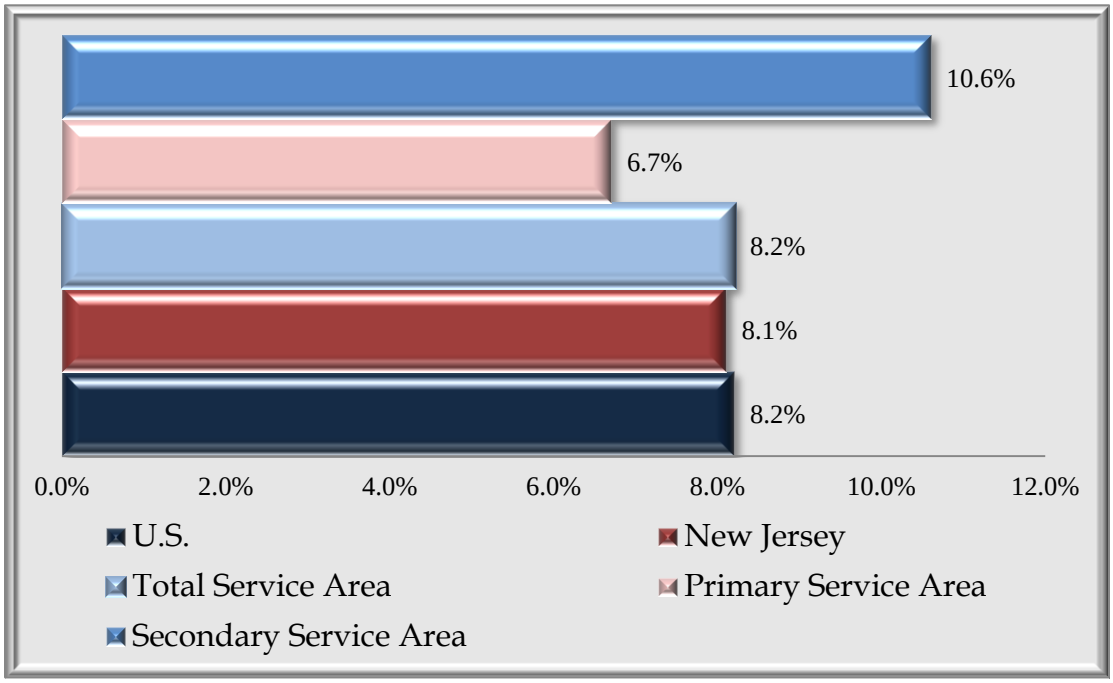


Figure 13. Infants born with low birth weight, 2008
Sources: Center for Disease Control and Prevention &
New Jersey Department of Health and Senior Services, 2008

Rates for chlamydia and suicide are notably higher in the secondary service area compared to the primary service area. The rate of chlamydia per 100,000 is 134.1 in the secondary service area and 68.4 in the primary service area. The suicide rate per 100,000 is 6.8 in the secondary service area and 3.7 in the primary service area.

FINAL THOUGHTS

The secondary data profile for the Chilton Hospital service area provided valuable context regarding how socioeconomic factors like income, education levels, and housing may influence local health outcomes. Based on a review of the secondary data, the following health issues appear to be areas of opportunity for the Chilton Hospital service area:

Areas of Opportunity

- Drug and alcohol admissions
  - Alcohol
  - Heroin and other opiates
- Cancer mortality rates
  - Breast cancer
  - Colon, rectum, and anus
  - All sites combined
- Secondary service area
  - Low birth weight
  - Teenage pregnancy
  - Chlamydia
  - Suicide

III. HOUSEHOLD TELEPHONE SURVEY OVERVIEW

BACKGROUND

A Household Telephone Survey was conducted based on the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a national initiative, headed by the Centers for Disease Control and Prevention (CDC) that assesses health status and risk factors among U.S. citizens.

The following section provides a summary of the Household Telephone Survey results including details regarding the research methodology as well as a summary of key findings. A full report of the Household Telephone Survey results is available in a separate document.

Methodology

Interviews were conducted by Holleran's teleresearch center between the dates of April 18 and August 3, 2012. Trained interviewers contacted respondents via land-line telephone numbers generated from a random call list. Statistical considerations for the study can be found in Appendix B.

Participants

A total of 783 individuals who reside within specific ZIP codes in the Chilton Hospital service area were interviewed by telephone to assess their health behaviors, preventive practices, and access to health care. Participants were randomly selected for participation based on a statistically valid sampling frame developed by Holleran.

Only respondents who were at least 18 years of age and lived in a private residence were included in the study. It is important to note that the sample only includes households with land-line telephones which can present some sampling limitations. Select participant demographics are included in Appendix C.

Survey Tool

The survey was adapted from the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS survey tool assesses health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. The customized survey tool consisted of approximately 100 factors selected from BRFSS surveys. A few customized questions were added to gather information about health issues specific to the service area. Depending upon respondents' answers to questions regarding cardiovascular disease, smoking, diabetes, etc., interviews ranged from approximately 15 to 30 minutes in length.

KEY FINDINGS

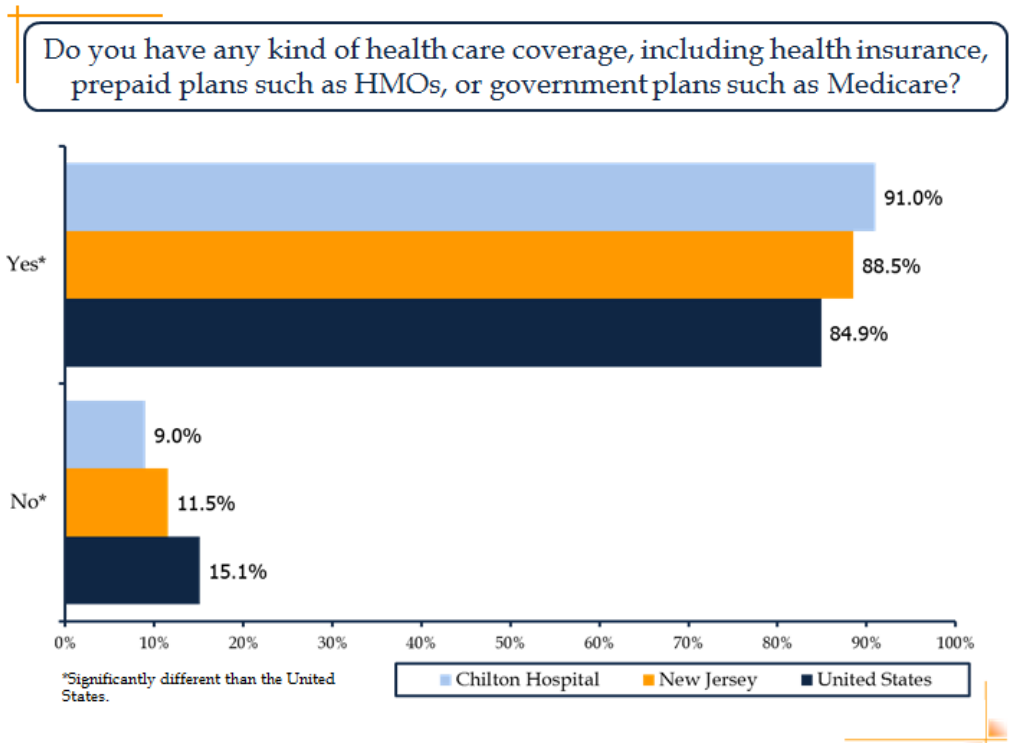
The following section provides an overview of key findings from the Household Telephone Survey including highlights of important health indicators and health disparities.

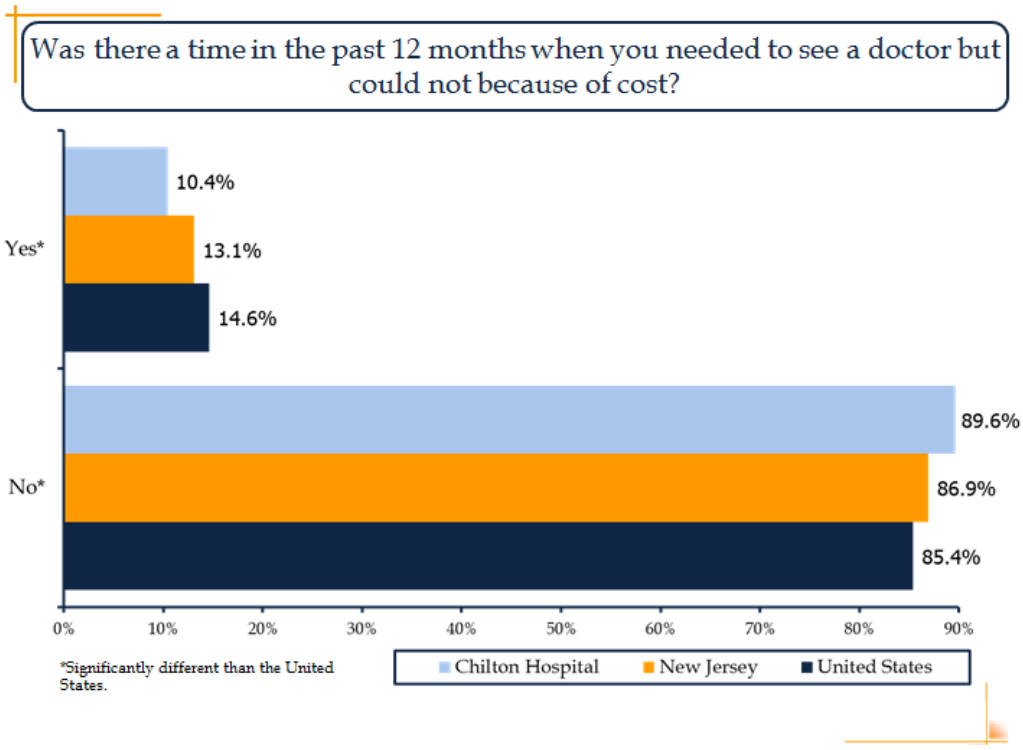
Access to Health Care

Overall, residents of the Chilton Hospital service area were more likely to have health care coverage (91%) compared to the state (88.5%) and the nation (84.9%). In addition, residents were more likely to have at least one person who they think of as their personal doctor or health care provider (90%) compared to the state (86.2%) and the nation (81.8%) and were less likely to have had a time in the past 12 months when they needed to see a doctor but could not because of cost. Local residents were also more likely to have received a routine checkup within the past year (78.7%) compared to the state (77%) and the nation (68.1%).

While access to health care indicators were favorable for the overall service area, disparities existed based on gender and ethnicity. Male respondents were less likely than female respondents to have health care coverage and to have a person who they think of as their personal doctor or health care provider. Hispanic respondents were less likely than Non-Hispanic respondents to have health care coverage and to have a person who they think of as

their personal doctor or health care provider. Hispanic respondents were also more likely than Non-Hispanic respondents to have had a time in the past 12 months when they needed to see a doctor, but could not because of cost.



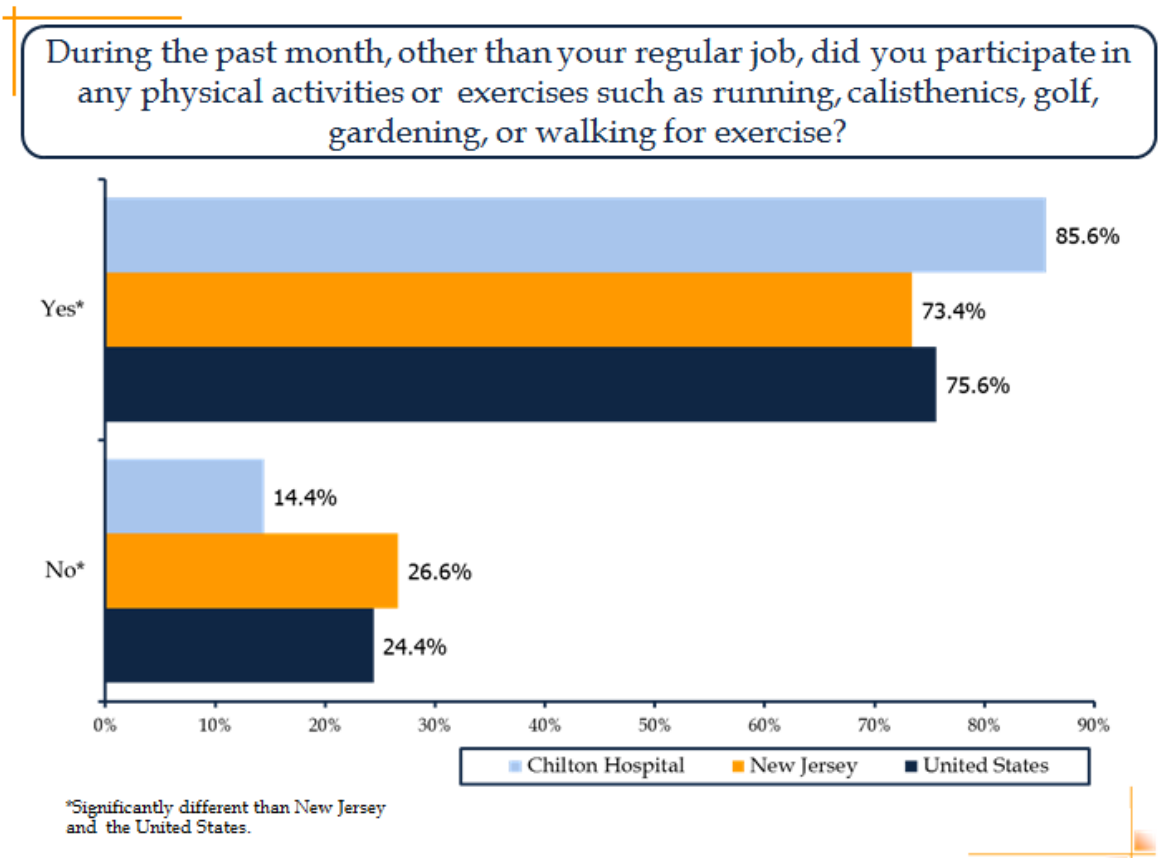


Health Risk Factors

Physical Activity, Fruit and Vegetable Consumption, & Obesity

A higher proportion of respondents (85.6%) reported engaging in physical activity outside their regular job during the past month compared to the state (73.4%) and the nation (75.6%). However, according to Body Mass Index (BMI) rates calculated from self-reported height and weight, more than 60% of respondents are considered overweight or obese. This is a considerable health concern given the connection between obesity and chronic health conditions.

Males were more likely than females to have exercised in the past month, but they were also more likely to be overweight. Females were less likely than males to exercise, but they were more likely to eat fruits and vegetables on a daily basis.

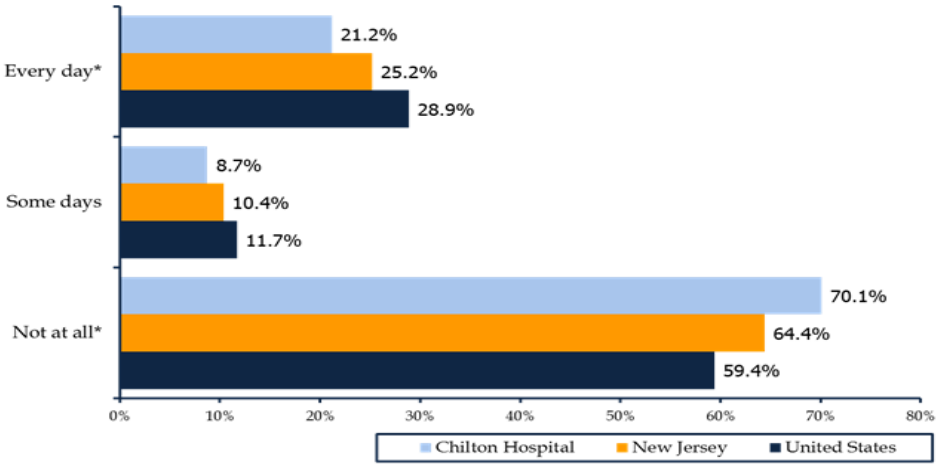


Tobacco & Alcohol Use

Respondents of the Chilton Hospital service area were slightly more likely to have smoked at least 100 cigarettes in their lifetime (45.1%) compared to the state (40.6%) and the nation (42%). However, of the respondents who smoked at least 100 cigarettes in their lifetime, fewer reported currently smoking every day or some days (29.9%) compared to the state (35.6%) and the nation (40.6%). Respondents were also more likely to have attempted to quit smoking during the past 12 months.

Do you now smoke cigarettes every day, some days, or not at all?

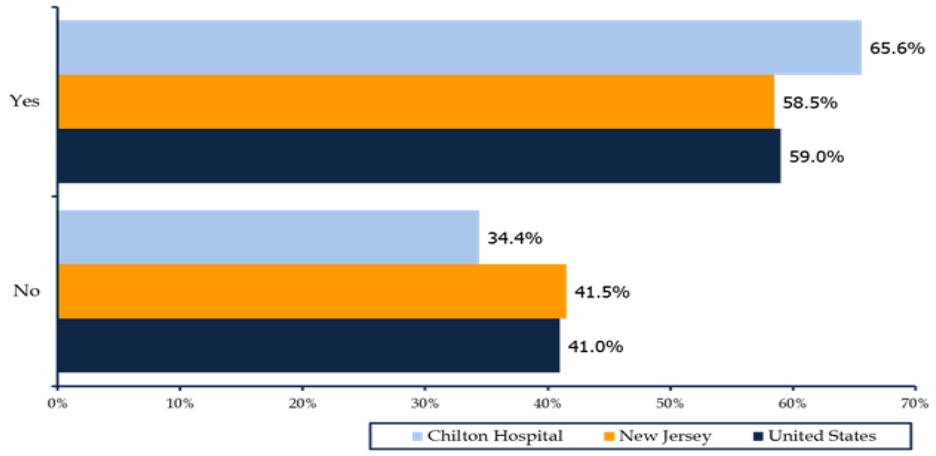
Respondents who have smoked at least 100 cigarettes in their entire life



*Significantly different than the United States.

During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

Respondents who now smoke cigarettes every day or some days



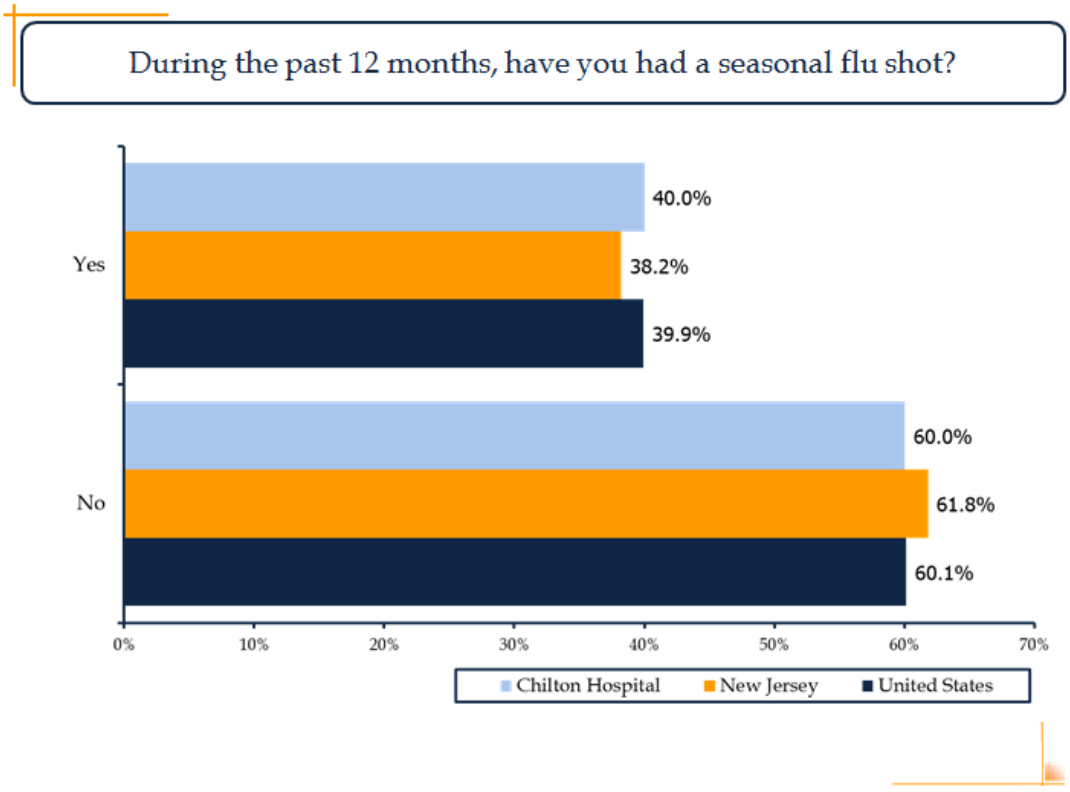
Chilton Hospital residents were more likely to have had at least one drink of alcohol during the past 30 days (61.2%) compared to the state (56.2%) and the nation (52.1%). However, they were not prone to excessive drinking or binge drinking (four or more drinks for women/five or more drinks for men on an occasion).

Despite overall favorable findings, disparities by gender and ethnicity were noted. Male respondents were more likely than female respondents to drink excessively (an average of five or more drinks and a maximum of four to 10 or more drinks per occasion). Hispanic respondents were more likely than Non-Hispanic respondents to binge drink.

Preventive Health Practices

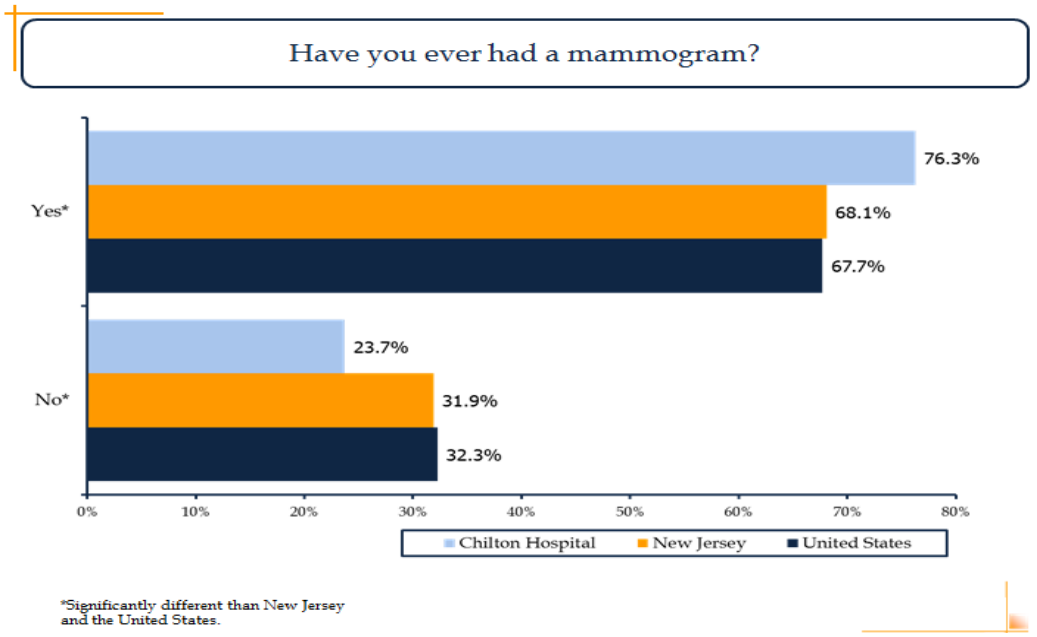
Immunizations

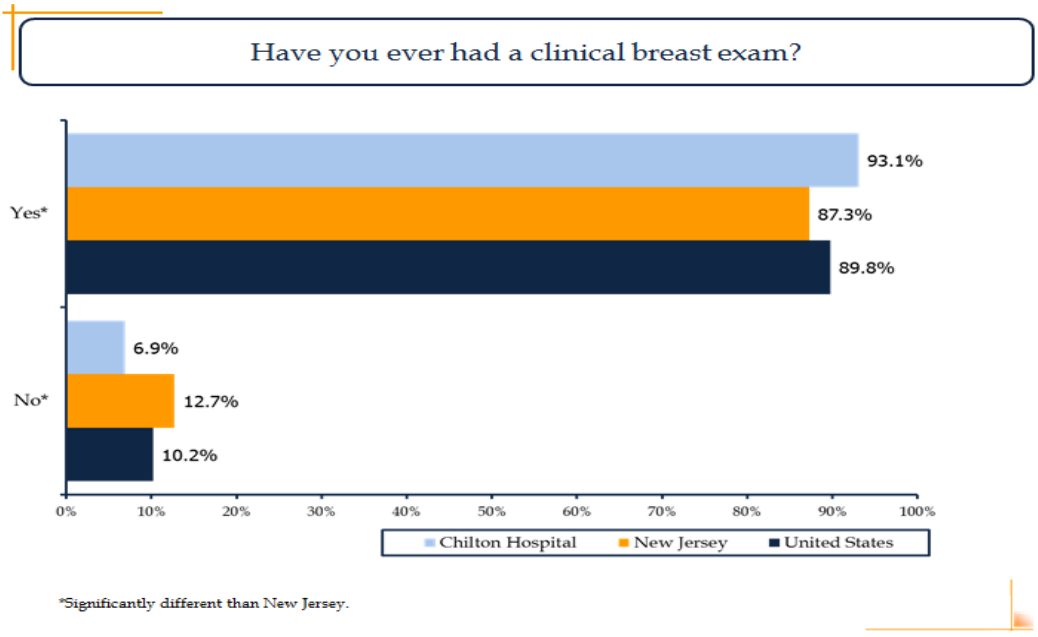
In general, Chilton Hospital residents were no more or less likely to receive immunizations. Forty percent (40%) received a flu shot in the past 12 months compared to 38.2% in New Jersey and 39.9% in the nation. Twenty seven percent (27%) received a pneumonia shot compared to 24.6% in New Jersey and 27.4% in the nation. Immunization rates increased for respondents 65 years of age or older, but not significantly when compared to the state or the nation. Approximately 70% of respondents 65 years of age or older received a seasonal flu shot in the past 12 months compared to 65.7% in New Jersey and 66.5% in the nation.



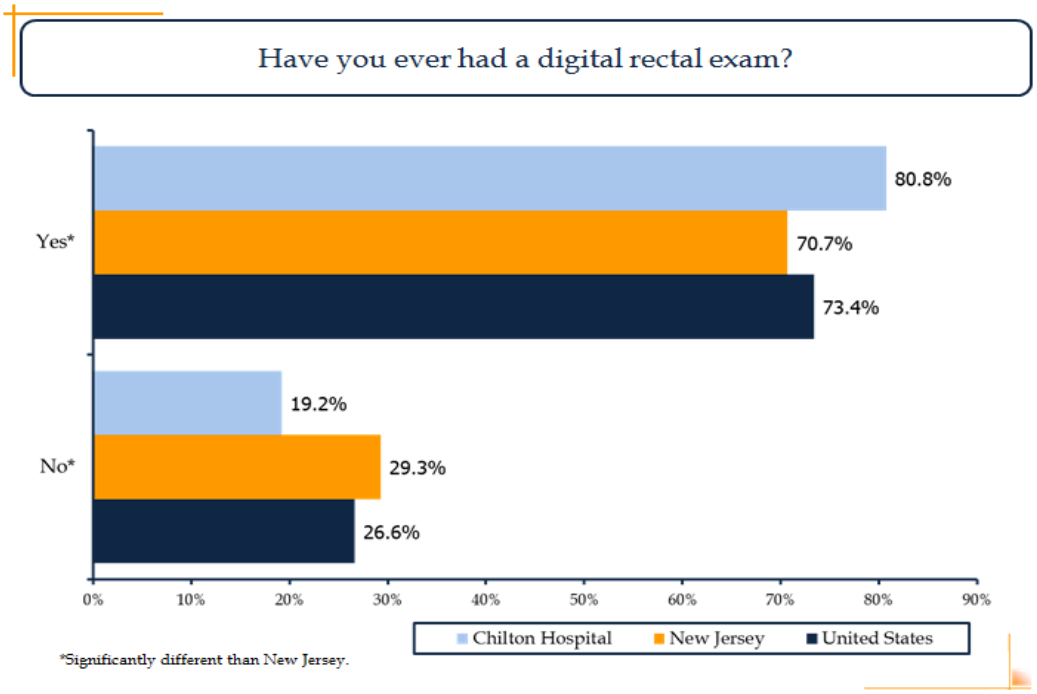
Screenings

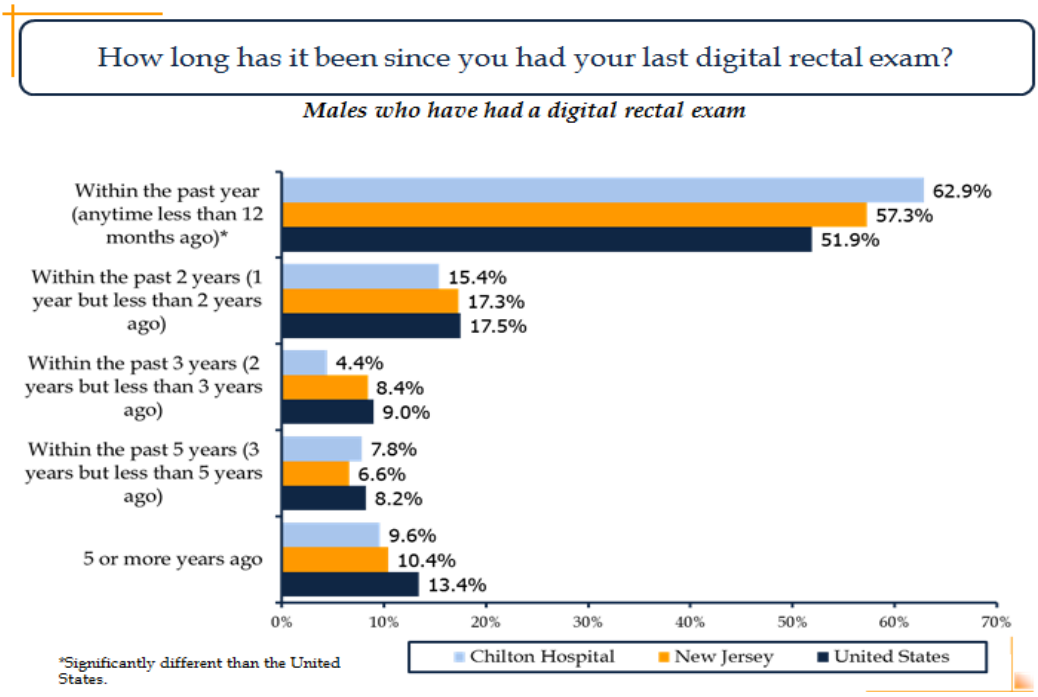
In general, female respondents of all ages were more likely to have had a mammogram (76.3%) compared to the state (68.1%) and the nation (67.7%). The majority of those same females had a mammogram within the past year (64.9%). Female respondents of all ages were also more likely to have had a clinical breast exam (93.1%) compared to the state (87.3%) and the nation (89.8%). The majority of those same females had a clinical breast exam within the past year (77.2%), which is significantly higher than females across the nation (68.4%). There are no reportable differences in the percentage of women who have had Pap test.





Male residents 40 years of age and older were slightly more likely to have had a PSA (Prostate Specific Antigen) test (73.4%) than males across the state (66.7%) and the nation (65%). They were also more likely to have had a digital rectal exam (80.8%) compared to males across the state (70.7%) and the nation (73.4%). Among males who had a digital rectal exam, a higher percentage had their last exam within the past year (62.9%). White males were more likely than Black/African American males to have had a PSA test.

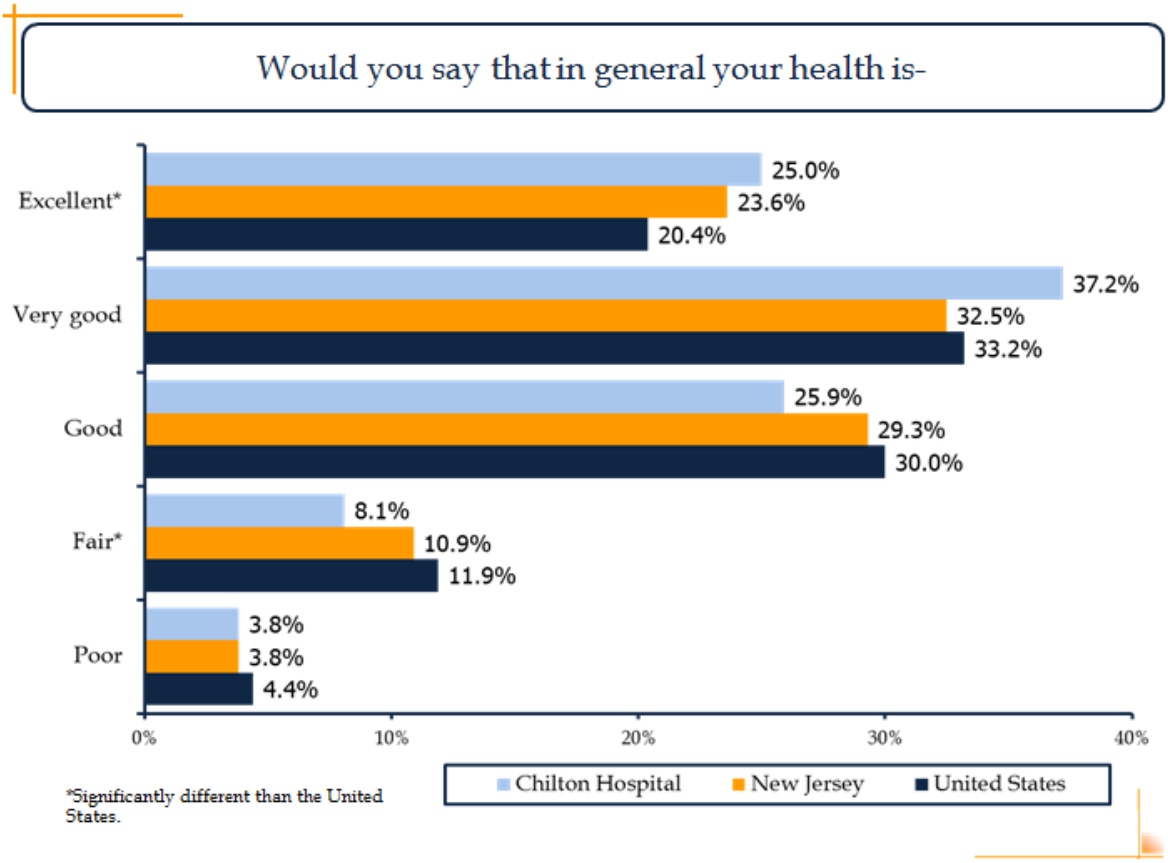




Health Status & Chronic Health Issues

Physical Health

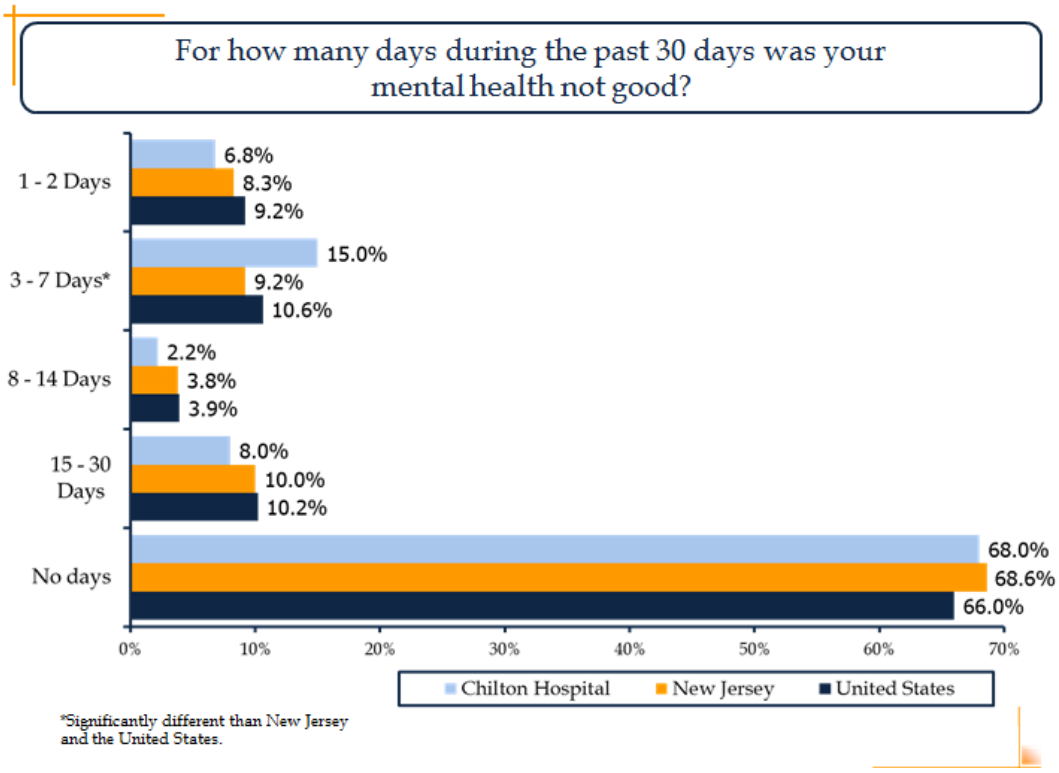
Overall, residents of the Chilton Hospital service area reported having excellent or very good health (62.2%). Only 11.9% of residents reported have fair or poor health compared to 14.7% across the state and 16.3% across the nation. In addition, the majority of residents did not experience any days of poor physical health during the past 30 days. The exception is Asian residents. Asian residents were more likely to report days of poor physical health than White residents.

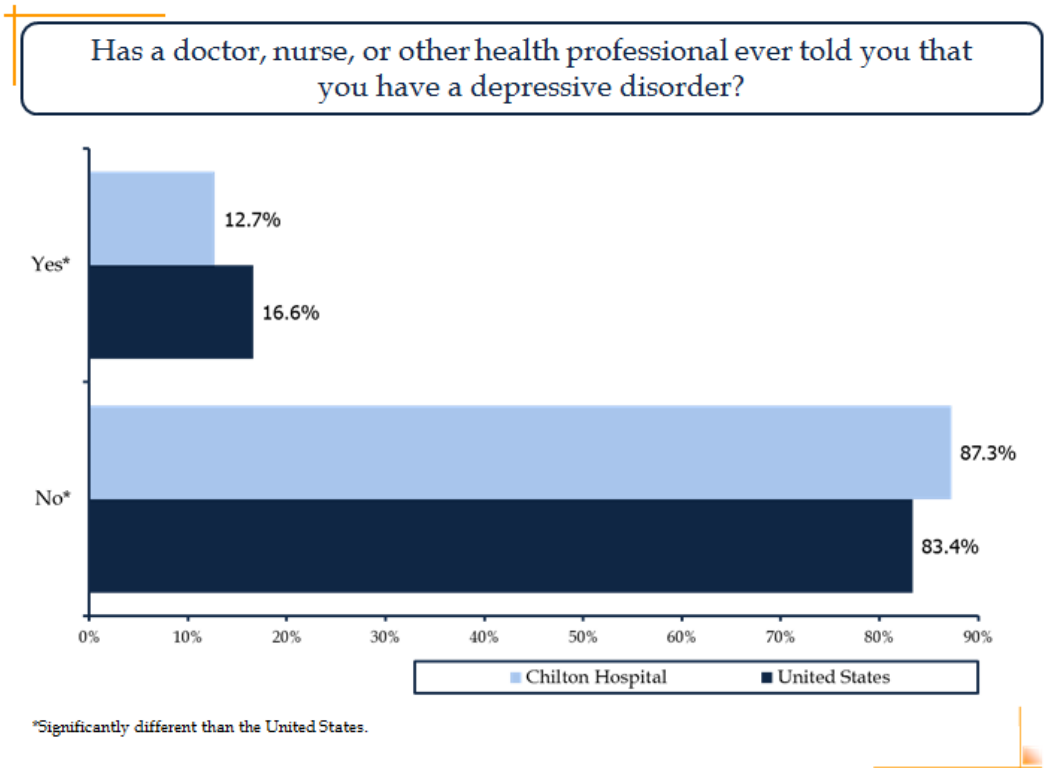


Mental Health

Based on the results of the household telephone survey, mental health is not a significant issue for the overall population served by Chilton Hospital. Residents were not prone to anxiety disorders and were less likely to have a depressive disorder (12.7%) when compared to the nation (16.6%). In addition, the majority of residents did not have any days during the past 30 days in which their mental health was not good. However, disparities exist based on gender and race/ethnicity. Female residents were more likely than male residents to have an anxiety and/or a depressive disorder. Females were also more likely to report 15 to 30 days of the past 30 days

in which their mental health was not good. Black/African American residents were more likely than White and Asian residents to report days of poor mental health during the past 30 days.



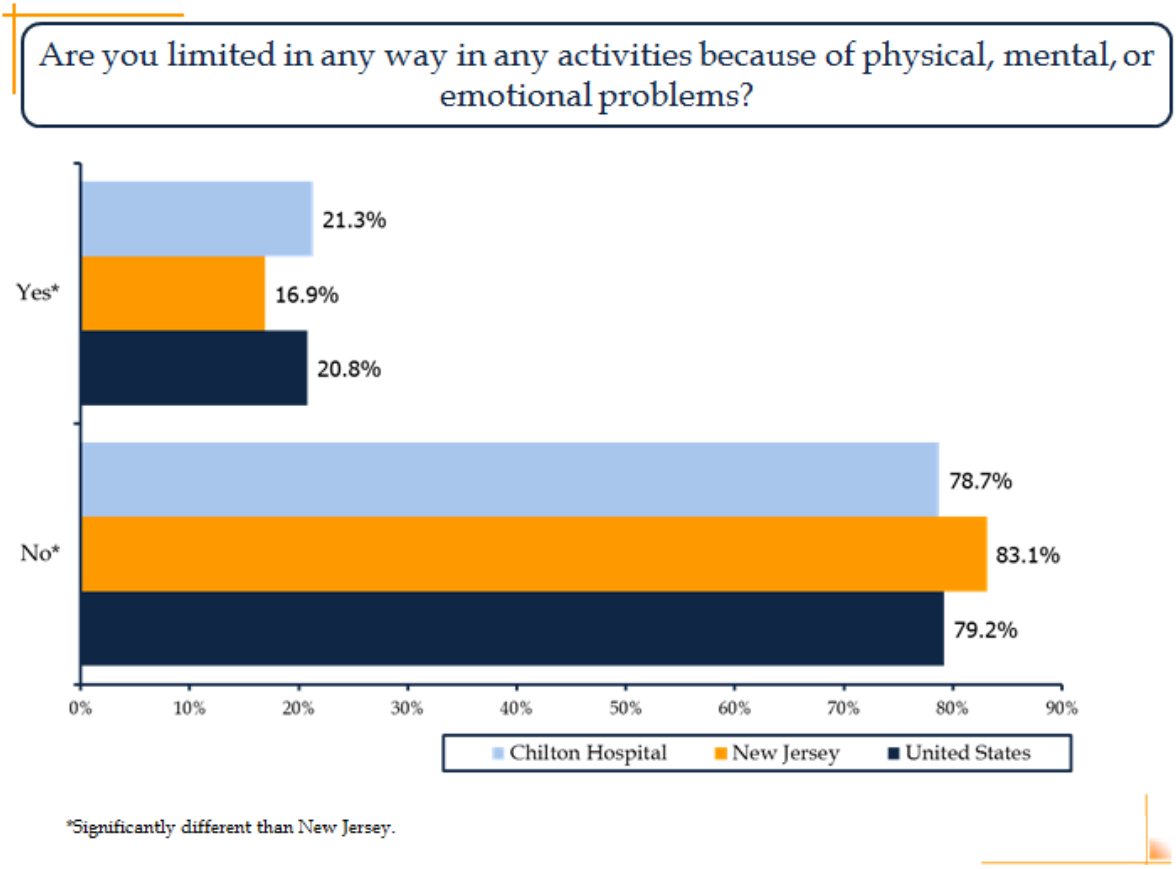


Chronic Health Issues

When asked if they had been diagnosed with various chronic health conditions such as heart disease, cancer, asthma, arthritis, kidney disease and diabetes, residents of Chilton Hospital's service area were no more or less likely to have a diagnosis in comparison to the state and the nation. In addition, there were no disparities identified based on gender and race/ethnicity.

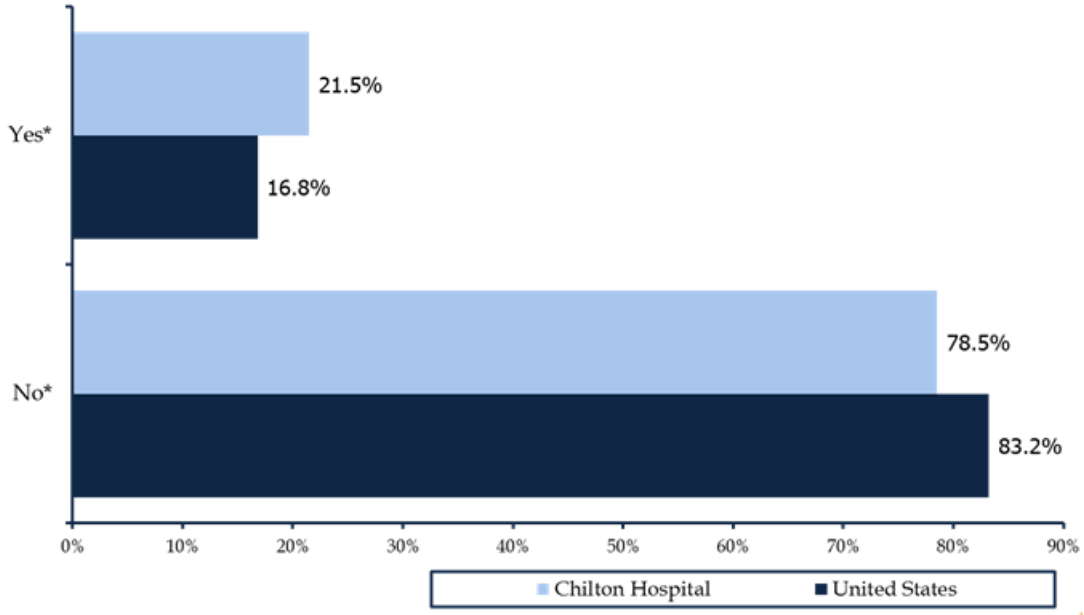
Disability & Caregiving Needs

Residents of the Chilton Hospital service area were more likely to report being limited in their activities because of physical, mental, or emotion problems (21.3%) compared to the state (16.9%). However, they were no more likely to require special equipment to assist them with their limitation.



A higher proportion of residents reported that they provided regular care or assistance to a friend or family member during the past month (21.5%) when compared to the nation (16.8%). The majority of caregivers cared for an adult 65 years or more (70.8%) and had been providing care for one or more years. The areas in which the person receiving care most needed help were transportation outside of the home, taking care of his/her residence, and taking care of himself/herself. The greatest difficulty that caregivers faced was stress.

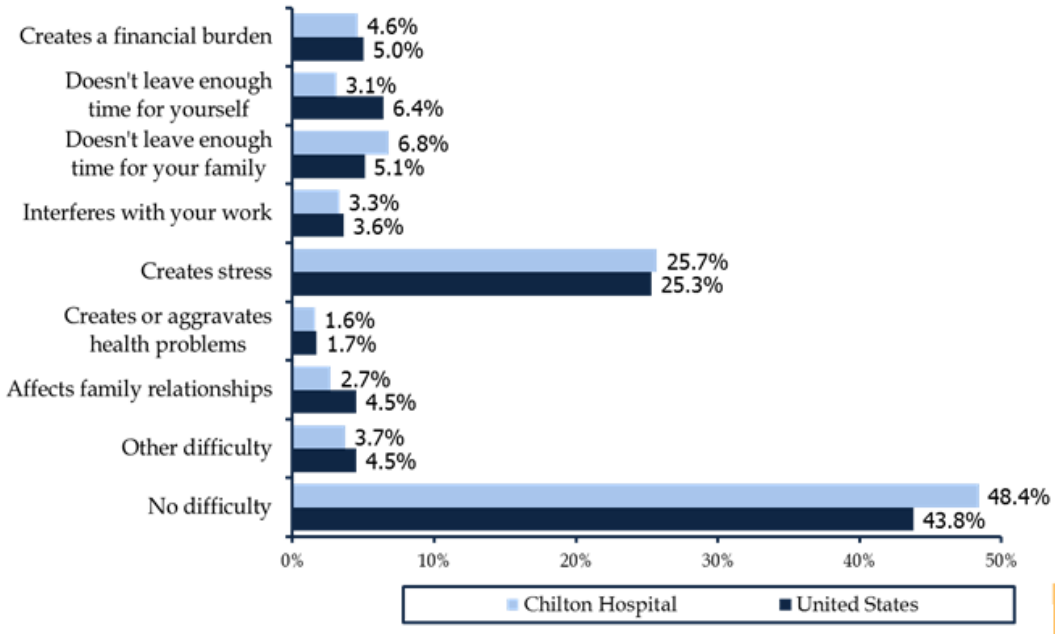
During the past month, did you provide regular care or assistance to a friend or family member?



*Significantly different than the United States.

Please indicate which one of the following is the greatest difficulty you have faced as a caregiver.

Respondents who provide regular care or assistance to a friend or family member



HOLLERAN

FINAL THOUGHTS

The Household Telephone Survey results provided important information about the current health status and health behaviors of residents in the Chilton Hospital service area. A review of the Household Telephone Survey results yields several areas of opportunity for the local community.

Areas of Opportunity

- Access to care
  - Males and Hispanics/Latinos
- Overweight/Obesity
- Alcohol Consumption
  - Males and Hispanics/Latinos
- Mental Health
  - Females and Blacks/African Americans
- Caregiver support
  - Mental well-being

IV. FOCUS GROUPS OVERVIEW

BACKGROUND

A total of four focus groups were held at various locations throughout Morris and Passaic Counties in March 2013. Focus group topics addressed Access to Care, Nutrition and Exercise, Cancer Screenings, and Cultural Competency. Each session lasted approximately 90 minutes and was facilitated by trained staff from Holleran.

Participants were recruited through local health and human service organizations and public news releases. In exchange for their participation, attendees were given a $50 gift card at the completion of the focus group. A discussion guide developed in consultation with Chilton Hospital, was used to prompt discussion and guide the facilitation (See Appendix D).

In total, 54 people participated in the focus groups. It is important to note that the results reflect the perceptions of a limited number of community members and may not necessarily represent all community members in Chilton Hospital's service area. Participants in the focus groups represented Hispanic/Latino, South Korean, South Asian Indian, and general consumer populations.

The following section provides a summary of the focus group discussions including key themes and select comments.

KEY THEMES

Access to Care

Access to care was an area of great variability among the different focus groups. Respondents in the Latino/Hispanic group struggled the most with obtaining health insurance coverage and accessing care. They acknowledged that they avoid seeking care whenever possible due to out-of-pocket costs and primarily utilize free clinics and federally qualified health centers when they do seek care. A number of the South Korean respondents also reported struggles in accessing care, primarily due to cost. One woman stated, "I used to go to a private doctor's office when I had insurance but now [since losing insurance] I don't go unless I am sick." Both of these groups cited language barriers and a need for increased bilingual services. In contrast, all of the general consumer respondents and a majority of the South Asian Indian respondents had health insurance coverage and a medical home. As a result, general consumer respondents cited barriers such as long wait times for appointments instead of cost. Despite a high rate of health insurance coverage among the group, South Asian Indian respondents reported cost as a barrier among individuals in their community. They also reported immigration status as a barrier due to a large population of undocumented immigrants that does not seek care for fear of being deported.

The groups offered similar suggestions for improving access to care. The first suggestion was to provide more information on what health services and health insurance programs are available and to assist individuals in connecting with the appropriate one. The second suggestion was to address the issue of cost, perhaps through more clinics and charity care. The group was also anxious for more patient education programs and workshops on various health topics.

Nutrition and Exercise

Nutrition and exercise are priority issues for all of the focus group populations except the South Asian Indian population. In the Latino/Hispanic group, only a quarter of respondents reported exercising on a regular basis. Lack of time and a need for sleep were cited as reasons for not exercising. A majority of Latino/Hispanic respondents reported that they are typically able to eat enough fruits and vegetables, but cost is a barrier. In the general consumer group, less than 30% reported regular exercise and just over half reported recommended fruit and vegetable consumption. The reasons for not exercising included lack of time, lack of motivation, and exhaustion, while the reason for not eating fruits and vegetables included taste and perishability. None of the respondents in the South Korean group reported regular exercise and only two reported eating enough fruits and vegetables. Their reasons for not exercising were similar to the other groups. One woman stated, "I have to raise my kids and work – I need time to sleep." In regard to nutrition, the group admitted that fruits and vegetables are available and cost is not

a barrier, but that they have a preference for prepared American foods and simply do not enjoy fruits and vegetables.

The groups were interested in additional sources of information, primarily related to nutrition. Specific requests were made for healthy recipes, nutritional information, and personalized vitamin and herbal supplement information. However, respondents reported that this information needs to make it to the correct person in the household. For example, one man stated, "My 'other half' cooks," implying that the way to get him to eat healthier was to reach out to his wife. In addition, respondents commented that the information needs to be in multiple languages and at an appropriate reading level. Preferred channels of communication were on-line sources, hospital newsletters, magazines, newspapers, and physician offices.

Cancer Screening

Respondents were familiar with cancer screenings such as mammograms, Pap smears, and prostate exams. However, the receipt of screenings was reliant upon access to care. Respondents with insurance were likely to receive screenings on a regular basis, but respondents without insurance were unable to afford them. A number of comments were made about the need for more free or low-cost services for the uninsured population. In addition, respondents felt that there needed to be better advertising for events that offer these services. For example, one Latino/Hispanic respondent shared a flyer advertising free/low-cost services; none of the other participants were aware of it.

Cultural Competency

A positive finding of the focus groups was that none of the respondents felt that they were treated differently by the health care system because of their race/ethnicity. Discrimination was not addressed as a concern and many of the responses to cultural competency questions were focused around time, communication issues, and the need for more patient education. Respondents in the Latino/Hispanic and South Korean groups were the most likely to report communication issues with their providers. This was primarily due to language barriers and limited bilingual capacity. However, respondents also reported feeling rushed in their communication and not having enough time to express themselves or get a full explanation from their provider.

Several issues were mentioned as being uncomfortable to discuss with a health care provider. The first was the use of home remedies and alternative medicines. One respondent said that he has a strong belief in these practices, but that his doctor does not always agree with them. They have agreed to not discuss them. The second issue was diet. Particularly in the Latino/Hispanic and South Asian Indian groups, respondents felt that providers do not understand their cultural

differences regarding food. For example, mothers feed their children different foods and herbs that are foreign to Western-trained physicians. Other issues that are avoided include sexuality in teenage girls, domestic abuse, mental health problems, and erectile dysfunction in men. One focus group participant commented, "The likelihood to discuss these issues is based upon the level of trust with the provider."

There was a very clear desire for more patient education on a wide range of health issues. All of the respondents saw a need to raise public awareness about how the health care system works and about the importance of healthy living and preventive screenings. Respondents thought that offering these events on Sundays after church services was the best option. However, they also felt that health information needed to be part of the culture and start with the youth. One respondent said, "Health awareness needs to be part of the social culture – starting in the schools. Kids are young and listen more."

FINAL THOUGHTS

The focus group participants were grateful for the opportunity to share their thoughts and experiences, and at the end of the sessions, many expressed support for community-wide efforts to improve health in Chilton Hospital's service area. Based on the feedback from the focus group participants, the following issues appear to be areas of opportunity for the local community.

Areas of Opportunity

- Access to Care was an area of variability among the groups. The Hispanics/Latino and South Korean populations were the least likely to have access due to lack of health insurance coverage, co-pays, and language barriers. Additional access issues included awareness of available resources and expansion of free/low-cost resources, time barriers due to long wait times for appointments and at the physician office, and lack of dental providers.
- Health information and additional community programs and workshops are needed, specifically around professional nutrition consultation. Information must be provided in multiple languages.
- Most groups acknowledged cost and access barriers to healthy foods. The South Korean population, specifically, was less likely to exercise or consume healthy foods.
- Lack of cancer screenings among the groups was mainly due to lack of health insurance coverage and out-of-pocket costs, if uninsured.
- The groups were interested in natural/holistic medical care approaches, but felt providers were not knowledgeable about the subject or not supportive of these types of practices.

V. IDENTIFICATION OF COMMUNITY HEALTH NEEDS

PRIORITIZATION SESSION

In October 2012, a broad group of community leaders met to discuss the CHNA results and identify priority community health needs. Four priority areas emerged: 1) Healthy Eating and Active Living (with an emphasis on early childhood), 2) Access to Care and Preventive Services (with an emphasis on the Hispanic/Latino population), 3) Mental and Behavioral Health (with an emphasis on senior adults and their caregivers), and 4) Cancer Prevention. A total of 33 individuals attended the session. These individuals included:

Name	Title	Organization
Nebesni, Steve	Municipal Alliance Coordinator	Human Services Morris County
Beloff, Joan	Director Community Outreach	Chilton Hospital
Mehta, Nisha	Manager, Community Outreach	Chilton Hospital
Franklin, John	CEO	United Way of Northern NJ
Borden, Michelle	Staff Representative	New Bridge Services
Blanchfield, Michele	Director Special Populations	Zufall Health Center
Cianci, LeeAnn	Health Clinician	Hope House
Shivas, Jane	Staff Representative	JBWS
Armstrong, Jane	Dean Corporate/Community Ed	County College of Morris
Stoller, Arlene	Health Educator	Morris County Office of Health Management
Correale, Peter	Health Officer	Pequannock Health Dept
Caputo, Mark	Health Officer	Randolph, Rockaway & Roxbury
Ruminska, Martyna	Staff Member	Prosecutors Office
Hayashida, Perla	Community Outreach	Neighborhood House
Guevara, Xiomara	Executive Director	Morris County Office Hispanic Affairs
Linder-Day, Rosemary	Director Community Relations	Lakeland Hills YMCA
Lanza, Denise	Parks Coordinator	Morris County Park Commission
Galloway, Stephanie	Manager, SCHS Marketing	Saint Clare's Health System
DeMartinez, Marie	Director, Marketing	Sant Clare's Health System
Lyons, Cynthia	Director, Community Relations	Saint Clare's Health System
Lapsley, James	VP Physician Enterprise	Saint Clare's Health System
Kirk, Christopher	Director Mission Development	Morristown Medical Center (AHS)
Orr, Christine	Manager, Community Health	Morristown Medical Center (AHS)
Hughes, Vicki	Manager, Community Health	Morristown Medical Center (AHS)
Walsh, MaryAnn	Coordinator Health Education	Morristown Medical Center (AHS)
Neigher, William	Chief Strategy Officer	Morristown Medical Center (AHS)
O'Donnell, Susan	Executive Director	El Primer Paso
Wilpert, Frank	Health Officer	Mount Olive, Wharton, Dover

Shermer, Robert	Consultant	Morris County Health Partnership
Roers, Michelle	Director	United Way of Northern NJ
Galton, Katy	Nutrition Educator	Interfaith Food Pantry
Scott, David	Coordinator, Exercise Physiology	Morristown Medical Center Goryeb Pediatric
DeGraw, Carol	Community Impact/Morris Office	United Way of Northern NJ

COMMUNITY HEALTH ISSUES

Healthy Eating and Active Living

The exercise and nutrition habits of area residents were identified as a top priority for the health of our community. While many people reported exercising regularly, 14.5% of the population was physically inactive (i.e. no exercise at all within the past month). One in five residents reported not eating vegetables on a daily basis, and 27.9% reported the same for fruits. Research has shown that sedentary behaviors and poor nutrition contribute to a variety of adverse health including obesity and diabetes. In the CHNA, more than one in five participants was obese (21.5%) and 7.7% reported being diagnosed with diabetes.

As shown in the attached scorecard, different groups were at greater risk for unhealthy behaviors. While females were more likely than males to report being physically inactive, males reported worse nutrition and higher rates of obesity than female respondents. Asian participants reported the best health behaviors overall, with higher rates of physical inactivity among Hispanics and higher rates of obesity among White and Black respondents. Socioeconomic indicators showed that lower income (<$75 K in annual household income) and lower education (less than a 4-year college degree) participants were more likely to be physically inactive, diabetic, and obese. These disparities suggest that targeted programs, policies, and resources may be needed to improve men's health and to promote health among adults of lower socioeconomic status.

At the October Community Needs Prioritization meeting, much of the discussion around physical activity and nutrition focused on helping children get a strong start in life by addressing programs and policies at young families. State-level data show that New Jersey has one of the highest rates of pre-school child obesity among low-income children. While the CHNA did not directly survey children or their health behaviors, we can derive a great deal of information by looking at the behaviors of parents. Parents of children 18 and under in the sample had behaviors that were similar to the overall population: 11.6% were physically inactive, 28.4% did not eat fruit on a daily basis, and 19% did not eat vegetables on a daily basis. These data suggest the possible need for programs, policies, and resources that can help parents of young children (and childcare facilities) develop healthy food environments and promote physical activity.

Access to Care and Preventive Services

A second priority area that was identified during the Prioritization meeting was access to care. While the Morris County area has some of the best healthcare and highest rates of insurance in the Nation, the CHNA shows that many lack access to the basic health and preventive services they need. In sum, almost one in ten residents reported that they were uninsured (9.2%), did not have a doctor (9.4%), and had needed to visit the doctor in the past year but were prevented due to cost (9.3%). While these numbers were small compared to many places in New Jersey and the U.S., they still represent a significant number of individuals in the area.

As shown in the attached scorecard, the burden of limited access to care falls disproportionally on Hispanic/Latino and lower income residents (<$75 K). Almost one in three Hispanic/Latinos were unable to visit a physician due to cost and one in five did not have insurance. Lower income individuals and those with less education were also more likely to have limited access to affordable health care. While access measures in the CHNA focused on cost alone, many individuals may lack access due to transportation concerns or have difficulty accessing usable health information due to limited English ability and low health literacy. A collaborative effort to improve access to affordable, culturally sophisticated and health literate health care may be needed to reduce these disparities.

Limited access also means that people may be unable to access preventive services, immunizations, and screenings that are recommended. The CHNA collected a great deal of information on various screenings and preventive services. The attached scorecard shows that lower income women may be at great risk for not maintaining their well-woman care. Hispanic/Latino and Black residents were less likely to get their flu shots. While Blacks did report greater rates of testing for HIV and diabetes, this may be an indicator of increased risk for these diseases. Additional programs, policies, and resources may be needed to promote immunizations among Black and Hispanic groups, while helping lower income women receive the recommended preventive services (e.g. mammograms, pap test).

Mental and Behavioral Health

Mental Health

The mental health of the population was identified as a priority area. While many in the area reported excellent mental health overall, approximately one in 10 reported poor mental health status (15+ days of poor mental health per month), 10.2% reported being diagnosed with an anxiety disorder, and 11.4% reported being diagnosed with depression. A total of 9% of the general population had at least one diagnosis of mental illness, and 6.3% had both depressive and anxiety disorders.

As shown in the attached scorecard, mental health concerns are more likely to be found among females and individuals with lower income and education. While significant differences were not found by age group, the growing number of individuals between 45 and 64 with mental health

challenges may warrant further exploration. At the CHNA Prioritization Meeting, many needs for lower income seniors were discussed. Lower income seniors had almost twice the rate of anxiety disorders (9.7% to 5.8%) and five times the rate of depressive disorder (10.9% to 1.5%) compared to higher income seniors. These numbers suggest that programs, policies, and resources may be needed to promote mental health (e.g. by decreasing isolation, increasing engagement) among the population aged 65 and above and connecting mentally-ill seniors to the appropriate community services.

The aging of our population also translates into more adults serving the role of unpaid caregiver in the life of an aging parent or family member. In the CHNA, 21.1% of participants reported they were currently a caregiver. These individuals cited stress and costs as key challenges. As shown in the attached scorecard, caregivers were more likely to report poor mental health status and a diagnosis of an anxiety disorder. This corresponds with the rates of depression (13.8%) and anxiety disorder (12.5%) among those in the age range of 45 to 64. These data suggest the need for integrated programs, policies and resources to support caregivers of aging family members and address their mental health needs alongside the needs of those they support. While violence was not chosen as a top CHNA priority, the exposure to trauma is a significant issue that relates to mental health concerns. Participants who reported exposure to intimate partner violence (IPV) reported worse poor mental health status and greater rates of depressive disorder with approximately twice the rate for these illnesses compared to those who had not experienced IPV. Interventions may want to consider trauma exposure (via IPV or other types) in the design of goals.

Substance Use and Abuse

Another priority area was substance use and abuse. This encompassed alcohol, tobacco, and other drugs. The CHNA revealed that people in the area were more likely to consume alcohol (59.8%), but less likely to binge drink (15.6%) or engage in heavy drinking (i.e. more than two daily drinks for men or more than one daily drinks for women; 1.2%) than national and New Jersey norms. At the same time, residents were less likely to have smoked across their lifetime (40.4%) and only 11.4% were current smokers. No specific questions were included in the assessment for illicit drug use, but admissions data (and other agency reports) suggest that prescription drug and heroin use is of concern in the area. While these data compare favorably with U.S. and New Jersey averages, the number of people affected by substance use/abuse remains large and more data are needed on other drugs that were not included in this CHNA.

As shown in the attached scorecard, males were more likely than females to have smoked in their lifetime and to engage in binge drinking. While Whites were more likely to drink at all (63.5%), almost one in four Hispanic/Latinos reported binge drinking. On the socioeconomic indicators, alcohol use was higher among higher income residents with cigarette use higher among those with less than a Bachelor's degree. These disparities may suggest the need for targeted interventions to reduce substance use and abuse in these areas.

While the CHNA did not include information on adolescents, much of the research and funding in substance use/abuse has focused on preventing or delaying the onset of substance use behaviors. The most recent Youth Risk Behavior Survey showed that 40.6% of New Jersey high school students had smoked cigarettes in their lifetime and 16.1% were current smokers. Similarly, 69.1% had consumed alcohol (14.4% of which did so before age 13) and 23.7% had engaged in binge drinking within the past month. Other lifetime drug use statistics of note included marijuana (21.1%), heroin (1.6%), un-prescribed prescription drugs (15.1%) and ecstasy (7.1%). These numbers suggest that many youth are starting adverse substance use habits early and increased preventive programs, policies and resources may be needed to avoid long-term health effects and lifetime usage.

Cancer Prevention

The final identified priority area was cancer prevention. The CHNA revealed that cancer is the second leading cause of death among residents. Specifically, the mortality rate for all cancer sites is 212.2 compared to 196.3 in New Jersey, and 186.6 in the nation. Cancers of particular concern in the area include breast cancer and colorectal cancer. As depicted in the table below, the mortality rates per 100,000 for breast and colorectal cancer are higher among area residents than residents across New Jersey and the Nation.

	U.S.		New Jersey		Total Service Area	
	n	Rate	n	Rate	n	Rate
Breast	40,970	13.6	1,421	16.4	58	18.7
Colon, rectum and anus	53,586	17.8	1,766	20.4	83	26.8

A contributing factor to the cancer mortality rate is the lack of screenings among residents. Approximately nine out of 10 (90.1%) residents aged 50 years and over did not complete a blood stool test in the past year and 47.5% did not complete a sigmoidoscopy or colonoscopy in the past five years. A third of residents (33.1%) reported never having a sigmoidoscopy/ colonoscopy. The percentage of women overall who received a mammogram and/or a clinical breast exam in the past year was favorable compared to state and national statistics. However, the breast cancer mortality rate is still an opportunity in the area and more self breast-health practices are needed. This is especially true of minority and low income women who are not as likely to receive screenings due to access to care issues.

EXISTING COMMUNITY RESOURCES

Chilton Hospital will work with area health and human service providers, community agencies, and others to address the identified community health needs. A list of existing community assets is below.

- American Red Cross
- Atlantic Health System
- Basking Ridge YMCA
- Catholic Charities
- Center for Prevention and Counseling
- Chilton Hospital
- Chronic Disease Coalitions Morris/Somerset and Sussex/Warren
- Community Hope
- County College of Morris
- DEA
- Diabetes Association
- Dover High School
- El Primer Paso
- Family Intervention
- Family Service of Morris County
- Goryeb Pediatric Sport & Exercise Medicine
- Head Start
- Hopatcong Health Advisory Committee
- Hope House
- Human Services Morris County and Sussex County
- Saint Clare's Visiting Nurse Association
- Skylands Medical Associates
- Sussex County Community College
- Sussex County Environmental and Public Health Services
- Interfaith Food Pantry
- Jersey Battered Women's Service
- Lakeland YMCA
- MC Human Services
- Mental Health Association
- Morris County Health Partnership (Health Office of Morris County)
- Morris County Office of Health Management
- Morris County Office of Hispanic Affairs
- Morris County Park Commission
- Morris County Prevention is Key
- Mrs. Wilson's Halfway House
- Neighborhood House
- Newton Medical Center
- NJCEED Morris and Sussex County
- Office of Health Management
- Project Self Sufficiency
- Prosecutors Office
- Randolph YMCA
- Saint Clare's Behavioral Health
- Saint Clare's Rehabilitation
- United Way of Northern New Jersey
- Visiting Nurse of Northern New Jersey
- Women's Health Center
- Zufall Health Center

APPENDIX A: SECONDARY DATA PROFILE REFERENCES

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APPENDIX B: HOUSEHOLD TELEPHONE STUDY STATISTICAL CONSIDERATIONS

The Household Telephone Study sampling strategy was designed to represent the service area of Chilton Hospital. For the purposes of this study, 33 ZIP codes within Morris, Passaic, Essex, Bergen and Sussex Counties were used to define the hospital service area.

The sampling strategy identified the number of completed surveys needed within each ZIP code based on the population statistics from the U.S. Census Bureau in order to accurately represent the service area. Call lists of household land-line telephone numbers were created based on the sampling strategy. The final sample (783) yields an overall error rate of +/-3.5% at a 95% confidence level. This means that if one were to survey all residents of Chilton Hospital's service area, the final results of that analysis would be within +/-3.9% of what is displayed in the current data set.

Data collected from the 783 respondents was aggregated and analyzed by Holleran using IBM SPSS Statistics. The detailed survey report includes the frequency of responses for each survey question. In addition, BRFSS results for New Jersey and the United States are included when available to indicate how the health status of Chilton Hospital's service area compares on a state and national level. All comparisons represent 2010 BRFSS data unless otherwise noted. It is important to note a few questions on the survey did not have comparisons to New Jersey and/or national data because of survey modifications.

Statistically significant differences between service area responses and state and/or national responses are also noted in the detailed report. In addition, statistically significant differences for select demographic characteristics (gender, race/ethnicity) are included in the report. Holleran runs Z-tests and Chi Square tests in SPSS to identify statistically significant differences and uses p values $\leq .01$ as the cutoff for significance.

It is common practice in survey research to statistically weight data sets to adjust for demographic imbalances. For example, in the current household survey, the number of females interviewed is above the actual proportion of females in the area (Sample: 62.5% female vs. Actual Population: 51.3% female). The data was statistically weighted to correct for this over-representation of females. The data set was weighted by age, gender, and race in order to more accurately represent the population. It should be noted that the national dataset (from the CDC) is also statistically weighted to account for similar imbalances.

APPENDIX C: HOUSEHOLD TELEPHONE STUDY PARTICIPANT DEMOGRAPHICS

Frequency of Responses by Zip Code

Zip	Percent	Zip	Percent	Zip	Percent
07004	1.1%	07419	5.0%	07444	3.2%
07005	1.9%	07420	1.7%	07456	3.6%
07035	3.1%	07421	1.0%	07457	1.1%
07045	2.8%	07422	1.8%	07460	1.7%
07058	0.8%	07424	3.8%	07461	13.3%
07082	1.7%	07435	0.4%	07462	2.7%
07403	2.3%	07436	1.8%	07465	1.9%
07405	5.5%	07438	2.4%	07470	14.4%
07416	3.1%	07439	1.0%	07480	4.6%
07417	1.7%	07440	1.4%	07508	3.1%
07418	1.3%	07442	3.6%	07512	1.4%

Gender

Gender	Chilton Hospital CHNA 2012	Chilton Hospital Census*
Male	37.5%	48.7%
Female	62.5%	51.3%

What is your age?

Age Group	Chilton Hospital CHNA 2012	Chilton Hospital Census*
18 - 24	3.5%	8.6%
25 - 34	3.2%	9.8%
35 - 44	11.7%	13.8%
45 - 54	26.1%	17.4%
55 - 64	32.6%	13.1%
65 years and over	22.9%	14.7%

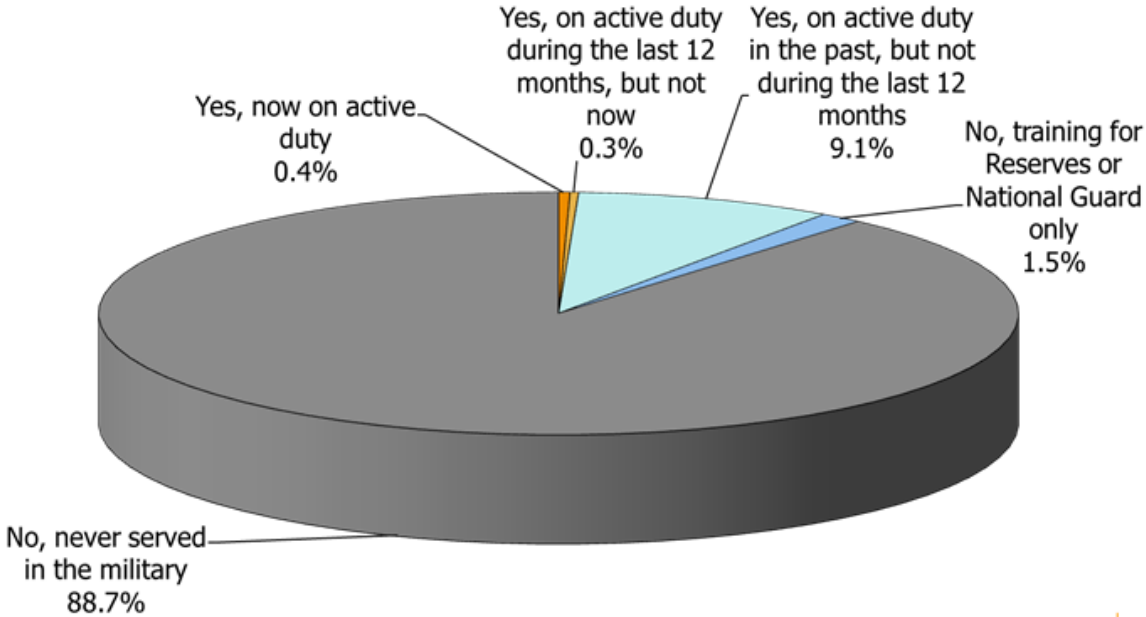
Are you Hispanic/Latino?

Hispanic/Latino	Chilton Hospital CHNA 2012	Chilton Hospital Census*
Yes	5.0%	9.1%
No	95.0%	90.9%

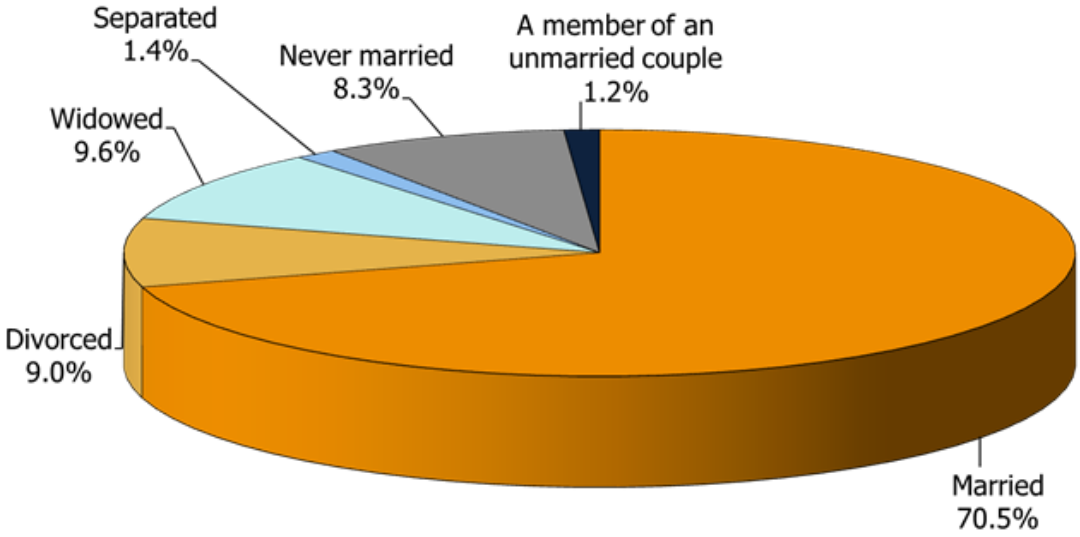
What is your race?

Race	Chilton Hospital CHNA 2012	Chilton Hospital Census*
White	93.3%	88.1%
Black or African American	1.6%	2.4%
Asian	2.4%	5.1%
Native Hawaiian or Other Pacific Islander	0.0%	0.0%
American Indian or Alaska Native	0.3%	0.2%
Other	2.5%	2.3%

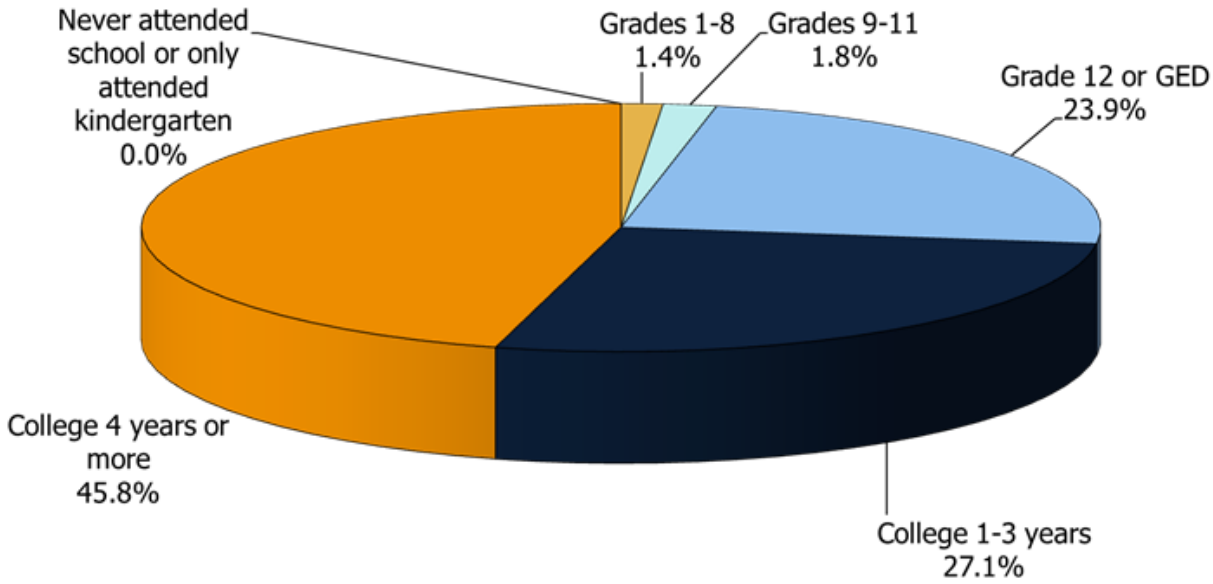
Have you ever served on active duty in the United States Armed Forces?



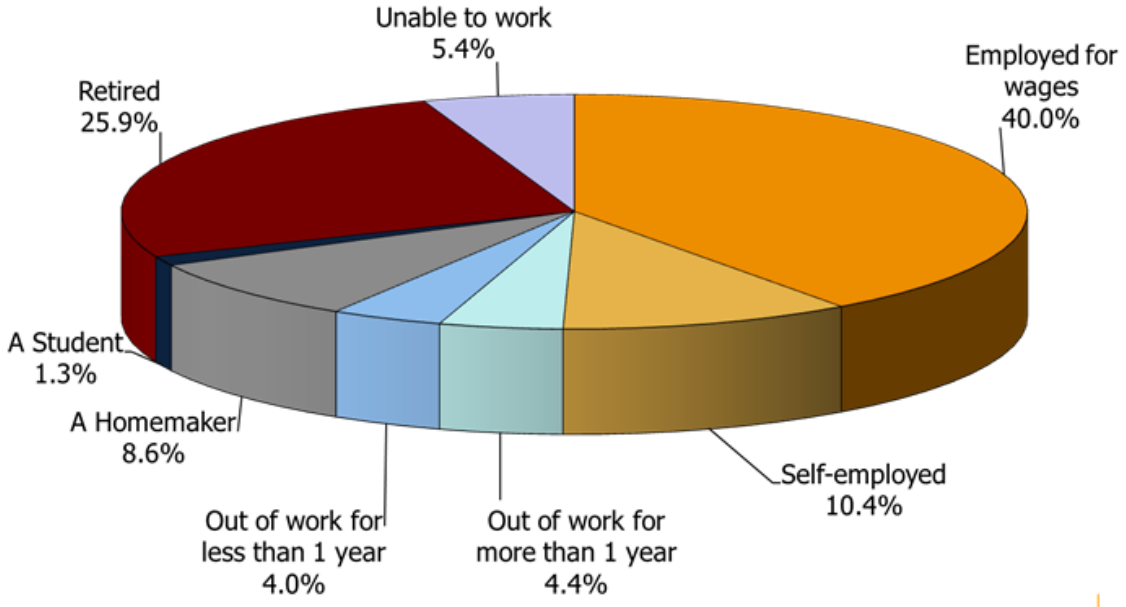
Marital Status



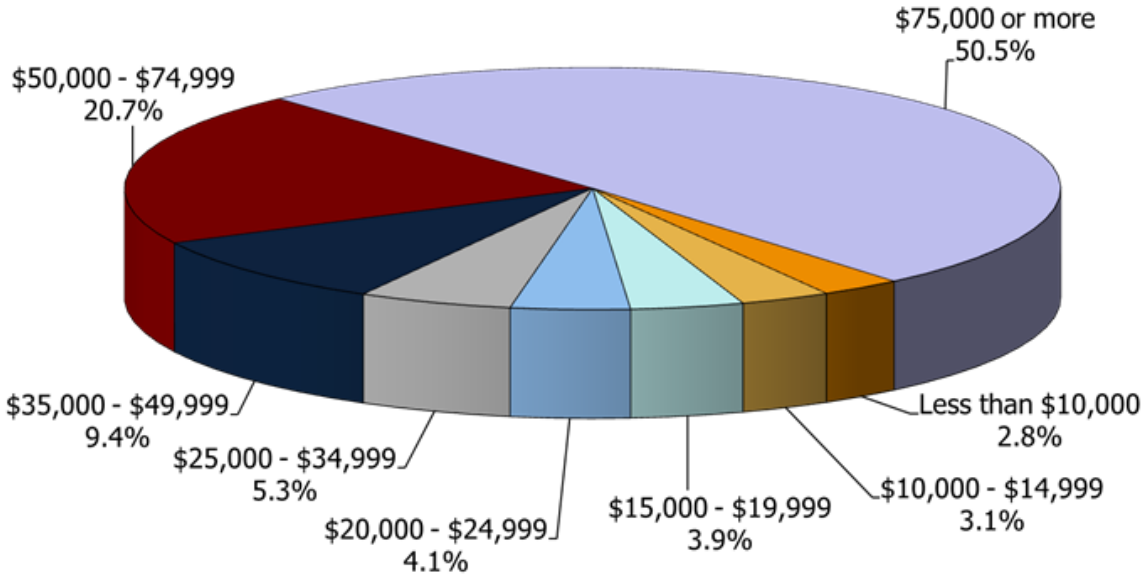
Highest Grade/Year of School Completed



Employment Status



Annual household income from all sources



APPENDIX D: FOCUS GROUP DISCUSSION GUIDE

ACCESS TO CARE

I'm going to begin the discussion with getting your feedback on health care as it relates to your ability to access health care.

1. **Where do you go for routine care and checkups? Where do you go for care when you are sick?** *Is there a difference? Do you get regular checkups or do you see a doctor only when you are sick or need treatment?*

2. **Have you or someone you know had difficulty obtaining health care services in the past few years? If yes, what are the reasons?**
   Probes: *What are the most significant barriers that keep people in the community from accessing health care? Ex. Insurance coverage, copays, availability of providers, transportation, cost, language/ cultural barriers, accessibility and awareness of services*

3. **Where do uninsured and underinsured individuals go when they need health care?** *Is that a good option? Why or why not?*

4. **What could help improve access to care in the community or make it easier to navigate the health care system?**

NUTRITION AND EXERCISE

Let's discuss what education options are available and what would be helpful to you.

5. **Where do you currently get health information related to nutrition and exercise? How do you like to receive health information?**

   ***Probes**: Health provider, clinic, pharmacist, health educator, nurse, nutritionist, churches, family members, magazine/newspaper, TV, radio, etc. Explore online/electronic options for getting health information; finding out if this is something they use and finding out if they would prefer to get information in this or any other format.*

6. **What other kinds of health information related to nutrition and exercise would be most helpful to you?**

   ***Probes**: Tips about healthy eating, recipes, exercise, etc. What format of information - Brochures, booklets, flyers, newspaper articles, church newsletters/programs, videos, radio programs, television programs, etc. do you prefer?*

7. **Do you exercise? If yes, what do you do? How often do you exercise? How much time do you usually spend exercising? If no, why not?**

8. **Do you think you eat enough fruits and vegetables every day? Why or why not?**

   Recommended daily consumption: 1.5 cups to 2 cups depending on age and gender or half your plate. Do you have any problems buying/affording fruits and vegetables?

CANCER SCREENING

Next, let's shift the discussion to cancer screenings and why you do/do not receive them.

9. What types of cancer have you been tested for and how often are you tested?

***Probes**: Pap test, mammogram, blood stool test, PSA test*

10. For those of you who have not been screened for cancer, why not?

***Probes**: Painful, cost, insurance coverage, feel fine, doctor did not recommend*

11. How can health providers make it easier for you to get tested for cancer?

CULTURAL COMPETENCY

Lastly, lets discuss how comfortable you are going to the doctor and how you can be more comfortable.

12. Do you find it easy or hard to communicate with your health care provider?

13. Are there any topics you do not discuss with your health care provider because you don't think they will understand your culture? What topics? Why don't they understand/relate?

14. Do you think that your health care provider treats you differently than because of your race/ethnicity?

15. Is your health care provider a welcoming place for you? What would it look like if it were?

16. Are you able to read/understand health information that your provider gives you? Do you use an interpreter? Is that helpful?

17. What recommendations do you have for health care providers to improve delivery of care for your (insert cultural/racial/ethnic group)?

18. What does/could your doctor do to show you that he or she is respectful of your cultural background and sensitive to your needs?

Those are all the questions I have for the group. Is there anything you thought we would talk about that we didn't? Is there anything else you'd like to add that could be helpful for Chilton Hospital as they work to provide programs and services that meet the needs of the community?

Thank you again for your participation. I appreciate your candid responses. Your feedback is valuable and will help Chilton Hospital to improve their services.

APPENDIX E: Prioritization Scorecard Results

Physical Activity/Nutrition Scorecard

	Gender			Race/Ethnicity					Income			Education	
Indicator	Male	Female		NH White	NH Black	Asian	Hispanic		<$75 K	$75 +		< 4-year	Bachelor's +
Physical Inactivity	11.8%	17.0%		13.3%	20.6%	8.7%	24.4%		21.4%	9.0%		18.3%	11.2%
No Daily Vegetables	26.2%	13.8%		18.7%	20.8%	21.8%	28.1%		21.3%	20.2%		21.4%	18.1%
No Daily Fruit	35.8%	20.9%		26.4%	33.0%	30.6%	35.5%		29.6%	27.6%		30.2%	26.2%
Diabetes	9.1%	6.5%		7.9%	8.7%	6.0%	9.0%		10.9%	5.5%		9.4%	6.3%
Obesity	24.5%	18.7%		22.3%	28.1%	3.9%	19.3%		29.2%	18.4%		26.4%	17.2%
Legend:	**Better**			**Same**								**Worse**	

Access to Care Scorecard

	Gender			Ethnicity					Income			Education	
Indicator	Male	Female		NH White	NH Black	Asian	Hispanic		<$75 K	$75 +		< 4-year	Bachelor's +
Access to Care													
Uninsured	6.4%	5.5%		6.2%	16.0%	4.6%	19.5%		14.8%	1.9%		10.9%	4.6%
No Doctor	8.4%	7.1%		9.3%	20.7%	9.1%	11.9%		12.2%	7.6%		11.9%	8.6%
No Doctor Visit Past Year	21.7%	18.4%		21.6%	19.5%	25.3%	26.5%		22.5%	23.4%		15.3%	19.3%
Cost Prohibited	7.1%	8.3%		7.7%	12.8%	6.7%	29.4%		17.0%	4.3%		13.0%	6.1%
Preventive Services													
No Seasonal Flu Shot	51.0%	49.2%		54.1%	67.1%	54.2%	66.2%		53.7%	58.5%		55.0%	55.7%
No Pneumonia Shot (65+)	30.6%	32.5%		30.8%	--	--	--		29.3%	33.8%		66/1%	71.9%
No Mammogram (40+, 2 yrs)	--	23.4%		23.5%	25.7%	32.1%	16.2%		31.4%	15.8%		28.5%	18.6%
No Clin. Breast Exam (2 yrs)	--	12.8%		17.0%	15.3%	30.2%	20.0%		26.3%	9.0%		24.8%	11.7%
No Pap Test (21+, 2 yrs)	--	27.4%		24.9%	24.5%	24.1%	22.3%		34.0%	10.5%		31.8%	14.7%
No PSA Test (40+, 2 yrs)	31.4%	--		32.9%	51.0%	63.4%	35.2%		35.7%	37.7%		39.4%	33.6%
No Dig. Rectal Ex. (40+, 2 yrs)	35.8%	--		34.5%	46.9%	62.2%	47.2%		52.1%	66.9%		48.2%	31.1%
No Blood Stool (50+, 2 yrs)	86.2%	90.5%		84.1%	--	--	74.0%		85.0%	84.2%		84.9%	82.8%
No Sigmoid/Colonoscopy (50+, 5 yr)	40.0%	45.4%		43.3%	--	--	46.8%		47.4%	37.5%		46.2%	40.5%
No HIV Test (Ever)	68.2%	63.7%		59.4%	45.9%	69.4%	54.1%		71.6%	62.3%		51.9%	56.3%
No Blood Sugar Test (3 yrs)	25.5%	30.1%		30.7%	23.5%	39.9%	43.1%		41.8%	36.8%		46.3%	35.8%
Legend:	**Better**					**Same**						**Worse**	

Mental Health (M.H.) and Well-Being

	Gender			Race/Ethnicity					Income			Education	
Indicator	Male	Female		NH White	NH Black	Asian	Hispanic		<$75 K	$75 +		< 4-year	Bachelor's +
Excellent M.H.	7.6%	8.6%		8.0%	7.7%	10.4%	5.2%		8.3%	7.7%		8.3%	8.0%
Poor M. H. Status	6.2%	10.8%		8.8%	12.8%	0.4%	10.3%		10.9%	6.0%		11.3%	6.3%
Anxiety Disorder	8.5%	11.8%		11.4%	2.8%	3.3%	9.7%		12.2%	8.9%		13.0%	7.7%
Depressive Disorder	10.4%	12.3%		11.6%	16.2%	3.4%	10.0%		15.3%	8.9%		12.5%	10.6%
Legend:	**Better**			**Same**								**Worse**	

Mental Health (M.H.) and Well-Being

	Caregiver			Age					IPV Exposure			Health Insurance	
Indicator	Yes	No		18-30	31-44	45-64	65+		Yes	No		Insured	Uninsured
Excellent M.H.	10.0%	7.8%		10.3%	9.2%	7.9%	5.4%		6.1%	8.5%		8.1%	8.6%
Poor M. H. Status	13.7%	7.2%		9.9%	7.0%	9.6%	8.2%		21.0%	7.5%		7.8%	17.9%
Anxiety Disorder	13.2%	9.4%		8.2%	8.4%	12.5%	9.5%		16.8%	9.6%		10.2%	10.2%
Depressive Disorder	12.2%	11.2%		11.7%	9.3%	13.8%	9.2%		19.6%	10.7%		11.0%	16.1%
Legend:	**Better**			**Same**								**Worse**	

Substance Use and Abuse

	Gender			Race/Ethnicity					Income			Education	
Indicator	Male	Female		NH White	NH Black	Asian	Hispanic		<$75 K	$75 +		< 4-year	Bachelor's +
Any Alcohol Use	62.8%	57.0%		63.5%	32.9%	50.9%	47.4%		49.7%	70.8%		51.4%	67.3%
Heavy Drinking	1.7%	0.8%		1.6%	--	--	--		0.7%	2.0%		0.8%	1.6%
Binge Drinking	18.1%	13.3%		15.9%	7.8%	8.4%	24.0%		10.2%	20.6%		15.5%	15.7%
Lifetime Tobacco Use	44.3%	36.9%		43.7%	19.8%	17.1%	32.2%		43.6%	38.7%		46.1%	35.3%
Current Smoker	13.0%	9.9%		11.8%	4.5%	8.1%	9.3%		14.0%	10.2%		15.0%	8.1%
Legend:	**Better**						**Same**					**Worse**	