SECTION 1: APPROACHES AND METHODS

This Comprehensive Community Health Needs Assessment (CCHNA) used a variety of approaches and methods in order to create a holistic view of the current needs in New Jersey. Using quantitative health outcomes data, qualitative disparate populations data, policy and environmental data, and Scarborough Research™ survey data, this needs assessment provides a multi-dimensional look at New Jersey.

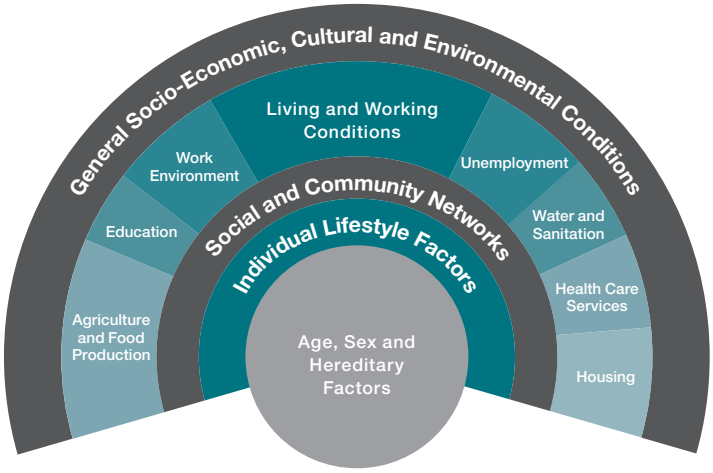
OVERARCHING FRAMEWORKS

The assessment – and the entire project development process – was guided by the idea that health is a multi-dimensional construct that is influenced by numerous social and economic factors. Given this, focusing interventions at the policy and systems level aims to have the largest impact on population health. The following section provides an overview of the approaches and frameworks used to guide this process.

Social Determinants of Health Framework

The social determinants of health framework addresses the distribution of wellness and illness among a population—its contours, its origins, and its implications. Building on this framework, this report approaches population data in a manner designed to identify who are the most healthy and least healthy in the community. It also aims to examine some of the larger social and economic factors associated with good and poor health. It is important to recognize that upstream factors such as housing, education, employment status, racial/ethnic disparities, and community-level resources critically affect population health. Figure 1 illustrates how a multitude of factors, from individual lifestyle choices to social networks to the larger community and social environment,can impact health. This report provides information on many of these factors, and reviews key health outcomes among the residents of the 13-countyfocus area.

Figure 1: Social Determinants of Health Framework

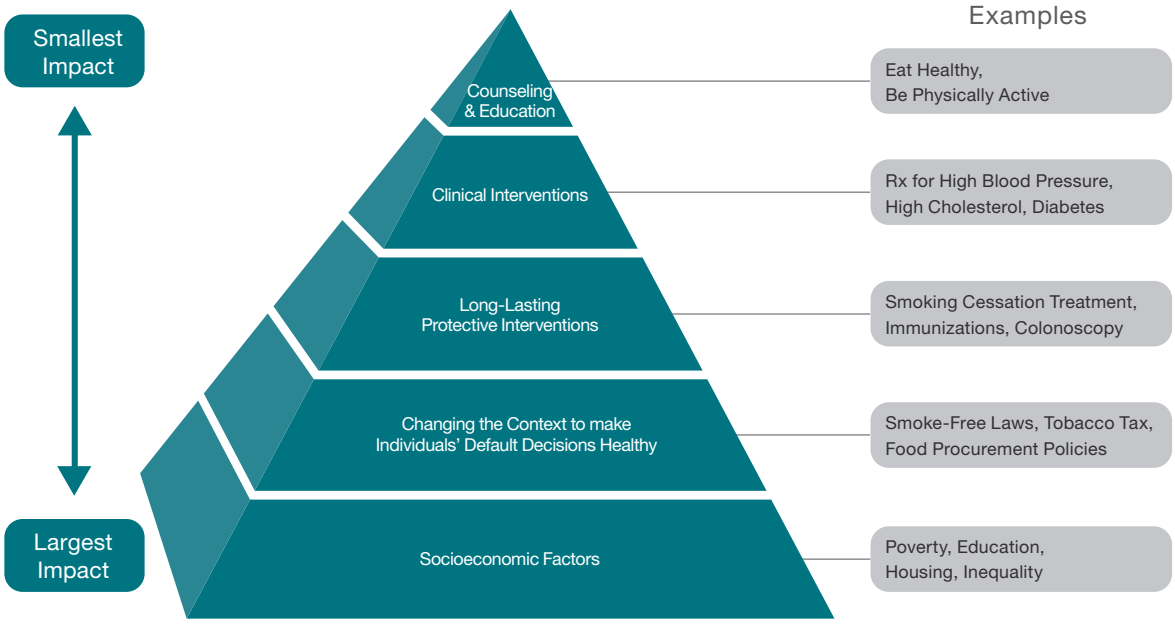


DATA SOURCE: World Health Organization, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health: Discussion paper for the Commission on the Social Determinants of Health, 2005.

Health Impact Pyramid

Figure 2 provides a visual illustration of the impact of larger population-based public health interventions as a framework towards improving health. The pyramid depicts interventions with the greatest potential impact on population health at its base –that is, efforts to address socioeconomic factors (e.g., poverty, education, housing and inequality). The second tier of the pyramid addresses contextual changes in the environment, thus creating spaces where individuals' default decisions are healthy ones (e.g., water fluoridation, smoke-free laws and increasing tobacco taxes). The Community Transformation Grant focuses primarily on these lower tiers of the pyramid, which are shown here to have the largest impact on factors that affect population health.

Figure 2: Health Impact Pyramid - Moving Public Health



DATA SOURCE: Frieden, T.R. A Framework for Public Health Action: The Health Impact Pyramid. American Journal of Public Health. April 2010, 100(4), 590-595.

Level of Analysis

This project is a unique one in that it is a partial statewide project targeting 13 of New Jersey's 21 counties. As noted earlier in this report, the Community Transformation Grant in New Jersey is focused on the 13 small counties due to the CDC's requirement. This was unique from most other assessments that are usually focused either statewide, county or local. The data that presented in this needs assessment takes a variety of approaches as it relates to comparisons: county compared to state statistics, county compared to other counties, or county or state compared to national statistics. In addition, the overall focus area is compared to the State of New Jersey as a whole. Each of these various views assisted in highlighting the needs and gaps that exist in the 13-county focus areas.

DATA COLLECTION

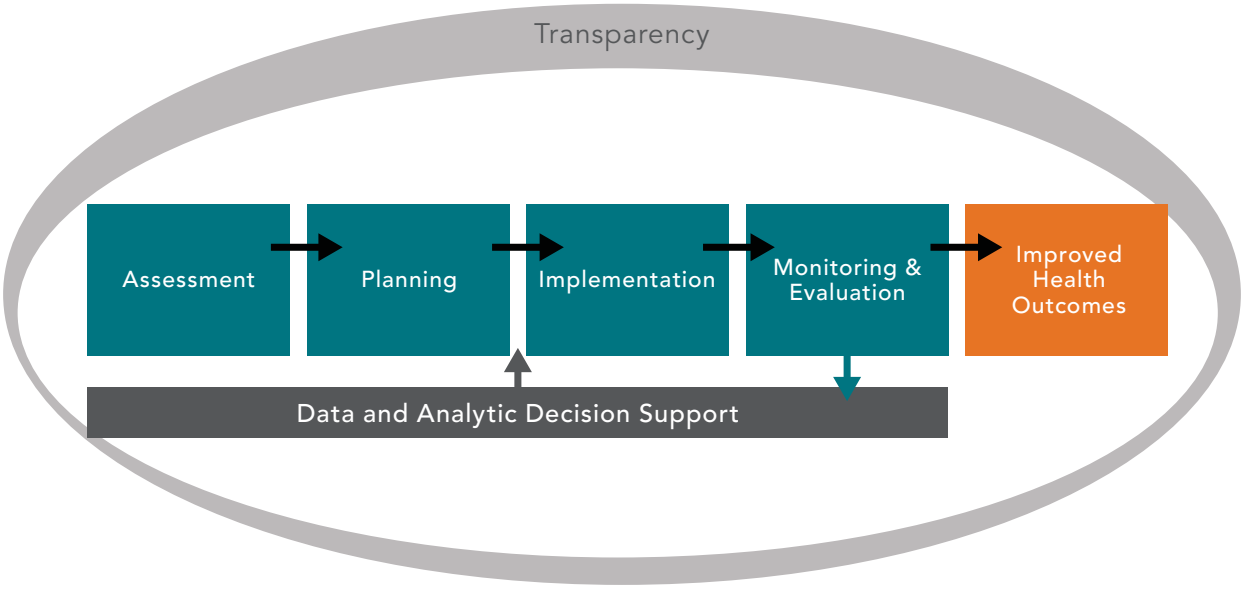
The Community Transformation Grant incorporated data from both quantitative and qualitative sources. New Jersey has many state and local data resources that examine community public health needs and assets. With this in mind,the initial key informant interviews and discussions at Coalition for a Healthy New Jersey (CHNJ) meetings have provided many existing statistical data sources such as Community Health Improvement Plans (CHIP), and the New Jersey Hospital Association (NJHA) Health Research and Education of New Jersey (HRET) County Health Profiles. The Comprehensive Community Health Needs Assessment consists of these identified existing data sources to avoid duplicating reports and to maximize the efforts made by CHNJ members and others in New Jersey. While this assessment attempted to encompass the chronic disease health indicators, it cannot measure all potential public health areas in the counties or state.

Quantitative Data Review

To develop a social, economic and health portrait of the 13-county focus area, the Strategic Advisory Groups (SAG), Executive SAG and the County Partners reviewed and compiled relevant existing data drawn from state and county data sources. This data was drawn from both primary and secondary sources and reflects indicators that address CDC's five strategic directions. Health Resources in Action (HIRA) then provided a final analysis. Data sources for this report included the 2013 Robert Wood Johnson Foundation's (RWJF) County Health Rankings, NJHA HRET County Health Profiles, the 2011 New Jersey Student Health Survey, existing community health assessment reports completed by several New Jersey agencies and the National Prevention Council Annual Status Report. Primary types of data included self-reported health behaviors from large, population-based surveys such as the Behavioral Risk Factor Surveillance Survey (BRFSS) as well as U.S Census Bureau data and vital statistics based on birth and death records.

The two major sources used were the NJHA HRET County Health Profiles and the RWJF's County Health Rankings & Roadmaps. The HRET profiles contained detailed information on the health indicators for each county in the areas of social determinants of health, health and healthcare. By providing detailed information about county-based chronic disease health indicators from each of these sources, it allowed us to review diverse data and provide a more accurate picture of the health disparities within these counties.

CDC's Unified Community Health Improvement Framework



Disparate Population Assessment

To enhance the quantitative data points, the County Partners,who are CTG's local grassroots connection, were asked to gather information about their populations and communities that were experiencing health disparities. It was understood that traditional data sources are not always able to reflect the immediate issues that communities face each day. The County Partners were charged with delving into their community through local data, key informant information, focus groups and identified populations currently experiencing health disparities.

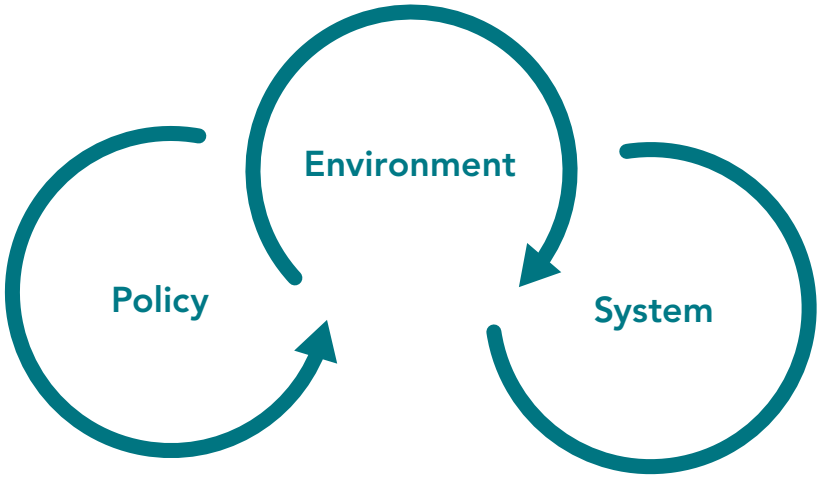
These mini-reports focused on at-risk populations,attempting to locate as best as possible the geographic locations within the county where these groups are concentrated. These reports also seek to identify how these populations are disproportionately affected by the priority issues within the CTG strategic directions. One page narratives are included in this report.

Environmental Policy Scan

Another component of the CCHNA is a policy scan conducted by the County Partners and NJPN staff. The intent of the policy scan was to identify the existing and missing policies that impact community health within the five strategic directions, with a special focus on identifying disparate populations. To that end, NJPN staff performed a scan of the readily accessible policy resources examining state and local areas. Further, the County Partners have provided local expertise and knowledge to identify the areas of concern within their communities. While conducting interviews as part of the Community Healthy Assessment Policy Tracking and Environmental Resources(CHAPTER) tool data collection process, County Partners asked the schools, worksites, municipalities and community institutions they interviewed to provide copies of policies that were in place at each of those locations. As this was a voluntary activity, and some interviewees were concerned about privacy, the number of policies collected through this method was comparatively low. However, the policies that were collected provide an insight into how sectors are changing to improve the health of the populations they serve.

Chronic Disease Resources Inventory Scan

The County Partners worked to identify resources (organizations that address chronic disease) within the 13-county focus area related to public health and the five strategic directions. In order to supplement this list, SAG members also contributed resources that they were aware of in each of the counties. As a result of these combined efforts, an extensive list of chronic disease resources was developed.



Limitations

As with all needs assessment documents, it attempts to capture a snap shot in time and will quickly become out of date.

1. For the quantitative data, the units of analysis and/or time frames may be inconsistent since the data were obtained from different sources. While every attempt was made to obtain the most current information, inconsistencies across datasets and time lags in data reporting were apparent.

2. While the unit of interest in this CCHNA is the county, it should be noted that county level data aggregates information from a potentially large geographic area. These figures may not capture the wide variation on an issue that can occur within a county.

3. Self-reported data, such as data from the Behavioral Risk Factor Surveillance System (BRFSS) and Scarborough Research™, should be interpreted with caution. In some instances, respondents may over or underreport behaviors and illnesses based on fear of social stigma or misunderstanding of the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly.

4. The process of gathering data with the CHAPTER tool is a subjective process. Although a training was provided to those leading the local collection process, there was no defined protocol to select team members. Team members assigned scores to each policy and environmental question based on their individual perceptions making the scores subjective in nature.

New Jersey Prevention Network