Jersey City Medical Center
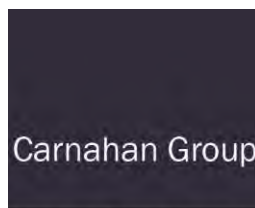
Community Health Needs Assessment

Adopted by the Joint Board of Trustees

September 26, 2013

Enhancing Life

Jersey City Medical Center

Carnahan Group

Strategic Healthcare Consulting
10 Years of Excellence

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Introduction

Jersey City Medical Center at a Glance

Jersey City Medical Center (JCMC) is located in Jersey City, NJ which is within the limits of Hudson County and overlooks the New York Harbor and Liberty State Park. JCMC is part of Liberty Health System and is located on a 15-acre campus that is home to two facilities, the Wilzig Hospital and the Provident Bank Ambulatory Center.

JCMC provides a high level of care for women and infants, trauma and cardiac patients, in addition to serving as a teaching affiliate for Mt. Sinai School of Medicine. In the 2012–2013 U.S. News and World Report's Best Hospital Rankings, JCMC was named a top regional hospital.

Community Overview

For the purpose of this report, Jersey City Medical Center defined its community as Hudson County. The map below represents the community served by JCMC.

Source: JCMC; Microsoft MapPoint 2013

Purpose

Community Health Needs Assessment Background

On August 6, 2012, Jersey City Medical Center contracted with Carnahan Group to conduct a Community Health Needs Assessment (CHNA) as required by the Patient Protection and Affordable Care Act (PPACA). Please refer to Appendix A: Carnahan Group Qualifications for more information about Carnahan Group.

The PPACA, enacted on March 23, 2010, requires not-for-profit hospital organizations to conduct a CHNA once every three taxable years that meets the requirements the Internal Revenue Code 501(r) set forth by the PPACA. The PPACA defines a hospital organization as an organization that operates a facility required by a state to be licensed, registered, or similarly recognized as a hospital; or, a hospital organization is any other organization that the Treasury's Office of the Assistant Secretary ("Secretary") determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under section 501(c)(3).

A CHNA is a report based on epidemiological, qualitative and comparative methods that assesses the health issues in a hospital organization's community and that community's access to services related to those issues. Based on the findings of the CHNA, an implementation strategy for Jersey City Medical Center that addresses the community health needs will be developed and adopted by the end of fiscal year 2013.

Requirements

As required by the Treasury Department ("Treasury") and the Internal Revenue Service (IRS), this CHNA includes the following:

- A description of the community served;
- A description of the process and methods used to conduct the CHNA, including:
    - A description of the sources and dates of the data and the other information used in the assessment; and,
    - The analytical methods applied to identify community health needs.
- A description of information gaps that impacted JCMC's ability to assess the health needs of the community served;

- The identification of all organizations with which JCMC collaborated, if applicable, including their qualifications;

- A description of how JCMC took into account input from persons who represented the broad interests of the community served by JCMC, including those with special knowledge of or expertise in public health and any individual providing input who was a leader or representative of the community served by JCMC; and,

- A prioritized description of all of the community health needs identified through the CHNA and a description of the process and criteria used in prioritizing those needs.

CHNA Strategy

This CHNA was conducted following the requirements outlined by the Treasury and the IRS, which included obtaining necessary information from the following sources:

- Input from persons who represented the broad interests of the community served by JCMC, which included those with special knowledge of or expertise in public health;

- Identifying federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by JCMC, leaders, representatives, or members of medically underserved, low-income, and minority populations with chronic disease needs in the community served by JCMC; and,

- Consultation or input from other persons located in and/or serving JCMC's community, such as:
  o Healthcare community advocates;
  o Nonprofit organizations;
  o Academic experts;
  o Local government officials;
  o Community-based organizations, including organizations focused on one or more health issues;
  o Healthcare providers, including community health centers and other providers focusing on medically underserved populations, low-income persons, minority groups, or those with chronic disease needs.

The sources used for JCMC's CHNA are provided in the References and Appendix B: Community Leader Interviewees. Information was gathered by conducting interviews with public health officials, Jersey

City and Hudson County government officials, physicians, hospital leaders and other community health leaders and focus groups with medically underserved community members.

Health Profile

Secondary Data Collection and Analysis Methodology

A variety of data sources were utilized to gather demographic and health indicators for the community served by JCMC. Commonly used data sources include Claritas, The U.S. Census American Community Survey (ACS), the New Jersey Department of Health and the Behavioral Risk Factor Surveillance System (BRFSS). Where applicable, Hudson County indicators are compared to the Healthy People 2020 (HP 2020) Goals. The HP 2020 Goals are science-based, ten-year national objectives for improving the health of all Americans. JCMC's community is defined as Hudson County, which consists of 14 ZIP Codes.

Demographics

Population in Hudson County

Figure 1 – Population Density by ZIP Code, 2013
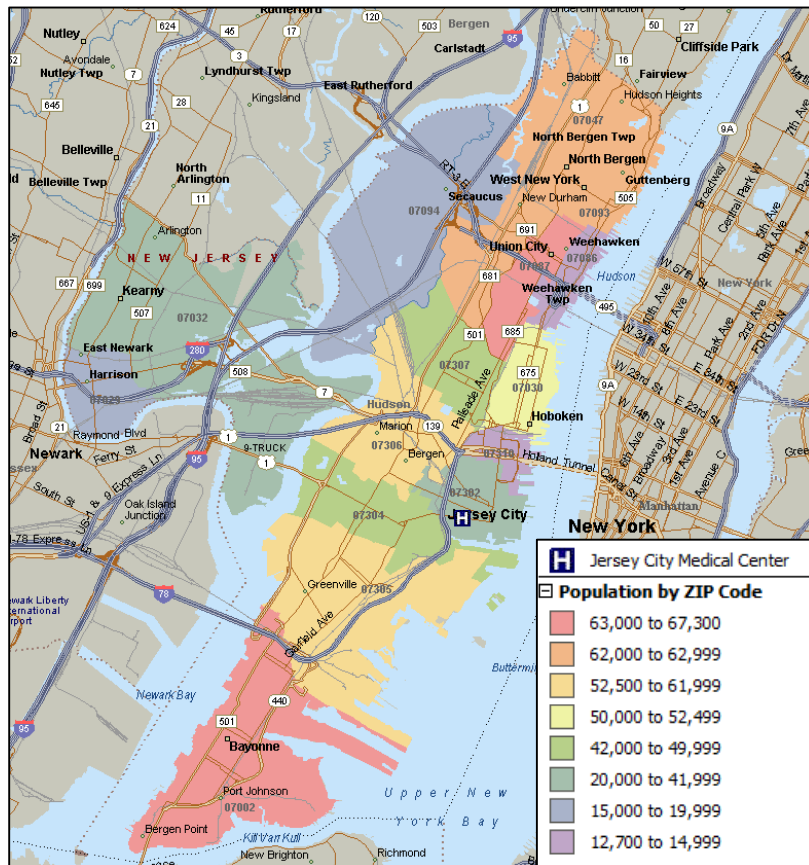
Sources: Claritas 2013; Microsoft MapPoint 2013

Population Change by ZIP Code

The overall community population is expected to grow 3.2% by 2018. Population growth is expected for all JCMC community ZIP Codes over the next five years. The majority of ZIP Codes are expected to grow slightly or moderately, while ZIP Code 07310 is expected to grow substantially (16.1%).

Table 1 – Population Change by ZIP Code, 2013–18

ZIP Code	Community	Population 2013	Population 2018	Percent Change
07087	Union City	67,285	68,541	1.9%
07093	West New York	62,104	64,625	4.1%
07002	Bayonne	63,937	65,085	1.8%
07047	North Bergen	62,794	64,755	3.1%
07305	Jersey City	61,620	63,496	3.0%
07306	Jersey City	52,766	53,701	1.8%
07030	Hoboken	52,437	55,665	6.2%
07307	Jersey City	44,108	44,519	0.9%
07032	Kearny	41,008	41,498	1.2%
07302	Jersey City	39,894	42,837	7.4%
07304	Jersey City	42,409	43,573	2.7%
07029	Harrison	16,002	16,037	0.2%
07094	Secaucus	16,517	16,876	2.2%
07310	Jersey City	13,628	15,818	16.1%
Total		**636,509**	**657,026**	**3.2%**

Source: Claritas 2013

Population Change by Age and Gender

The populations of children ages 0–17 and adults ages 45–64 are expected to grow moderately (6.3% and 8.8%, respectively). A population decline is expected for individuals ages 18–44 (-4.6%). Substantial population growth is expected for individuals ages 65 and older (16.7%).

Table 2 – Population Change by Age and Gender, 2013–18

Age Group	2013 Male	2013 Female	2013 Total	2018 Male	2018 Female	2018 Total	Percent Change Male	Percent Change Female	Percent Change Total
Age 0 through 17	68,711	65,118	133,829	72,973	69,349	142,322	6.2%	6.5%	6.3%
Age 18 through 44	145,192	136,985	282,177	138,999	130,178	269,177	-4.3%	-5.0%	-4.6%
Age 45 through 64	72,701	77,240	149,941	79,953	83,208	163,161	10.0%	7.7%	8.8%
Age 65 and older	28,674	41,888	70,562	33,964	48,402	82,366	18.4%	15.6%	16.7%
Total	**315,278**	**321,231**	**636,509**	**325,889**	**331,137**	**657,026**	**3.4%**	**3.1%**	**3.2%**

Source: Claritas 2013

Population by Race and Ethnicity

The most common race/ethnicity in Hudson County is Hispanic (42.8%), followed by white (29.5%), Asian (14.3%), black/African American (11.1%), individuals of two races (1.4%) and other races (0.9%).

Figure 2 – Race Composition, 2013
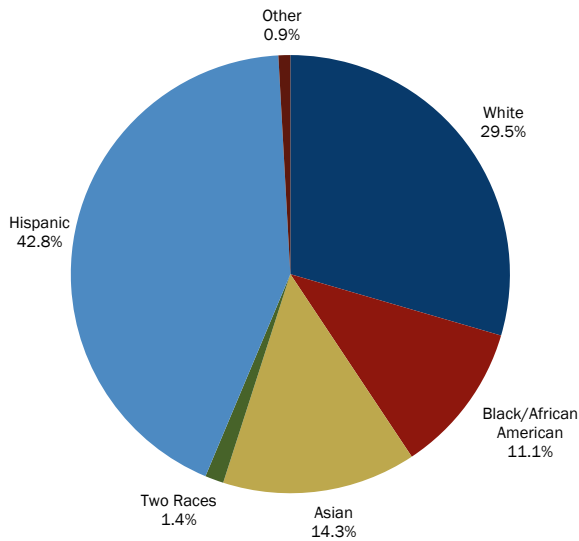
Source: Claritas 2013

Population Change by Race and Ethnicity

The Asian population is expected to grow substantially (14.1%) over the next five years. Slight population growth is expected for Hispanics (4.4%), while the population of individuals of other races

is expected to grow moderately (6.3%). Marginal population declines are expected for whites (-1.2%) and black/African Americans (-0.3%). Substantial population decline is expected for individuals of two races (-22.7%).

Table 3 – Population Change by Race and Ethnicity, 2013–18

Race & Ethnicity	Population 2013	Population 2018	Percent Change
White	187,912	185,586	-1.2%
Black/African American	70,964	70,733	-0.3%
Asian	90,891	103,696	14.1%
Two Races	8,706	6,730	-22.7%
Hispanic	272,494	284,392	4.4%
Other	5,542	5,889	6.3%

Source: Claritas 2013

Asian Population Change

Overall, the Asian population is expected to increase substantially (14.1%) by 2018. Substantial population growth is expected for the majority of ZIP Codes, while a decline is expected in only one ZIP Code (07302).

Table 4 – Asian Population Change by ZIP Code, 2013–18

ZIP Code	Community	Population 2013	Population 2018	Percent Change
07306	Jersey City	17,946	19,582	9.1%
07302	Jersey City	11,506	13,676	18.9%
07310	Jersey City	9,643	12,100	25.5%
07305	Jersey City	9,700	10,655	9.8%
07307	Jersey City	8,783	9,673	10.1%
07304	Jersey City	6,358	7,048	10.9%
07002	Bayonne	5,388	6,359	18.0%
07093	West New York	4,200	5,152	22.7%
07047	North Bergen	4,073	4,433	8.8%
07030	Hoboken	4,015	4,841	20.6%
07094	Secaucus	3,617	4,215	16.5%
07029	Harrison	2,528	2,809	11.1%
07032	Kearny	1,639	1,518	-7.4%
07087	Union City	1,495	1,635	9.4%
Total		90,891	103,696	14.1%

Source: Claritas 2013

According to the CDC, the leading cause of death among Asian American or Pacific Islanders is cancer. Other leading causes of death for this population can be found in Table 5.

Table 5 – Leading Causes of Death for Asian American or Pacific Islanders in the U.S., 2010

Top 10 Leading Causes of Death	
1. Cancer	6. Influenza and Pneumonia
2. Heart Disease	7. Chronic Lower Respiratory Disease
3. Stroke	8. Nephritis, Nephrotic Syndrome and Nephrosis
4. Unintentional Injuries	9. Alzheimer's Disease
5. Diabetes	10. Suicide

Source: CDC, NVSR: Deaths, Final Data for 2010

Other health issues affecting Asian Americans include HIV/AIDS, Hepatitis B, smoking and tuberculosis.

Hispanic Population Change

Overall, the Hispanic population is expected to increase slightly (4.4%) by 2018. Hispanic population growth is expected for the majority of ZIP Codes in Hudson County over the next five years. Population declines are expected in four ZIP Codes (07306, 07030, 07302 and 07310).

Table 6 – Hispanic Population Change by ZIP Code, 2013–18

ZIP Code	Community	Population 2013	Population 2018	Percent Change
07087	Union City	57,245	58,392	2.0%
07093	West New York	47,219	48,914	3.6%
07047	North Bergen	44,026	46,781	6.3%
07307	Jersey City	21,413	21,809	1.8%
07002	Bayonne	17,612	19,447	10.4%
07032	Kearny	17,528	19,292	10.1%
07306	Jersey City	14,523	14,431	-0.6%
07305	Jersey City	13,780	15,177	10.1%
07304	Jersey City	13,008	13,944	7.2%
07029	Harrison	7,782	8,146	4.7%
07030	Hoboken	7,620	7,571	-0.6%
07302	Jersey City	6,785	6,250	-7.9%
07094	Secaucus	3,283	3,623	10.4%
07310	Jersey City	670	615	-8.2%
Total		**272,494**	**284,392**	**4.4%**

Source: Claritas 2013

According to the CDC, the leading cause of death among Asian American or Pacific Islanders is cancer. Other leading causes of death for this population can be found in Table 7.

Table 7 – Leading Causes of Death for Hispanics in the U.S., 2010

Top 10 Leading Causes of Death	
1. Cancer	6. Chronic Liver Disease and Cirrhosis
2. Heart Disease	7. Chronic Lower Respiratory Disease
3. Unintentional Injuries	8. Influenza and Pneumonia
4. Stroke	9. Homicide
5. Diabetes	10. Nephritis, Nephrotic Syndrome and Nephrosis

Source: CDC, NVSR: Deaths, Final Data for 2010

Other health issues affecting Hispanics include asthma, Chagas disease, HIV/AIDS, infant mortality, overweight and obesity, and smoking.

Black/African American Population Change

Black/African American population growth is expected for the majority of ZIP Codes in Hudson County over the next five years. Population declines are expected in four ZIP Codes (07304, 07306, 07302

and 07310). Overall, the black/African American population is expected to decline marginally (-0.3%) by 2018.

Table 8 – Black/African American Population Change by ZIP Code, 2013–18

ZIP Code	Community	Population 2013	Population 2018	Percent Change
07305	Jersey City	29,049	29,242	0.7%
07304	Jersey City	16,672	16,055	-3.7%
07306	Jersey City	6,442	6,279	-2.5%
07002	Bayonne	5,071	5,555	9.5%
07302	Jersey City	3,408	2,954	-13.3%
07032	Kearny	1,752	1,808	3.2%
07307	Jersey City	2,492	2,576	3.4%
07030	Hoboken	1,282	1,287	0.4%
07093	West New York	1,216	1,270	4.4%
07087	Union City	1,113	1,196	7.5%
07047	North Bergen	1,136	1,209	6.4%
07094	Secaucus	574	575	0.2%
07310	Jersey City	548	491	-10.4%
07029	Harrison	209	236	12.9%
Total		**70,964**	**70,733**	**-0.3%**

Source: Claritas 2013

According to the CDC, the leading cause of death among black/African Americans is heart disease. Other leading causes of death for this population can be found in

Table 9.

Table 9 – Leading Causes of Death for Black/African Americans in the U.S., 2010

Top 10 Leading Causes of Death	
1. Heart Disease	6. Nephritis, Nephrotic Syndrome and Nephrosis
2. Cancer	7. Chronic Lower Respiratory Disease
3. Stroke	8. Homicide
4. Diabetes	9. Septicemia
5. Unintentional Injuries	10. Alzheimer's Disease

Source: CDC, NVSR: Deaths, Final Data for 2010

Other health issues affecting black or African Americans include asthma, high cholesterol, HIV/AIDS, hypertension, infant mortality, overweight and obesity, seasonal influenza, smoking and tuberculosis.

Children Ages 0–17 Population Change

Overall, the population of children ages 0–17 is expected to grow by 6.3% by 2018. Population growth is expected in 13 of 14 ZIP Codes in Hudson County. A population decline is expected for ZIP Code 07032 (2.1%). Substantial population growth is expected in ZIP Codes for 07302 (26.9%), 07030 (30.9%) and 07310 (54.6%).

Table 10 – Children Ages 0–17 Population Change by ZIP Code, 2013–18

ZIP Code	Community	Population 2013	Population 2018	Percent Change
07087	Union City	15,943	16,348	2.5%
07305	Jersey City	15,412	15,694	1.8%
07002	Bayonne	14,157	14,155	0.0%
07047	North Bergen	13,345	13,764	3.1%
07093	West New York	13,292	14,540	9.4%
07306	Jersey City	10,553	11,148	5.6%
07304	Jersey City	10,548	10,792	2.3%
07307	Jersey City	10,024	10,337	3.1%
07032	Kearny	8,305	8,134	-2.1%
07030	Hoboken	7,463	9,767	30.9%
07302	Jersey City	6,293	7,984	26.9%
07029	Harrison	3,387	3,442	1.6%
07094	Secaucus	3,187	3,248	1.9%
07310	Jersey City	1,920	2,969	54.6%
Total		**133,829**	**142,322**	**6.3%**

Source: Claritas 2013

Women at Childbearing Age Population Change

Overall, the population of women at childbearing age (15-44) is expected to decline slightly (-4.9%). In 13 of 14 Hudson County ZIP Codes, the populations of women at childbearing age are expected to decline. Slight population growth is expected for ZIP Code 07310 (1.9%).

Table 11 – Women at Childbearing Age Population Change by ZIP Code, 2013–18

ZIP Code	Community	Population 2013	Population 2018	Percent Change
07030	Hoboken	16,570	15,590	-5.9%
07087	Union City	14,469	13,643	-5.7%
07305	Jersey City	13,982	13,468	-3.7%
07093	West New York	13,627	12,965	-4.9%
07047	North Bergen	13,020	12,454	-4.3%
07002	Bayonne	12,978	12,408	-4.4%
07306	Jersey City	11,698	11,042	-5.6%
07302	Jersey City	11,350	10,786	-5.0%
07307	Jersey City	9,835	9,216	-6.3%
07304	Jersey City	9,704	9,266	-4.5%
07032	Kearny	8,186	7,755	-5.3%
07310	Jersey City	4,602	4,688	1.9%
07029	Harrison	3,525	3,284	-6.8%
07094	Secaucus	3,210	3,028	-5.7%
Total		**146,756**	**139,593**	**-4.9%**

Source: Claritas 2013

Individuals Ages 65 and Older Population Change

The overall projected growth for individuals aged 65 and older is 16.7%. Substantial growth is expected in all Hudson County ZIP Codes over the next five years.

Table 12 – Individuals Ages 65 and Older Population Change by ZIP Code, 2013–18

ZIP Code	Community	Population 2013	Population 2018	Percent Change
07002	Bayonne	9,009	10,419	15.7%
07047	North Bergen	8,896	10,175	14.4%
07093	West New York	7,601	8,560	12.6%
07087	Union City	7,419	8,332	12.3%
07305	Jersey City	7,242	8,551	18.1%
07306	Jersey City	5,644	6,734	19.3%
07032	Kearny	4,811	5,693	18.3%
07307	Jersey City	4,496	5,333	18.6%
07304	Jersey City	4,275	5,193	21.5%
07030	Hoboken	3,398	3,918	15.3%
07302	Jersey City	2,944	3,741	27.1%
07094	Secaucus	2,739	3,118	13.8%
07029	Harrison	1,605	1,923	19.8%
07310	Jersey City	483	676	40.0%
Total		**70,562**	**82,366**	**16.7%**

Source: Claritas 2013

Socioeconomic Characteristics

According to the U.S. Bureau of Labor Statistics, the 2011 annual unemployment average for Hudson County (10.3%) is slightly higher than New Jersey (9.3%).

The U.S. Census ACS publishes median household income and poverty estimates. According to 2008–2010 estimates, the median household income in Hudson County ($56,269) is lower than New Jersey's ($69,400).

Poverty thresholds are determined by family size, number of children and age of the head of the household. A family's income before taxes is compared to the annual poverty thresholds. If the income is below the threshold, the family and each individual in it are considered to be in poverty. In 2010, the poverty threshold for a family of four was $22,314. The ACS estimates indicate that Hudson County residents are more likely to be in poverty (15.1%) compared to all New Jersey residents (9.5%). Children in Hudson County are substantially more likely to be living below poverty level (23.5%) compared to all children in New Jersey (13.5%).

Table 13 – Socioeconomic Indicators

	Hudson County	New Jersey
Unemployment Rate[1]	10.3%	9.3%
Median Household Income[2]	$56,269	$69,400
Individuals Below Poverty Level[2]	15.1%	9.5%
Children Below Poverty Level[2]	23.5%	13.5%

[1]Source: Bureau of Labor Statistics, 2011 annual average
[2]Source: Census - American Community Survey, 2008–2010 estimates

Educational Attainment

The ACS publishes estimates of the highest level of education completed for residents 25 years and older. The ACS 2008–2010 estimates indicate that more Hudson County residents aged 25 years and older have earned less than a high school degree or equivalent (19.7%) compared to all New Jersey

residents aged 25 years and older (12.4%). In Hudson County and New Jersey, more than 80% of residents have either a high school degree or equivalent or a bachelor's degree.

Table 14 – Highest Level of Education Completed by Persons 25 Years and Older, 2008–2010

	Hudson County	New Jersey
Less than a High School Degree	19.7%	12.4%
High School Degree or Equivalent	45.7%	52.7%
Bachelor's Degree	34.6%	34.9%

Source: Census - American Community Survey, 2008–2010 estimates

Social Environment

Crime data for the state of New Jersey and by county is reported by the New Jersey State Police. The rates below were calculated using 2010 crime totals for each offense and the 2010 population estimates reported by the U.S. Census. The number of crimes was divided by the total population, and then multiplied by 100,000. Thus, rates are reported per 100,000 population.

The murder rate in Hudson County (5.4 per 100,000 population) is approximately twice the New Jersey rate (2.9 per 100,000 population), while the rape rate (2.0 per 100,000 population) is roughly half the New Jersey rate (3.7 per 100,000 population). Robbery and aggravated assault rates are substantially higher in Hudson County than in New Jersey (see Table 15).

Crime Rates

Table 15 –Violent Crime Rates, 2010

	Hudson County	New Jersey
Murder	5.4	2.9
Rape	2.0	3.7
Robbery	83.1	44.1
Aggravated Assault	132.1	95.7

Sources: New Jersey State Police; U.S. Census State and County Quick Facts

Rates are per 100,000 population

Built Environment

A community's built environment refers to structures influenced and created by humans. This includes infrastructure, buildings, parks, restaurants, grocery stores, recreational facilities and other structures that affect how people interact and the health status of the community. Business and shopping amenities such as farmers markets and fast food restaurant density are factors that contribute to the community's health.

According to the USDA Food Environment Atlas, there are 10 recreational facilities per 100,000 population in Hudson County. There are substantially more fast food restaurants (79 per 100,000 population) compared to farmer's markets (2 per 100,000 population) and grocery stores (42 per 100,000 population).

Table 16 – Select Built Environment Characteristics, 2009

	Hudson County	New Jersey
Recreational Facility Rate	10	N/A
Fast Food Restaurant Density	79	N/A
Farmer's Market Density	2	N/A
Grocery Store Density	42	N/A

Source: USDA Food Environment Atlas

Rates are per 100,000 population

Health Outcomes

The Institute for Health Metrics and Evaluation and New Jersey Health Department publish life expectancies by gender for Hudson County and New Jersey, respectively. The life expectancy for males in Hudson County is lower (75.8 years) compared to New Jersey (79.7 years). Female life expectancies are similar in Hudson County and New Jersey (81.3 years and 81.9 years, respectively).

According to the New Jersey Department of Health, the age-adjusted death rates in Hudson County (716.6 per 100,000 population) and New Jersey (716.0 per 100,000 population) are similar.

Mortality Indicators

Table 17 – Life Expectancy at Birth and Age-Adjusted Death Rate

	Hudson County	New Jersey
Male Life Expectancy at Birth, 2007	75.8 [1]	79.7 [2]
Female Life Expectancy at Birth, 2007	81.3 [1]	81.9 [2]
Age-Adjusted Death Rate, 2008[2]	716.6	716.0

[1]Source: Institute for Health Metrics and Evaluation

[2]Source: New Jersey Department of Health

Rates are per 100,000 population

Leading Causes of Death

The top two leading causes of death in Hudson County and New Jersey are heart disease and cancer. Diabetes is the third leading cause of death in Hudson County and the sixth leading cause of death in New Jersey. Chronic lower respiratory disease (CLRD) is the fourth leading cause of death in Hudson County and third leading cause of death in New Jersey. Stroke is the fifth leading cause of death in Hudson County and fourth leading cause of death in New Jersey. The HIV mortality rate in Hudson County is nearly double the New Jersey rate. Other leading causes of death in Hudson County and New

Jersey include septicemia, unintentional injuries, kidney disease, Alzheimer's disease, influenza and pneumonia, and suicide.

Table 18 – Select Leading Causes of Death, 2008

	Hudson County	New Jersey
Heart Disease	214.4	191.2
Cancer	160.0	174.6
Diabetes	37.2	23.1
CLRD	32.5	33.8
Stroke	32.1	32.9
Septicemia	23.2	18.3
Unintentional Injuries	21.0	26.2
Kidney Disease	17.5	17.5
Alzheimer's Disease	14.6	18.3
Influenza and Pneumonia	14.5	14.2
HIV	9.4	4.8
Suicide	4.2	6.7

Source: New Jersey Department of Health

Rates are per 100,000 population

Heart Disease

The following heart disease and stroke mortality data from The Centers for Disease Control and Prevention (CDC) are presented using age-adjusted rates, which are preferred because they allow for better comparison of rates across county and state data. The CDC defines age-adjusted rates as disease or mortality rates that have been statistically modified to eliminate the effect of different age distributions among different populations. The CDC reported age-adjusted mortality rates (directly age-adjusted to the standard 2000 United States population) for various heart disease outcomes, which are presented in Tables 15–18.

Residents aged 65 and older in Hudson County are more likely to die from heart disease (1,379.7 per 100,000 population aged 65 and older) compared to all New Jersey residents (1,293.6 per 100,000 population aged 65 and older). Whites in Hudson County are more likely to die from heart disease (1,676.1 per 100,000 population aged 65 and older) compared to blacks (1,573.3 per 100,000 population aged 65 and older). Males in Hudson County and New Jersey are 1.5 times as likely to die from heart disease compared to females.

Table 19 – Age-Adjusted Heart Disease Mortality Rates, Adults Aged 65 and Older by Race and Gender, 2007–2009

	Hudson County	New Jersey
Heart Disease, All	1,379.7	1,293.6
Heart Disease, White (Non-Hispanic)	1,676.1	1,351.5
Heart Disease, Black (Non-Hispanic)	1,573.3	1,371.9
Heart Disease, Male	1,703.3	1,604.1
Heart Disease, Female	1,163.1	1,098.6

Source: Centers for Disease Control and Prevention

Deaths from acute myocardial infarctions (AMI), commonly known as heart attacks, are slightly more common in Hudson County than in New Jersey. The overall heart attack mortality rate for residents aged 65 and older in Hudson County (299.1 per 100,000 aged 65 and older) is slightly higher than in New Jersey (262.3 per 100,000 aged 65 and older). Whites in Hudson County are more likely to die from a heart attack compared to blacks (see Table 20). In Hudson County and New Jersey, males are more likely to die from a heart attack (368.3 per 100,000 aged 65 and older) compared to females (253.9 per 100,000 aged 65 and older).

Table 20 – Age-Adjusted Heart Attack (Acute Myocardial Infarction) Mortality Rates, Adults Aged 65 and Older by Race and Gender, 2007–09

	Hudson County	New Jersey
Heart Attack, All	299.1	262.3
Heart Attack, White (Non-Hispanic)	358.6	267.5
Heart Attack, Black (Non-Hispanic)	323.6	336.2
Heart Attack, Male	368.3	334.4
Heart Attack, Female	253.9	216.8

Source: Centers for Disease Control and Prevention

Hypertension mortality in persons aged 65 and older in Hudson County (664.0 per 100,000 aged 65 and older) is higher than in New Jersey (581.8 per 100,000 aged 65 and older). Blacks in Hudson County and New Jersey are substantially more likely to die from hypertension compared to whites (see Table 21). In Hudson County and New Jersey, hypertension mortality is substantially more likely to occur in males (752.6 per 100,000 aged 65 and older) than females (604.9 per 100,000 aged 65 and older).

Table 21 – Age-Adjusted Hypertension Mortality Rates, Adults Aged 65 and Older by Race and Gender, 2007–09

	Hudson County	New Jersey
Hypertension, All	664.0	581.8
Hypertension, White (Non-Hispanic)	701.8	563.5
Hypertension, Black (Non-Hispanic)	1,235.9	967.7
Hypertension, Male	752.6	621.2
Hypertension, Female	604.9	548.9

Source: Centers for Disease Control and Prevention

Hudson County residents aged 65 and older are slightly less likely to die from a stroke (216.2 per 100,000 aged 65 and older) than residents in New Jersey (234.1 per 100,000 aged 65 and older). Black residents in Hudson County and New Jersey are more likely to die from a stroke compared to white residents (see Table 22). In Hudson County and New Jersey, stroke mortality in males (235.4 per 100,000 aged 65 and older) is more common than in females (198.8 per 100,000 aged 65 and older).

Table 22 – Age-Adjusted Stroke Mortality Rates, Adults Aged 65 and Older by Race and Gender, 2007 – 09

	Hudson County	New Jersey
Stroke, All	216.2	234.1
Stroke, White (Non-Hispanic)	260.3	236.0
Stroke, Black (Non-Hispanic)	329.3	310.5
Stroke, Male	235.4	243.9
Stroke, Female	198.8	225.8

Source: Centers for Disease Control and Prevention

Cancer

According to the State Cancer Profile, published by the National Cancer Institute, the incidence rate from total cancer is substantially lower in Hudson County (435.1 per 100,000 population) compared to New Jersey (501.0 per 100,000 population).

In Hudson County, prostate cancer incidence (144.4 per 100,000 males) is substantially lower compared to New Jersey (172.2 per 100,000 males).

Breast cancer incidence is lower in Hudson County (109.8 per 100,000 females) compared to New Jersey (130.0 per 100,000 females).

Lung and bronchus cancer incidence in Hudson County (55.9 per 100,000 population) is lower than in New Jersey (64.5 per 100,000 population).

Cervical cancer incidence is approximately 20% higher in Hudson County (10.6 per 100,000 females) than in New Jersey (8.8 per 100,000 females).

Table 23 – Select Age-Adjusted Cancer Incidence Rates, 2005–09

	Hudson County	New Jersey
Total Cancer[1]	435.1	501.0
Prostate[2]	144.4	172.2
Breast[3]	109.8	130.0
Lung and Bronchus[1]	55.9	64.5
Cervical[3]	10.6	8.8

Source: National Cancer Institute

[1]Rates are per 100,000 population

[2]Rates are per 100,000 males

[3]Rates are per 100,000 females

The mortality rate from total cancer is lower in Hudson County (169.8 per 100,000 population) compared to New Jersey (179.0 per 100,000 population).

Lung and bronchus cancer mortality is lower in Hudson County (42.3 per 100,000 population) compared to New Jersey (46.2 per 100,000 population).

Breast cancer mortality rates are similar in Hudson County (26.4 per 100,000 females) and New Jersey (26.1 per 100,000 females).

Mortality from prostate cancer is lower in Hudson County (20.5 per 100,000 males) than in New Jersey (22.4 per 100,000 males).

Cervical cancer mortality is nearly 30% higher in Hudson County (3.1 per 100,000 females) than in New Jersey (2.4 per 100,000 females) and approximately 41% higher than the HP 2020 Goal (2.2 per 100,000 females).

Table 24 –Select Age-Adjusted Cancer Mortality Rates, 2005–09

	Hudson County	New Jersey	Healthy People 2020
Total Cancer[1]	169.8	179.0	160.6
Lung and Bronchus[1]	42.3	46.2	45.5
Breast[2]	26.4	26.1	20.6
Prostate[3]	20.5	22.4	21.2
Cervical[2]	3.1	2.4	2.2

Sources: National Cancer Institute; Healthy People 2020

[1]Rates are per 100,000 population

[2]Rates are per 100,000 females

[3]Rates are per 100,000 males

Cancer Screenings and Risk Factors

According to the CDC's Behavioral Risk Factor Surveillance System (BRFSS), Hudson County adults aged 50 and older are less likely to have had a blood stool test in the past year or to have ever had a sigmoidoscopy or colonoscopy compared to New Jersey adults aged 50 and older (see Table 25).

Men aged 50 and older in Hudson County are less likely to have received a PSA test in the past two years (49.4%) compared to New Jersey men aged 50 and older (58.2%).

Hudson County women aged 40 and older are less likely to have had a mammogram in the past two years (74.0%) compared to New Jersey women aged 40 and older. Women aged 18 and older in Hudson County are less likely to have had a pap test in the past three years (81.1%) than women aged 18 and older in New Jersey (84.1%).

Hudson County adults are slightly less likely to be smokers (14.0%) compared to New Jersey adults (14.4%).

Table 25 – Select Cancer Screenings and Risk Factors, 2010

	Hudson County	New Jersey
Had a blood stool test in the past year[1]	11.1%	17.4%
Ever had a sigmoidoscopy or colonoscopy[1]	58.2%	65.6%
Had a PSA test within the past two years[2]	49.4%	58.2%
Had a mammogram in the past two years[3]	74.0%	77.3%
Had a pap test within the past three years[4]	81.1%	84.1%
Adults who are current smokers	14.0%	14.4%

Source: BRFSS

[1]Adults aged 50 and older

[2]Men aged 40 and older

[3]Women aged 40 and older

[4]Women aged 18 and older

Diabetes

According to the CDC County Level Estimates of Diagnosed Diabetes, Hudson County adults are about as likely to be diagnosed with diabetes (8.3%) compared to all New Jersey adults (8.7%).

Table 26 – Age-Adjusted Diabetes in Adults Ages 20 and Older, 2009

	Hudson County	New Jersey
Adults with Diagnosed Diabetes	8.3%	8.7%

Source: Centers for Disease Control and Prevention

Sexually Transmitted Infections

The New Jersey Department of Health publishes rates of reported sexually transmitted infections. In Hudson County, the rate of persons living with HIV/AIDS (769.2 per 100,000) is substantially higher than in New Jersey (409.8 per 100,000).

Gonorrhea and chlamydia rates are higher in Hudson County than in New Jersey (see Table 27).

The primary and secondary syphilis rate in Hudson County (8.2 per 100,000 population) is almost three times the New Jersey rate (2.8 per 100,000 population).

Table 27 – Reported Sexually Transmitted Infections, 2010

	Hudson County	New Jersey
Persons Living with HIV/AIDS	769.2	409.8
Chlamydia	351.7	297.3
Gonorrhea	71.9	66.8
Primary and Secondary Syphilis	8.2	2.8

Source: New Jersey Department of Health

Rates are per 100,000 population

Maternal and Child Health

According to the New Jersey Department of Health, the birth rate in Hudson County (16.4 per 1,000) is slightly higher than New Jersey (13.0 per 1,000). The teen birth rate in Hudson County (42.8 per 1,000) is nearly double the New Jersey rate (24.4 per 1,000).Infant mortality is similar in Hudson County (5.4 per 1,000) and New Jersey (5.3 per 1,000).

Table 28 – Birth Rates and Infant Mortality Rates, 2008

	Hudson County	New Jersey
Birth Rate[1]	16.4	13.0
Teen Birth Rate[2]	42.8	24.4
Infant Mortality Rate[3]	5.4	5.3

Source: New Jersey Department of Health

[1]Rate is per 1,000 population

[2]Rate is per 1,000 live births to women aged 15-19

[3]Rate is per 1,000 live births

Hudson County and New Jersey are similar with respect to low birthweight, very low birthweight and preterm births (see Table 29).

Women in Hudson County are less likely to receive prenatal care in the first trimester (66.4%) compared to all New Jersey women (75.6%).

Adequate prenatal care in this report is defined as receiving 80% or more of the expected prenatal visits based on the Kotelchuck Index. Women in Hudson County are less likely to receive adequate prenatal care (53.0%) compared to New Jersey (62.0%).

Table 29 – Select Maternal and Child Health Indicators, 2008

	Hudson County	New Jersey
Low Birthweight	7.5%	8.1%
Very Low Birthweight	1.5%	1.5%
Preterm Births	9.3%	10.0%
Prenatal Care in the First Trimester	66.4%	75.6%
Adequate Prenatal Care	53.0%	62.0%

Source: New Jersey Department of Health

Health Status, Risk Factors and Behaviors

The CDC publishes Selected Metropolitan/Micropolitan Area Risk Trends (SMART) from the Behavioral Risk Factor Surveillance System (BRFSS). Health status reflects the percentage of adults who reported general health as fair or poor. Adults in Hudson County are more likely to report fair or poor general health (19.7%) compared to all New Jersey adults (14.7%).

Physical inactivity refers to adults who reported doing no leisure time physical activity in the past 30 days. Hudson County adults are slightly more likely to report physical inactivity (28.7%) compared to New Jersey adults (26.6%).

Flu vaccination reflects the percentage of residents ages 65 years and older who had a flu shot in the past 12 months. Residents ages 65 and older in Hudson County are more likely to have had a flu shot (49.5%) than New Jersey residents ages 65 and older (34.3%).

Binge drinking refers to the percentage of adults who reported having five or more drinks on an occasion, one or more times in the past month. Binge drinking is slightly higher in Hudson County (14.5%) than in New Jersey (13.8%).

Adult obesity (body mass index ≥ 30) is similar in Hudson County (25.5%) and New Jersey (24.8%).

Adults in Hudson County are less likely to report consuming at least five servings of fruits and vegetables per day (22.8%) compared to all New Jersey adults (26.4%).

Table 30 – Health Status, Risk Factors and Behaviors

	Hudson County	New Jersey
Health Status*	19.7%	14.7%
Physical Inactivity*	28.7%	26.6%
Flu Vaccination*	49.5%	34.3%
Binge Drinking*	14.5%	13.8%
Obesity*	25.5%	24.8%
Fruit and Vegetable Consumption^	22.8%	26.4%

Source: SMART BRFSS

*2010

^2009

Access to Care

According to the ACS 2008–2010 estimates, Hudson County residents are less likely to have health insurance coverage (78.8%) compared to all New Jersey residents (87.3%).

Private insurance coverage is substantially less common in Hudson County (58.5%) than in New Jersey (73.7%).

Public insurance coverage is slightly higher in Hudson County (26.4%) and New Jersey (24.5%).

Hudson County adults are substantially more likely to be uninsured (21.2%) compared to all New Jersey adults (12.7%). Children in Hudson County are also more likely to be uninsured (9.6%) compared to all children in New Jersey (6.4%).

Table 31 – Health Insurance Coverage, 2008–10

	Hudson County	New Jersey
Health Insurance Coverage	78.8%	87.3%
Private Insurance	58.5%	73.7%
Public Coverage	26.4%	24.5%
No Health Insurance Coverage	21.2%	12.7%
No Health Insurance Coverage (Children)	9.6%	6.4%

Source: Census - American Community Survey, 2008–2010 estimates

Jersey City Medical Center Discharges

The most common inpatient discharge reasons at Jersey City Medical Center during 2012 were psychoses (1,102), alcohol/drug abuse or dependence without rehabilitation therapy without MCC (997), vaginal delivery without complicating diagnoses (762), septicemia without mechanical ventilation 96+ hours with MCC (470) and Cesarean section without CC/MCC (445). There were 1,235 normal newborns that were not included in the table. Other common inpatient discharge reasons can be found in Table 32.

Table 32 – Top 20 Inpatient Discharge Reasons at JCMC, 2012

Description	Count	Share
Psychoses	1,102	6.85%
Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	997	6.20%
Vaginal delivery w/o complicating diagnoses	762	4.74%
Septicemia w/o mechanical ventilation 96+ hours w/MCC	470	2.92%
Cesarean section w/o CC/MCC	445	2.77%
Cesarean section w/CC/MCC	431	2.68%
Esophagitis, gastroenteritis & misc. digestive disorders w/o MCC	299	1.86%
Red blood cell disorders w/o MCC	287	1.78%
Cellulitis w/o MCC	241	1.50%
Seizures w/o MCC	238	1.48%
Alcohol/drug abuse or dependence, left against medical advice	210	1.31%
Neonate w/ other significant problems	209	1.30%
Kidney & urinary tract infections w/o MCC	201	1.25%
Circulatory disorders except AMI, w/ cardiac catheterization w/o MCC	193	1.20%
Heart failure & shock w/CC	178	1.11%
Other antepartum diagnoses w/ medical complications	175	1.09%
Chest pain	169	1.05%
Chronic obstructive pulmonary disease w/o CC/MCC	162	1.01%
Prematurity w/o major problems	160	0.99%
Bronchitis & asthma w/o CC/MCC	155	0.96%

Source: JCMC

MCC=Major Complications and Comorbidities

CC=Complications and Comorbidities

Community Input

The interview and focus group data is qualitative in nature and should be interpreted as reflecting the values and perceptions of those interviewed. This portion of the CHNA process is meant to gather input from persons who represent the broad interest of the community serviced by the hospital facility, as well as individuals providing input who have special knowledge or expertise in public health. It is meant to provide depth and richness to the quantitative data collected.

Community Leader Interviews

Interview Methodology

Seventeen interviews were conducted in-person when possible and via phone when necessary, based on the availability of the interviewee. In-person interviews were conducted from January 22–24, 2013. The interviews required approximately 30 minutes to complete. Interviewers followed the same process for each interview, which included documenting the interviewee's expertise and experience related to the community. Additionally, the following community-focused questions were used as the basis for discussion:

- Interviewee's name
- Interviewee's title
- Interviewee's organization
- Overview information about the interviewee's organization
- What are the top health strengths of the community?
- What are the top health concerns of the community?
- What are the health assets and resources available in the community?
- What are the health assets or resources that the community lacks?
- What are the barriers to obtaining health services in the community?
- What is the single most important thing that could be done to improve the health in the community?
- What other information can be provided about the community that has not already been discussed?

Community Leader Interview Summary

The majority of interviewees discussed the health strengths of the Hudson County/Jersey City area primarily in the context of available healthcare services and resources. Interviewees commonly mentioned services and outreach programs provided by JCMC as strengths in the community. Four interviewees discussed the Take Your Daddy to the Doctor, Wealth from Health and Dinner with the Doctors programs sponsored by JCMC as health strengths in the Jersey City community. Three interviewees highlighted the high quality of trauma care provided by JCMC. The availability of healthcare services provided by the federally qualified health centers (FQHCs) for low-income residents

was mentioned by two interviewees. Other interviewees discussed intangibles, such as the resiliency and resourcefulness of community members, strong family units and the political power used to generate grant money, as community health strengths.

The most commonly mentioned health concerns were hypertension, diabetes, HIV, substance abuse and care for the elderly. Hypertension and diabetes were the most frequently mentioned health conditions, with two interviewees mentioning these conditions as being higher among African Americans and Hispanics. Multiple interviewees discussed issues with drugs such as crack and heroin, while one interviewee linked the high rates of HIV to substance abuse. Substance abuse was also discussed as a concern among teens. Some interviewees feel that elderly care is insufficient because many chronic conditions are undetected until they reach a level of severity. There was also an expressed concern for the lack of healthcare services for the elderly due to the growth of this population. Multiple interviewees also discussed sickle cell, obesity, cardiovascular disease, cancer, the strain placed on hospitals' emergency departments and a lack of access to health services, particularly primary care and Pediatrics. Cancer was discussed primarily in the context of potential hazards to due residential developments in close proximity to previously industrial areas. Reasons for the overuse of emergency departments include the influx of immigrants, lack of affordable and quality care at the FQHCs, and lack of primary care utilization. Other less commonly mentioned health concerns in the Hudson County/Jersey City community were the lack of specialty care for low-income residents and difficulty providing charity care due to budget cuts.

When asked about the health resources available in the community, most interviewees mentioned the FQHCs. The three FQHCs located in Hudson County are Horizon Health Center, North Hudson Community Action Corporation Health Center and Metropolitan Family Health Network. Interviewees also discussed community clinics operated by JCMC, other area hospitals, behavioral and mental health services, the Ryan White Project, Mount Carmel Guild and a number of programs operated by the Jersey City Department of Health and Human Services. Most interviewees feel there are good healthcare resources in the Hudson County/Jersey City area, and if a certain resource is not available, it is likely close by in New York City. Still, the majority of interviewees identified healthcare resources needed by the community. The most commonly discussed resourced needed by the community is primary care, both private practice and community-based. Multiple interviewees discussed this need as particularly important for low-income, undocumented and homeless individuals in the community. Many interviewees expressed this need primarily due to the overuse of emergency departments as primary care. Pediatric care services were also mentioned by multiple interviewees as a serious need

in the community. Other healthcare resource needs expressed by interviewees include funding for additional programs, specialty care for low-income residents, clinics for the homeless and resources for those suffering from addiction and mental illness.

Homeless and undocumented immigrant populations were most frequently identified as medically underserved by interviewees. Multiple interviewees also mentioned the working poor and uninsured/underinsured as medically underserved populations. A range of issues were identified when discussing barriers to obtaining health services. Most interviewees mentioned cost of health services, particularly the $25 copay at the FQHCs, or health insurance as some of the major barriers. They feel that the fee is too high for most families utilizing the FQHCs, given their low socioeconomic status. Interviewees also discussed patients' inability to attend their appointments due to scheduling, resulting in an expressed need for after-hours clinics. Other less commonly mentioned barriers include transportation, lack of knowledge of available services, identification and lack of culturally competent services.

When asked about the single most important thing that could be done to improve the health of the residents in the Hudson County/Jersey City community, the most common responses related to education and the provision of services for individuals of lower socioeconomic status. Three interviewees discussed the need for health education and awareness, while another mentioned a need for improving the education system in order to create a more productive work force. Four interviewees mentioned the importance of free or low-cost clinics for homeless and low-income populations. Other interviewees discussed outreach programs, critical service transportation, universal healthcare, primary care and preventive care as critical to improving the health of the community.

Focus Groups

Three focus groups were conducted at Jersey City Medical Center from January 23–24, 2013. The purpose of the focus groups was to gather information about health concerns from particular interest groups in Hudson County to add to the richness of the quantitative data collected. Participants provided information about their experiences in the community and ways in which they think the services and resources provided to the community can be improved.

Focus Group Methodology

Focus groups consisted of adult community members. Target populations that represent a cross section of Hudson County were recruited through promotion in the media and outreach to

organizations to glean potential leads on participants. The three focus groups were: Hispanic, fifty-five and over and general adult community members.

Focus group participants were notified prior to divulging information that it would be used solely to benefit the public good, and all information would be presented in an anonymous nature. All participants were encouraged to share their ideas, opinions and experiences, including any positive or negative feedback. Participants completed a demographic questionnaire and a consent form agreeing to participate in the focus group.

A focus group session required approximately two hours to complete and followed this agenda:
- Session Opening – 15 Minutes
    o Introductions
    o Explanation of the purpose of the focus group
    o Overview of the rules governing the session
- Nominal Group Technique was utilized to identify priority health needs in the community. The Nominal Group Technique process is as follows:
    o Participants are instructed to separately write on a piece of paper their top three perceived health concerns within the community
    o Each participant calls out in order the health concerns round robin style until all options for every person have been exhausted
    o Participants instruct the facilitator on which like items, if any, they would like to combine
    o Participants are instructed to separately rank the items most important (3) to least important (1)
    o Each member calls out round robin style his or her 3's, then 2's and so on until all ranked items have been exhausted and recorded
    o The facilitator adds up the rankings for each item, ranking the highest to lowest in importance based on the added result, taking the item that has the largest number as highest importance and so on
- After this process has been completed, a discussion is facilitated about the results of the process. Examples of these questions include:
    o Was there anything that surprised you?
    o Why do you feel these are the top health concerns?
    o How do you feel these needs could be addressed in the community?

- Session Conclusion – 15 minutes
  - o Summary of findings
  - o Closing discussion
  - o Distribution of incentives for participation

The fifty-five and over focus group was conducted by asking open-ended questions about health concerns, resources, barriers to accessing care and opportunities for improvement.

Data Analysis

The collected qualitative data was analyzed using Dedoose software utilizing a thematic approach. These themes and the resulting analysis, combined with quantitative data, served as the foundation of the CHNA, including identifying areas where the needs of the community were properly addressed and where service offerings could be improved.

Demographic Data of Focus Groups

Across the three focus groups, twenty-four of the thirty focus group participants reported living in the service area, while the remaining members live or work in or around the service area. Apart from the fifty-five and over focus group, the majority of participants were between the ages of eighteen and forty-four. The youngest member was twenty-three and the oldest participant was eighty-nine. Focus group participant household income largely fell above the median household income for Hudson County. The majority of participants reported a total household income of less than $75,000 per year. Seventeen participants reported holding a college degree or higher and three participants reported receiving less than a high school education.

Table 33 – Age of Focus Group Participants

Age Group	Focus Group Members
18–44	8
45–64	11
65 and older	10
Unknown	1
Grand Total	30

Table 34 – Income of Focus Group Participants

Household Income	Female	Male	Grand Total
<$25,000	3	3	6
$25,000–$49,999	11	3	14
$50,000–$74,999	3	2	5
$75,000–$99,999		2	2
$100,000–$149,999	1		1
$150,000+			0
Unknown	2		2
Total	20	10	30

Table 35 – Educational Attainment of Focus Group Participants

Gender	Female	Male	Grand Total
Less than High School	1	2	3
High School	5	1	6
Some College	3	1	4
College Degree	7	3	10
Graduate School	4	3	7
Grand Total	20	10	30

Table 36 – Racial Composition of Focus Group Participants

Race	Hispanic	Non-Hispanic	Unknown	Grand Total
Asian		2	1	3
Black		3		3
Other	3		1	4
Unknown	3			3
White	5	11	1	17
Grand Total	11	16	3	30

Hispanic Focus Group

The most prevalent topics among this group were affordability of healthcare, quality of care, accessibility of healthcare services and senior care.

Participants often discussed affordability in conjunction with access to services. A main concern was that not all providers accept the same types of insurance. Because there is no standard for which

insurance policies providers accept, patients are often put in situations where they are required to pay for a large portion of their care out-of-pocket. Focus group members on Medicaid expressed frustration with specialists not accepting their insurance. A suggestion to assist community members in identifying insurance providers is to have an up-to-date directory of specialists and primary care providers with the insurance types they accept.

A charity care program was also discussed in relation to assisting those who are uninsured. However, many individuals expressed that those who need it are unaware that it exists or that they qualify, and providers do not always tell those in need about it. One facet of the charity care program is that patients are at times unsure of what types of services are covered. Focus group participants expressed that providers and medical staff need to receive continuing education about the details of the charity care program and what it covers so that they can explain it to patients, assess eligibility and point individuals in the right direction on how to sign up for coverage.

Some participants felt that more outreach from Jersey City Medical Center would be beneficial in educating community members about the services provided and encourage them to stay in the area for healthcare. Outreach through organizations and senior living homes was a suggested way for the hospital to get the word out in Hudson County. Patient advocates were also discussed as a method of increasing the quality of care at the medical center; a concern was that individuals are not encouraged to have a dialogue with those assisting in discharges and continuation of care efforts. In addition to enhancing the quality of care upon discharge, focus group members felt it would be beneficial for the medical center to enhance their patient advocacy services.

In relation to access, transportation and cultural competency, especially as it relates to language barriers, were discussed by focus group members. While there is public transportation, there is no line that takes the majority of people straight to the medical center. There is both a light rail and a bus system, but for many people getting to the hospital requires switching from one to the other, and the process can take almost an hour. Language barriers were discussed in great detail in relation to cultural competency. There are some resources available in the healthcare arena in Hudson County. Many resources are geared towards Spanish speaking residents, but there does not seem to be a competency level among those translating, which sometimes leads to inaccurate information being dispersed. Additionally, inconsistencies in availability of translation services for languages other than Spanish create a problem for accessing services. One suggestion was a telephone service for individuals at the medical center so that, if there is not a person working in-house to assist in translating, there will always be someone available, even if it is just by phone.

Follow-up after hospital discharge was a concern in relation to senior care. Participants suggested a two part process to encourage a smooth recovery and transition into their routines. Prior to discharge seniors should be connected with existing services in the county. After discharge, follow-up to ensure that seniors have been successful obtaining services for which they qualify.

Fifty-five and Over Focus Group

Senior issues, diabetes and cultural competence were the most discussed topics among focus group participants.

Knowledge of services available to seniors was one issue mentioned by participants. Many of them felt that there were services available to meet their needs, but they felt they had to go out into the community and search for them. One individual mentioned that every year there is a public forum discussing needs of senior issues as well as a senior book that has resources available, but no one else in the focus group was aware that these existed.

Another senior-specific issue is the cost of equipment many individuals need including dentures, vision assistance technology and hearing assistance. Many seniors are on social security or fixed income, and the amount they have available each month is sometimes not enough to cover basic needs, much less healthcare services and equipment. One participant explained that there are some resources available both at local and national levels that offer monetary assistance if one needs to purchase health equipment, and suggested that this information also be made available in places that seniors frequent including community centers, churches and libraries.

Diabetes was the most prevalent health issue discussed, and focus group members felt it was a concern among all age groups. In relation to seniors, discussion of nutrition in senior day facilities was a primary subject, as some participants stated that attention is not directed towards providing a diabetic-friendly diet. Because of this, some seniors are not receiving the education that they need in order to manage their diabetes.

Diabetic resources and education in physician offices and hospitals when people are diagnosed was a suggested improvement strategy. For example, when someone comes to a medical facility and is diagnosed with diabetes, they should be directed to resources in the community and receive education about diabetes and how to manage it.

Cultural competency, in relation to navigating the healthcare system, was discussed. The main issues were lack of translation and advocate services for various cultures. One suggestion was to create a

network of advocates who are knowledgeable in various cultures and languages. These advocates can collaborate with various community entities to provide education sessions on health conditions and health system resources. Some populations participants perceived as lacking in culturally competent services were Indians, Russians and Filipinos.

General Population Focus Group

The most common topics of discussion among focus group members were healthcare accessibility, cultural competence and senior issues.

Home care was a mentioned as a need in relation to senior issues, particularly after hospitalization. Some seniors do not have access to the care needed to recuperate after a hospitalization and subsequent rehabilitation, and they often are unaware of what resources are available to them. After discharge, individuals often receive no further contact from the hospital if no continuation of care is required. This is problematic because seniors still may need some assistance that is not physician directed. Participants suggested coordinated efforts by healthcare providers and social service agents to plan home care prior to discharge.

 The cost of health insurance was a barrier mentioned by multiple focus group participants; some cited the monthly cost as a reason why they are uninsured. The concern of a few focus group members was the cost of preventive care services. Preventive services are costly for those without insurance, but even the insured participants expressed that they often delay accessing preventive screenings and other services because of the cost. Some individuals worried that cost may prevent them from seeking preventive care, which may force them into a serious, untreatable phase of the disease process. Suggestions to combat this issue included expansion of affordable community clinics, as well as awareness in the community of affordable preventive care clinics. Some types of clinics mentioned that could benefit those who need affordable services are mobile clinics, urgent care clinics and after hours clinics, though a few already exist locally.

Additionally, many felt that general knowledge of healthcare services is lacking in Hudson County and suggested an updated comprehensive directory system online, in paper and over the phone that is readily available throughout the community. Some individuals mentioned 211 as a resource similar to this during the discussion, but many focus group members felt it was outdated. Health fairs were also discussed as a vehicle for increasing knowledge of available services in the community. Focus group members felt that health fairs are a good way to reach a broad range of people in the community by

offering them in places that people frequented, and that if properly advertised this could be a good venue for screening and educating community members about resources that exist in the county.

Another access barrier discussed was transportation. Some individuals mentioned the lack of local transit services; one service discussed were jitneys, which are large vans that provide public transit at a reduced rate. It was discussed that expansion of the jitney system or creation of another type of public transit that is similar in affordability is needed because the jitney system does not reach all of the county.

In discussing cultural competency, access to resources for those who do not speak English as a first language was a frequent topic. In the context of language barriers, focus group members discussed to the Asian community as an underserved population. Advertisement of technological resources to assist community members in accessing services was a suggestion to help alleviate language barriers.

Health Needs Prioritization

Community Health Priorities

The overarching goal in conducting this Community Health Needs Assessment is to identify those health needs perceived by the community as important, and consequently to assess the comprehensiveness of JCMC's strategies in addressing these needs. For the purpose of identifying health needs for JCMC, a health priority is defined as a medical condition or factor that is central to the state of health of the residents in the community. With this in mind, a modified version of Fowler and Dannenberg's Revised Decision Matrix was developed to capture priorities from the primary and secondary data. This matrix tool is used in health program planning intervention strategies, and uses a ranking system of "high," "medium" and "low" to distinguish the strongest options based on effectiveness, efficiency and sustainability.

An exhaustive list of health needs was compiled based on the health profile, interviews and focus group data. From this list of health concerns, larger categories were created. For example, conditions

such as hypertension and other adverse cardiovascular events are included in the cardiovascular disease category. Concerns that did not fall within the definition of an identified health priority, such as social determinants of health, are discussed in conjunction with the health priorities where applicable.

The seven health priorities on this list include cancer, cardiovascular disease, diabetes, healthcare access and availability, maternal and child health, STIs and substance abuse. For the sake of continuity, the health priorities are ordered alphabetically.

Cancer

- Cancer is the second leading cause of death in Hudson County, with a mortality rate above the HP 2020 Goal.
- Breast cancer mortality is approximately 28% higher than the HP 2020 Goal.
- Women ages 40 and older in Hudson County are slightly less likely to receive mammograms compared to women ages 40 and older in New Jersey.
- Cervical cancer incidence is approximately 20% higher in Hudson County than in New Jersey.
- Mortality from cervical cancer in Hudson County is nearly 30% higher than in New Jersey and approximately 41% higher than the HP 2020 Goal.
- Women ages 18 and older are slightly less likely to be screened for cervical cancer compared to women ages 18 and older in New Jersey.

Cardiovascular Disease

Included in the cardiovascular disease category are heart disease mortality, acute myocardial infarctions (AMI) and hypertension.

- Heart disease is the leading cause of death in Hudson County, with a mortality rate higher than New Jersey's.
- Death rates from heart disease and AMI among residents aged 65 and older are higher in Hudson County compared to New Jersey.
- Hypertension mortality among residents aged 65 and older is substantially higher in Hudson County than in New Jersey.
- Hypertension was one of the most commonly discussed topics in the community leader interviews. Multiple interviewees discussed the high prevalence of hypertension in African Americans and Hispanics.

Diabetes

- Diabetes is the third leading cause of death in Hudson County, with a mortality rate substantially higher than New Jersey.
- Diabetes was frequently discussed in community leader interviews, particularly for its prevalence in African Americans and Hispanics.
- Diabetes was one of the priority health concerns in the senior focus group; it was discussed as an issue in all age groups.

Healthcare Access and Availability

- Multiple interviewees discussed a lack of healthcare services for the elderly.
- Overuse of emergency departments and lack of healthcare services, particularly primary care and Pediatrics, were topics frequently mentioned in the community leader interviews.
- Interviewees also discussed barriers to obtaining health services such as the inability to afford the $25 copay at the FQHCs, transportation, proper identification and culturally competent services.
- Transportation, affordability, and cultural competency were barriers to accessing healthcare services discussed among focus group participants.
- Increasing community awareness in the form of a directory and outreach done by JCMC medical staff was discussed as a way to combat the lack of utilization of healthcare services among residents.
- Language was the most prevalent cultural competency barrier discussed in all three focus groups, particularly relating to advocacy and translation services.

Maternal and Child Health

Included in the maternal and child health category are teen birth rate and prenatal care.

- The teen birth rate in Hudson County is substantially higher than New Jersey.
- Women in Hudson County are less likely to receive early and adequate prenatal care.

Sexually Transmitted Infections

- The HIV mortality rate in Hudson County is nearly double the New Jersey rate.
- Chlamydia and gonorrhea rates in Hudson County are substantially higher than in New Jersey.
- The primary and secondary syphilis rate in Hudson County is nearly four times the rate in New Jersey.

- Multiple interviewees mentioned HIV infection as a serious health concern in the community, with one interviewee discussing its relation to substance abuse.
- HIV/AIDS education in the Asian community was discussed in the general population focus group.

Substance Abuse

- Substance abuse, particularly crack and heroin, was discussed as a health concern in the community leader interviews.
- Interviewees also discussed substance abuse as a problem among teens.
- Substance abuse was discussed in relation to HIV infection.

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Appendix A: Carnahan Group Qualifications

Carnahan Group is an independent and objective healthcare consulting firm that focuses on the convergence of regulations and planning. For nearly 10 years, Carnahan Group has been trusted by healthcare organizations throughout the nation as an industry leader in providing Fair Market Valuations, Medical Staff Demand Analyses, Community Health Needs Assessments and Strategic Planning. Carnahan Group serves a variety of healthcare organizations, such as, but not limited to, hospitals and health systems, large and small medical practices, imaging centers and ambulatory surgery centers. Carnahan Group offers services through highly trained and experienced employees, and Carnahan Group's dedication to healthcare organizations ensures relevant and specific insight into the needs of our clients.

Our staff members offer diverse capabilities and backgrounds, including:
- CPAs, JDs, Ph.Ds., and others with medical and clinical backgrounds;
- Degrees that include Masters of Business Administration, Masters of Science, Masters of Public Health, Masters of Accounting and Masters of Health Administration; and,

- Serving as members of the American Institute of CPAs (AICPA), Medical Group Management Association (MGMA) and the National Association of Certified Valuation Analysts (NACVA).

Appendix B: Community Leader Interviewees

Name	Title/Organization	Area Represented
Harry Melendez	Director, Jersey City Department of Health and Human Services	Public Health Expert
Daniel Altilio	President, United Way of Hudson County	Community Health and Service Organization
Yvonne Sedar Argento	Director, MASSH Program	Community Health and Service Organization
Nancy Floom	Assistant Director of Social Work and Case Management, JCMC	Hospital Leader
Rosemary McFadden	Chief of Staff, City of Jersey City	Government Official
Pam Baker	Director, Self-Help Center of Jersey City	Community Health and Service Organization
Tom Degise	Hudson County Executive	Government Official
Bill Gaughan	Councilman, City of Jersey City; Chief of Staff for Hudson County Executive	Government Official
Charles Mainor	Assemblyman, Legislative District 31	Government Official
Linda Sacco	Administrator, Behavioral Health Services, JCMC	Hospital Leader
Nancy Pain	Nurse Practicioner, Palliative Care, JCMC	Hospital Staff
Dr. Susan Walsh	ACO Medical Director, JCMC	Hospital Leader
Robert Luckritz	Director of Government Relations, JCMC	Hospital Leader
Kabili Tayari	Deputy Mayor, City of Jersey City	Government Official
Dr. Douglas Ratner	Vice President and Chairman of Medicine, JCMC	Hospital Leader
Joe Scott	President and CEO, JCMC	Hospital Leader
Dr. Kenneth Garay	Chief Medical Officer, JCMC	Hospital Leader

Appendix C: Demographic Analysis for the Heights, Greenville and Waterfront Areas

Neighborhood	ZIP Codes
Waterfront	07307
	07305
	07002
	07302
	07310
	07030
Heights	07307
Greenville	07305

	Waterfront	Heights	Greenville
Population 2013	231,516	44,108	61,620
Population 2018 (projected)	242,901	44,519	63,496
Percent Growth	4.9%	0.9%	3.0%
Age Composition			
0–17	19.5%	22.7%	25.0%
18–24	8.1%	8.8%	9.8%
25–44	40.8%	34.2%	28.7%
45–64	21.6%	24.1%	24.8%
65 and over	10.0%	10.2%	11.8%
Race/Ethnicity			
White	42.9%	23.3%	10.8%
Black/African American	17.0%	5.6%	47.1%
Hispanic	20.1%	48.5%	22.4%
Asian	17.4%	19.9%	15.8%
Other	2.6%	2.7%	3.9%
Average Household Income	$107,720	$69,653	$73,928

Source: Claritas 2013