Chapter 1: Environmental Scan

The purpose of this section is to provide a snapshot of the current national and state trends in healthcare and to provide an overview of the work of the New Jersey Action Coalition's direction and progress in meeting the recommendations from the Institute of Medicine's (2011) landmark report, *The Future of Nursing: Leading Change, Advancing Health.*

New Jersey Demographics

According to the 2010 survey by the U.S. Census Bureau, there is greater racial diversity within New Jersey than there is in the whole United States (United States Census Bureau, 2015). When compared to the rest of the country, a smaller proportion of New Jersey residents identified themselves as White alone, not Hispanic or Latino. A greater proportion of New Jersey residents identified themselves as being Hispanic or Latino, Black or African American, or Asian.

Table 1-A. Demographics Comparison

Race	New Jersey	United States
White alone, not Hispanic or Latino	56.2%	64.6%
Hispanic or Latino	19.7%	17.6%
Black or African American	14.8%	13.3%
American Indian or Alaska Native	0.6%	1.2%
Asian	9.7%	5.6%
Native Hawaiian or Other Pacific Islander	0.1%	0.2%
Two or More Races	2.1%	2.6%

(United States Census Bureau, 2015)

When compared to the United States as a whole, New Jersey also has a higher rate of high school and college graduation. The percentage of New Jersey residents with a high school degree is 2.1% greater than that of the United States overall. Likewise, the percentage of New Jersey residents with a Baccalaureate degree is 7.1% greater.

Table 1-B. Education Comparison

Education Level	New Jersey	United States
High School degree or higher, Percentage of persons 25+	88.4%	86.3%
Baccalaureate Degree of higher, Percentage of persons 25+	36.4%	29.3%

(United States Census Bureau, 2015)

New Jersey Population Demographics and Health Rankings

According to the U.S. Census Bureau, New Jersey had 8,944,469 people in 2016 (United States Census Bureau, 2016). County and state trends show differences in demographics in age, race, sex, and ethnicity. These results can be found in **Appendix A**, pages 13-14 of this report (New Jersey Department of Labor and Workforce Development, 2017). Appendix 1 shows the breakdown by county with fastest and slowest growth rates in each demographic category. In **Appendix B**, pages 15-22 of this report, you may find the 2017 County Health Rankings report, which provides an overview of where New Jersey stands in terms of healthcare outcomes by state and county level data (County Health Rankings, 2017). These rankings help to identify some of the issues facing New Jersey citizens inclusive of the social determinants that impact health such as employment and housing.

Healthcare System Scan

Table 1-C. National and State Healthcare System Scan

Changes	National Trends	State Examples
Consolidation	• Hospitals and medical group acquisitions	• There are increasing numbers of large Healthcare Systems in New Jersey. • Robert Wood Johnson Barnabas Health System and Hackensack Meridian Health are the two largest systems (1).
Move toward value-based payment models by government and commercial payer groups	• Patient-centered medical homes • Bundled payment, Accountable Care Organizations (ACOs)	• 23 Federally Qualified Health Centers (FQHCs) 80% are recognized as Patient Centered Medical Homes • Cardiac and Joint replacement bundled payment model starting July 2017 by CMS in certain selected geographic areas • ACOs include: Barnabas North ACO; Atlantic Health; Hackensack University Medical Center and Optimus Healthcare Partners LLC; Holy Name Medical Center Hospital/Physician ACO; Barnabas Central Jersey ACO; Meridian ACO; Summit Health-Virtua; AtlantiCare; Walgreens; *Medicaid ACOs*; Camden Coalition of Healthcare Providers; Healthy Greater Newark ACO; and the Trenton Health Team
Care model innovations	• Retailers providing care, telehealth, and mobile technology	• 37 CVS Minute Clinics • Insurance providers creating and supporting new models
Increased focus on post-acute care	• ACO preferred models	• ACOs connecting the continuum of services
Patient volume	• Expansion of Medicaid continues. • Chronic disease and obesity are major health issues. • People with chronic illnesses cost the health care system about 75% of the total health care expenditures (5). • Aging population • Mental health issues are	• As of 4/17, New Jersey has 1.8 million individuals in Medicaid and CHIP, an increase of 38.03% since 2013. (2) • 250,000 residents have gained coverage through the marketplace. (3) • The uninsured rate fell from 15% to 6% with the ACA. (3) • Every county has had an increase in the elderly between 2010 and 2016. Five

	increasing and the number of providers is inadequate. 60% of adults with a mental illness receive no mental health services.	counties with the largest population of 65+ residents are now Bergen, Ocean, Essex, Middlesex, and Monmouth counties. (4) • Mental health issues are increasing in NJ and there is a shortage of providers.
Price and cost pressures	• Across the continuum • Alignment of incentives through ACOs and bundled payment	• Same as national issues
Talent management	• Need leaders who can drive change in demand • New leadership skills which require an expansion of talents • Turnover of leadership	• Same as national issues
Information Technology	• Population health tools and analytics in demand • New Electronic Healthcare Records (EHR) • System breaches of concern	• Shifts in EHR records and integration of population health analytics in system by insurers • Breaches of concern in New Jersey

1. http://www.njha.com/membership/list-of-nj-providers/healthcare-systems/
2. https://www.medicaid.gov/Medicaid/by-state/stateprofile.html?state=new-jersey
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Future of Nursing Update for New Jersey

Linking the NJAC focus on building nursing capacity to improving health and healthcare in New Jersey has required changes in structure. While we continue to work on building capacity, other organizations have taken on many of those initiatives. Moving nurses into the community is now a major goal of the NJAC, which is housed at the NJCCN. This is being accomplished by developing nurse coaches and volunteers in every county in New Jersey and working with key partners across the state, including NJDOH, NJHCQI, YMCA, Library Association, NJPN, RUHealth, and AARP. These partnerships will provide opportunities for nurses to become engaged in their communities. These coaches and nurse volunteers will integrate into the cities and municipalities to engage nurses in current and future projects that improve the health and healthcare of New Jersey citizens. Information on this program can be found at *njac.njccn.org*.

Recommendation: Implement nurse residency programs:

Residency programs across the spectrum are being evaluated such as acute care (NJCCN and the Leadership Council housed at ONL/NJ), and post-acute care (NJAC). These programs help new nurses transition into new roles. Through the work of the NJAC a book on developing nurse residency programs in post-acute setting has been developed to help organizations develop their own program. Evaluation of this program has also been published in peer reviewed journals.

Cadmus, E., Salmond, S., Hassler, L, Bohnarczyk, N., & Black, K. (2017). *Developing a residency in post-acute care.* Indianapolis, IN. Sigma Theta Tau International.

Recommendation: Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.
The national campaign to engage nurses on boards has been transferred to the organization of Nurse Leaders/NJ to continue our role in having nurses take a leadership role in shaping health and healthcare. This aligns with their mission and vision of their organization.

The NJCCN has been awarded funding by NJHI the statewide grant making program of the Robert Wood Johnson Foundation. The funding supports the vision of NJCCN to expand the leadership capacity of school nurse and their communities. This is being implemented through the framework of the 21st century school nurse practice ™ developed by NASN. Retreats, education, and standards application are currently underway in collaboration with the NJSSNA. One key area of focus is on the mental health first aid certification for school nurses who are confronted with needs of students and families in their schools.

Recommendation: Nurses should work to the full extent of their education and training.
The NJSNA continues to focus on access to care for consumers by working on legislation surrounding APN practice. The NJCCN has focused on looking at inconsistencies in APN practices in hospital settings to provide direction to hospital leadership.

Recommendation: Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
Academic Progression continues to be the work of the NJAC to ensure seamless academic progression. Pilots continue to be developed and implemented to improve this process for nurses with the goal of 80% BSN by 2020. To meet this goal, New Jersey needs to continue to work on this recommendation.

Recommendation: Prepare and enable nurses to lead change to advance health.
Through the funding by the Robert Wood Johnson Foundation and support by the NJHA/HRET, NJNI is focused on transforming nursing education. Reshaping curricula and experiences for nurse to change the way students are prepared for future demands in community-based care and improving population health. For more information: *http://www.njni.org/about/*

Appendix A: Estimates of 2016 State and County Population by Age, Race, Sex and Hispanic Origin

HIGHLIGHTS

- ✓ Similar to the national trend, New Jersey's population continued to become older and racially and ethnically diversified. Minority population (persons other than non-Hispanic whites) had increased their share in New Jersey's total population to 44.2% in 2016, up from 40.4% in 2010.

- ✓ Non-Hispanic white population declined in almost every county in NJ except Ocean between 2010 and 2016. Middlesex (-34,938) and Bergen (-32,367) counties experienced the largest numeric loss of non-Hispanic whites. Their rate of decline in Middlesex County (-8.7%) was also the steepest in the state.

- ✓ African American population grew by 4.4% in New Jersey since the 2010 Census, led by Middlesex County's net gain of 10,270. African Americans increased the fastest bin Warren County (+30.2%) from a small base. However, Black population declined somewhat in five countries during this period: Atlantic, Salem, Cape May, Hunterdon and Monmouth.

- ✓ With a hefty 17.5% increase, Asian was the fastest growing race group in NJ since 2010 Census. Asians grew in every county. The net gain of 29,516 in Middlesex County was the largest, while the 27.6% increase in Somerset County was the fastest. Sussex County had the slowest growth of 7.2%.

- ✓ NJ's net increase of 152,575 total residents was the result of a net loss of 78,949 non-Hispanics and a net gain of 231,524 Hispanics. Hispanics grew in all counties led by Bergen's 36,822 and Union's 27,022 gains. Hispanic growth rates between 2010 and 2016 ranged from 9.3% in Hudson County to 28.4% in Gloucester County.

- ✓ In 2016, six counties were the "majority-minority" counties (less than 50% residents were non-Hispanic whites) in NJ: Hudson, Essex, Union, Passaic, Middlesex, and Cumberland. However, the share of minority population remained low in Sussex (13.2%) and Hunterdon (14.1%) counties, as of 2016.

- ✓ New Jersey's median age increased from 39.0 in 2010 to 39.7 in 2016, as the state's elderly population (65 & over) increased substantially (+15.7%) while number of children (under 18) declined (-3.9%).

- ✓ Elderly population increased in every county between 2010 and 2016. Bergen (+17,740) and Middlesex (+18,938) counties had the largest numeric growth, while Hunterdon's 29.47% and Sussex's 27.9% growth were the most repaid. Bergen (154,843), Ocean (131,778) and Middlesex (118,400) had more elderly population than other counties, as of 2016.

- ✓ In 2016, more than one in every five residents in Cape May (25.0%) and Ocean (22.2%) counties were senior citizens. On the other hand, Hudson (11.0%) and Essex (12.9%) counties had relatively low percentages of elderly population. These four counties also had the highest and lowest percentages of elderly population in 2010.

- ✓ Number of children declined in most counties except Hudson, Ocean and Union. The -14,943 decrease in Monmouth County was the most severe between 2010 and 2016. The rate of change among children population ranged from -18.0% in Sussex County to +5.8% in Hudson County.

- ✓ Three rural counties had the most noticeable increase of median age between 2010 and 2016: Sussex (+2.8), Hunterdon (+2.7) and Warren (+2.5). Hudson County had the state's lowest median age (34.2) in 20146+, while median ages were the highest in Cape May (49.0), Hunterdon (46.2) and Sussex (44.6) counties.

- ✓ NJ's sex ratio (men per 100 women) increased somewhat from 94.8 in 2010 to 95.4 in 2016, as male population grew at a faster pace (2.1%) than their female counterparts (1.4%). Sex ratio ranged from 92.7 Essex County to 105.1 in Cumberland County, as of 2016.

Prepared by New Jersey Department of Labor and Workforce Development, Division of Labor Market and Demographic Research, on June 23, 2017.

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

2017 *County Health Rankings*

New Jersey

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

University of Wisconsin Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

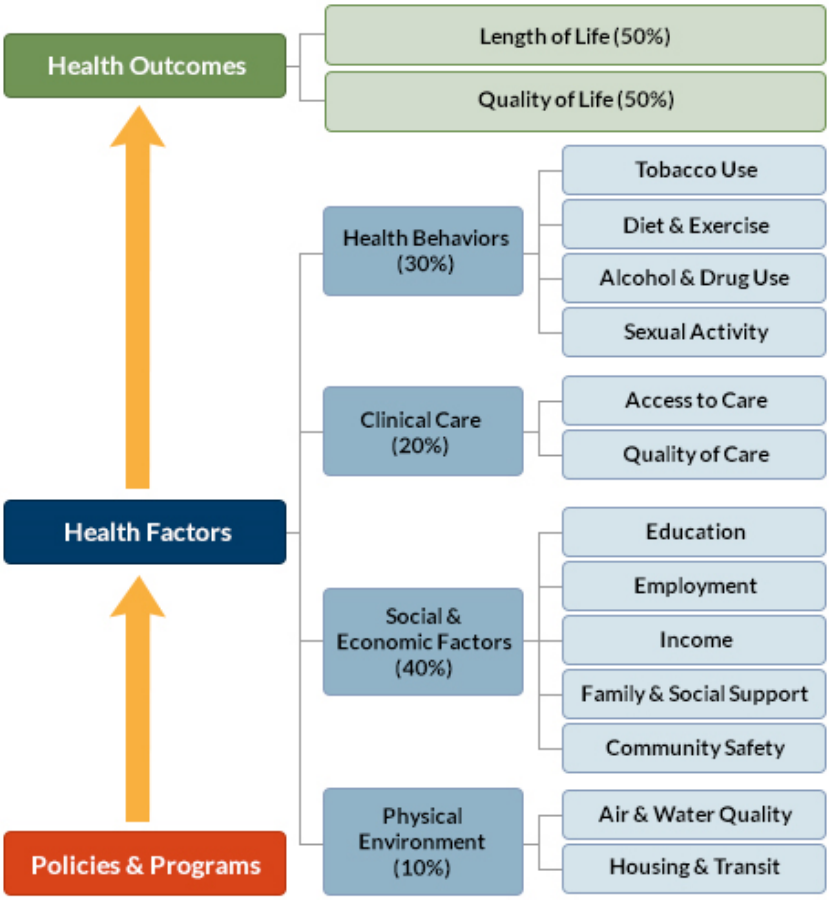
Support provided by
Robert Wood Johnson Foundation

INTRODUCTION

The *County Health Rankings & Roadmaps* program brings actionable data and strategies to communities to make it easier for people to be healthy in their homes, schools, workplaces, and neighborhoods. Ranking the health of nearly every county in the nation, the *County Health Rankings* illustrate what we know when it comes to what is making people sick or healthy. The *Roadmaps* show what we can do to create healthier places to live, learn, work, and play. The Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin Population Health Institute (UWPHI) to bring this program to cities, counties, and states across the nation.

WHAT ARE THE *COUNTY HEALTH RANKINGS*?

Published online at **countyhealthrankings.org**, the *Rankings* help counties understand what influences how healthy residents are and how long they will live. The *Rankings* are unique in their ability to measure the current overall health of nearly every county in all 50 states. They also look at a variety of measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, obesity, and teen births. Communities use the *Rankings* to help identify issues and opportunities for local health improvement, as well as to garner support for initiatives among government agencies, healthcare providers, community organizations, business leaders, policy makers, and the public.



DIGGING DEEPER INTO HEALTH DATA

Although we know that a range of factors are important for good health, every state has communities that lack both opportunities to shape good health and strong policies to promote health for everyone. Some counties lag far behind others in how well and how long people live – which we refer to as a "health gap." Find out what's driving health differences across your state and what can be done to close those gaps. Visit countyhealthrankings.org/reports.

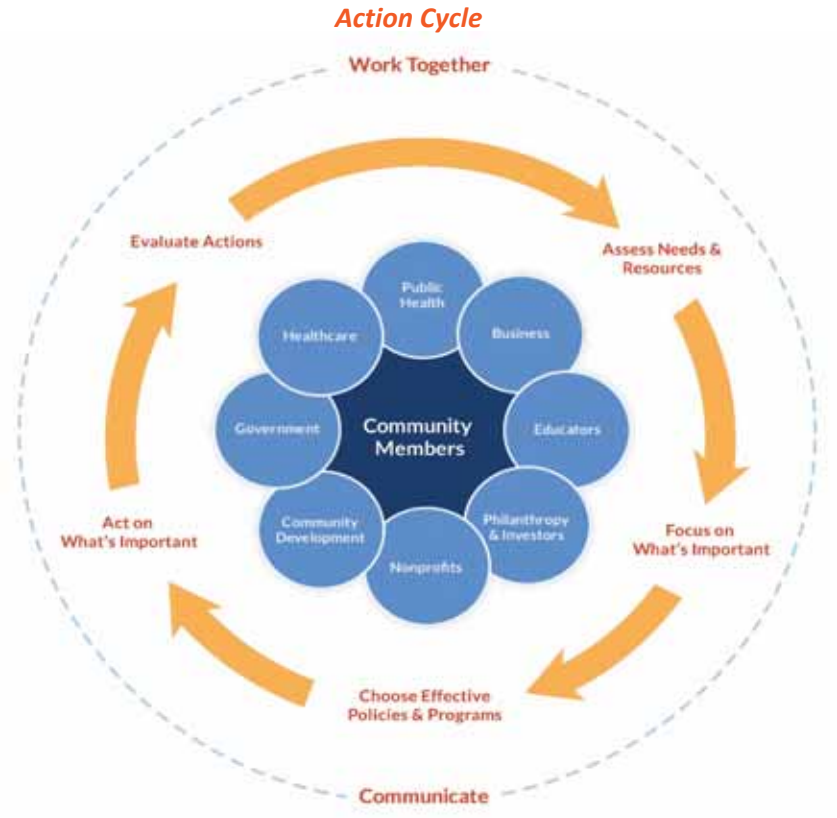
To further explore health gaps and other data sources in your community, check out the feature to find more data for your state and dig deeper on differences in health factors by geography or by population sub-groups. Visit countyhealthrankings.org/using-the-rankings-data.

MOVING FROM DATA TO ACTION

Roadmaps to Health help communities bring people together to look at the many factors that influence health and opportunities to reduce health gaps, select strategies that can improve health for all, and make changes that will have a lasting impact. The *Roadmaps* focus on helping communities move from *awareness* about their county's ranking to *actions* designed to improve everyone's health. The *Roadmaps to Health* Action Center is a one-stop shop of information to help any community member or leader who wants to improve their community's health by addressing factors that we know influence health, such as education, income, and community safety.

Within the Action Center you will find:

- Online step-by-step guidance and tools to move through the Action Cycle
- *What Works for Health* – a searchable database of evidence-informed policies and programs that can improve health
- Webinars featuring local community members who share their tips on how to build a healthier community
- Community coaches, located across the nation, who provide customized consultation to local leaders who request guidance in how to accelerate their efforts to improve health. You can contact a coach by activating the Get Help button at countyhealthrankings.org



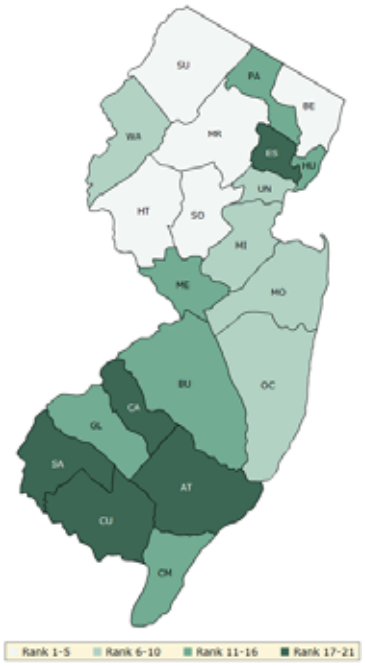
HOW CAN YOU GET INVOLVED?

You might want to contact your local affiliate of United Way Worldwide, the National Association of Counties, Local Initiatives Support Corporation (LISC), or Neighborworks– their national parent organizations have partnered with us to raise awareness and stimulate action to improve health in their local members' communities. By connecting with other leaders interested in improving health, you can make a difference in your community. In communities large and small, people from all walks of life are taking ownership and action to improve health. Visit countyhealthrankings.org to get ideas and guidance on how you can take action in your community. Working with others, you can improve the health of your community.

HOW DO COUNTIES RANK FOR HEALTH OUTCOMES?

The green map below shows the distribution of New Jersey's **health outcomes**, based on an equal weighting of length and quality of life.

Lighter shades indicate better performance in the respective summary rankings. Detailed information on the underlying measures is available at **countyhealthrankings.org**.

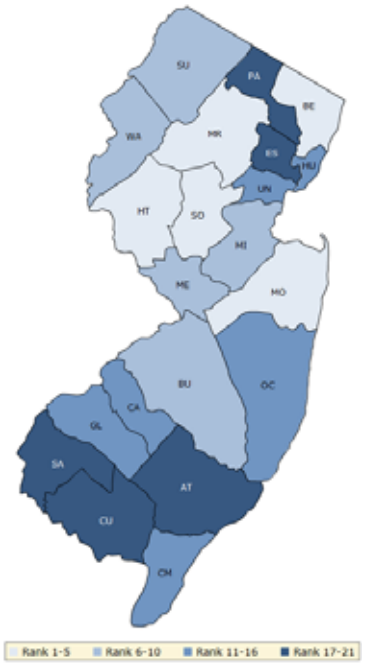


County	Rank	County	Rank	County	Rank	County	Rank
Atlantic	17	Essex	20	Monmouth	7	Sussex	5
Bergen	4	Gloucester	14	Morris	2	Union	8
Burlington	11	Hudson	13	Ocean	10	Warren	9
Camden	18	Hunterdon	1	Passaic	15		
Cape May	16	Mercer	12	Salem	19		
Cumberland	21	Middlesex	6	Somerset	3		

HOW DO COUNTIES RANK FOR HEALTH FACTORS?

The blue map displays New Jersey's summary ranks for **health factors**, based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment.

Lighter shades indicate better performance in the respective summary rankings. Detailed information on the underlying measures is available at **countyhealthrankings.org**



County	Rank	County	Rank	County	Rank	County	Rank
Atlantic	18	Essex	19	Monmouth	5	Sussex	7
Bergen	4	Gloucester	13	Morris	3	Union	12
Burlington	9	Hudson	16	Ocean	11	Warren	10
Camden	15	Hunterdon	1	Passaic	17		
Cape May	14	Mercer	8	Salem	20		
Cumberland	21	Middlesex	6	Somerset	2		

2017 *COUNTY HEALTH RANKINGS*: MEASURES AND NATIONAL/STATE RESULTS

Measure	Description	US Median	State Overall	State Minimum	State Maximum
HEALTH OUTCOMES					
Premature death	Years of potential life lost before age 75 per 100,000 population	7,700	5,500	3,900	8,300
Poor or fair health	% of adults reporting fair or poor health	16%	15%	9%	22%
Poor physical health days	Average # of physically unhealthy days reported in past 30 days	3.8	3.2	2.3	4.0
Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	3.8	3.4	2.9	4.1
Low birthweight	% of live births with low birthweight (< 2500 grams)	8%	8%	6%	10%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	% of adults who are current smokers	17%	14%	10%	20%
Adult obesity	% of adults that report a BMI ≥ 30	31%	26%	21%	35%
Food environment index	Index of factors that contribute to a healthy food environment, (0-10)	7.3	8.2	6.8	9.4
Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	26%	23%	17%	28%
Access to exercise opportunities	% of population with adequate access to locations for physical activity	62%	95%	65%	100%
Excessive drinking	% of adults reporting binge or heavy drinking	17%	18%	15%	20%
Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	30%	24%	17%	38%
Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	294.8	336.0	121.9	701.9
Teen births	# of births per 1,000 female population ages 15-19	38	19	4	54
CLINICAL CARE					
Uninsured	% of population under age 65 without health insurance	14%	13%	6%	19%
Primary care physicians	Ratio of population to primary care physicians	2,030:1	1,170:1	2,400:1	810:1
Dentists	Ratio of population to dentists	2,570:1	1,210:1	3,210:1	800:1
Mental health providers	Ratio of population to mental health providers	1,105:1	580:1	1,990:1	310:1
Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	56	50	38	72
Diabetes monitoring	% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring	86%	85%	80%	89%
Mammography screening	% of female Medicare enrollees ages 67-69 that receive mammography screening	61%	61%	51%	70%
SOCIAL AND ECONOMIC FACTORS					
High school graduation	% of ninth-grade cohort that graduates in four years	88%	90%	82%	96%
Some college	% of adults ages 25-44 with some post-secondary education	57%	67%	40%	78%
Unemployment	% of population aged 16 and older unemployed but seeking work	5.3%	5.6%	4.1%	10.9%
Children in poverty	% of children under age 18 in poverty	22%	16%	5%	27%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	4.4	5.1	3.8	6.5
Children in single-parent households	% of children that live in a household headed by a single parent	32%	30%	15%	47%
Social associations	# of membership associations per 10,000 population	12.6	8.3	4.8	13.9
Violent crime	# of reported violent crime offenses per 100,000 population	198	280	40	681
Injury deaths	# of deaths due to injury per 100,000 population	77	47	34	76
PHYSICAL ENVIRONMENT					
Air pollution – particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	9.2	9.8	7.9	10.7
Drinking water violations	Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation.	NA	NA	No	Yes
Severe housing problems	% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities	14%	23%	16%	34%
Driving alone to work	% of workforce that drives alone to work	81%	72%	38%	86%
Long commute – driving alone	Among workers who commute in their car alone, % commuting > 30 minutes	30%	42%	25%	58%

2017 COUNTY HEALTH RANKINGS: DATA SOURCES AND YEARS OF DATA

	Measure	Data Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Premature death	National Center for Health Statistics – Mortality files	2012-2014
Quality of Life	Poor or fair health	Behavioral Risk Factor Surveillance System	2015
	Poor physical health days	Behavioral Risk Factor Surveillance System	2015
	Poor mental health days	Behavioral Risk Factor Surveillance System	2015
	Low birthweight	National Center for Health Statistics – Natality files	2008-2014
HEALTH FACTORS			
HEALTH BEHAVIORS			
Tobacco Use	Adult smoking	Behavioral Risk Factor Surveillance System	2015
Diet and Exercise	Adult obesity	CDC Diabetes Interactive Atlas	2013
	Food environment index	USDA Food Environment Atlas, Map the Meal Gap	2010 & 2014
	Physical inactivity	CDC Diabetes Interactive Atlas	2013
	Access to exercise opportunities	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files	2010 & 2014
Alcohol and Drug Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2015
	Alcohol-impaired driving deaths	Fatality Analysis Reporting System	2011-2015
Sexual Activity	Sexually transmitted infections	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2014
	Teen births	National Center for Health Statistics - Natality files	2008-2014
CLINICAL CARE			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2014
	Primary care physicians	Area Health Resource File/American Medical Association	2014
	Dentists	Area Health Resource File/National Provider Identification file	2015
	Mental health providers	CMS, National Provider Identification file	2016
Quality of Care	Preventable hospital stays	Dartmouth Atlas of Health Care	2014
	Diabetes monitoring	Dartmouth Atlas of Health Care	2014
	Mammography screening	Dartmouth Atlas of Health Care	2014
SOCIAL AND ECONOMIC FACTORS			
Education	High school graduation	EDFacts[1]	2014-2015
	Some college	American Community Survey	2011-2015
Employment	Unemployment	Bureau of Labor Statistics	2015
Income	Children in poverty	Small Area Income and Poverty Estimates	2015
	Income inequality	American Community Survey	2011-2015
Family and Social Support	Children in single-parent households	American Community Survey	2011-2015
	Social associations	County Business Patterns	2014
Community Safety	Violent crime	Uniform Crime Reporting – FBI	2012-2014
	Injury deaths	CDC WONDER mortality data	2011-2015
PHYSICAL ENVIRONMENT			
Air and Water Quality	Air pollution - particulate matter [2]	CDC National Environmental Public Health Tracking Network	2012
	Drinking water violations	Safe Drinking Water Information System	FY2013-14
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2009-2013
	Driving alone to work	American Community Survey	2011-2015
	Long commute – driving alone	American Community Survey	2011-2015

[1] State sources used for California and Texas.
[2] Not available for AK and HI.

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