

Community and Urban Health Working Group Report: Analysis of Existing Strengths, Critical Gaps, and Opportunities for Collaboration

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Community health is a subset of public health, and another term now in common use is population health. For this Strategic Planning Proposal, we are defining these concepts as follows:

Community Health: Community health encompasses a broad spectrum of circumstances that assure the “physical, mental, and social well-being” (WHO Definition) of a population. The population may be defined by geographic boundaries, or may share social or other characteristics. (e.g. the community of immigrants).

Population Health: Population health is an evolving concept that involves provision of health services to an enrolled population. Services range from preventive medicine through the most specialized of clinical care.

Public Health: Public health is the foundation for community health, which insures that the community is protected from risks to health that can only be achieved by community-level health promotion activity. For example, to protect against devastating childhood infections “public health” requires immunization with safe and effective vaccines. One tool for the ongoing assurance of public health is the continuous assessment of public health surveillance data and dissemination of that data to those who need the information for planning of effective interventions. These may range from public health interventions such as community education to planning for and provision of the most advanced specialty clinical care.

Also included in this foundation is the understanding that there is an association between an individual’s and community’s health and the: 1) living and working conditions in homes and communities, 2) the economic and social opportunities and resources available. These concepts are articulated by the overarching goals of Healthy People 2020, which are to:

- Attain high-quality, longer lives free of preventable disease, disability, injury and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.

Why is Urban Health named specifically in this strategic plan while other communities are not? Community may be defined in many ways. For example a community may be a geographic location, a population defined by a social, economic or demographic characteristic, or a group described by their employment, and in other ways. It is accepted that to insure health and wellbeing that the needs of each “community” should be assessed and appropriate services and other beneficial interventions crafted and employed. We choose to include Urban Health in this document because urban issues are a major concern in New Jersey and the topic is not otherwise addressed in this strategic planning process. We expect that other “communities” may not be visible in this first round of RBHS strategic planning and that this will be remedied in future iterations.

ANALYSIS

1.1 Strengths

Analysis of the list of activities and the list of projects funded in the current year suggests there is substantial activity in each of the 5 areas of community health that our subcommittee has identified. Those areas are social and environmental determinates of health, public health, population health, primary care, and specialty care important to preserving health.

Starting with social and environmental determinants of health, important health and well-being activities abound in almost every corner of RU. There is interest and activities related to service, research, and training. For example, Dr. Hanaa Hamdi is carefully gaining a profound understanding of the distribution of food in Newark and how that will impact health. Her activities are not limited to research and include innovative

methods for growing vegetables Newark while creating jobs for residents of Newark who have been incarcerated. Other examples include a project evaluating the effects of air pollution and stress on childhood asthma in Newark, and the Alliance for Healthier New Brunswick a collaborative partnership with a 10 year history of convening community stakeholders to work on health issues in the New Brunswick community.

The second domain of community health is public health. RBHS is a partner in public health in New Jersey at all levels from involvement at the municipal level (working with both governmental and community organizations); through engagement with New Jersey government (Departments of Health, Housing, Environmental Protection, Education, and Social Services). RBHS involvement includes service, research, and training in public health. While ultimate accountability for governmental responsibilities in public health resides with government, State government in New Jersey sometimes contracts public health functions to universities. Some examples of these partnerships include a strong partnership developed post 9/11 between Department of Preventive Medicine and Community Health (DPMCH) and the Newark Department of Health (NDOH). DPMCH is funded for mapping disease and injury in New Jersey; maps of elevated childhood lead and also of cervical cancer have been important in facilitating progress with the health department. The Rutgers School of Dental Medicine (RSDM) also runs the Department of Dental Health as part of the Rutgers School of Public Health. This unique resource, located at the university's Newark campus, ensures that dental health professionals are equipped with a broad knowledge of oral public health issues, including oral epidemiology, so that they can become leaders in oral disease prevention, oral health research and oral health education.

Population Health, defined here, as the provision of health services to a defined cohort of individuals, is the third domain of community health. Increasingly this domain is one by which health care providers are being measured and judged for their success. When considering population health, it is important to recognize that the evolving health policy environment and related health care delivery system and payment reforms have important implications for the future direction of community health. These include required community health needs assessment by nonprofit hospitals, shift to quality of care rather than the volume of care, payment reforms aimed at improving population health, and the development of innovative payment systems such as shared savings agreements resulting in better health for enrolled populations. Population Health examples at Rutgers include the East Orange VA, a major provider of "population health" to veterans. Other examples of efforts to provide services to definable populations include the formation of Robert Wood Johnson Partners, starting as a Medicare ACO. There are also ongoing projects between the School of Public Health, RWJ University Hospital (Department of Community Outreach) and the Eric B. Chandler Health Center to improve health outcomes for disadvantaged Latino populations with diabetes. Research in population health is strong at the Center for State Health Policy (CSHP). CSHP's portfolio of research aims to inform policy makers and stakeholders in policy formulation and implementation. Current projects include a long term evaluation of the impact of changes in food and physical activity on children obesity and behavior in five New Jersey cities. Other work, examining health care delivery system reforms identifies the potential for Medicaid ACOs to improve care and reduce costs in 13 low income communities in New Jersey by examining avoidable/preventable hospital utilization.

Provision of Primary Health Care is the fourth domain of Community Health. RBHS is a major leader in primary health care in New Jersey and is working towards a model of community engagement where the community participates in the healthcare decision-making that is planned and implemented. Currently services to community residents are provided through telephone calling centers that provide advice and guidance and by Community Health Workers who provide outreach and education to residents of the communities they serve. Primary care is also provided to patients through hospital clinics, affiliated private practices, academic health practices, mobile and freestanding community based health centers. Many of these services are provided by inter-professional teams of health professionals and students of the health professions. RBHS involvement includes service, research and training in primary health care.

The Rutgers RWJMS Eric B. Chandler Health Center is a federally qualified community health center operating in New Brunswick. At its core, the Health Center provides access to those most in need in the greater New

Brunswick area. As a FQHC the health center's scope also extends into other community health domains. Through its Health Care Plan the center is responsible for understanding and acting on the major health issues facing its communities. The Health Center is also charged to partner with other community based organizations to extend the reach of the Health Center into the community.

At Chandler Health Center, as well as other primary care sites, these services are a major part of the training programs for health care workers in both cities. The New Jersey Children's Health Project, the Jordan and Harris Community Health Center and the FOCUS Wellness Center, all in Newark, are demonstrating the power of providing primary care services to an engaged community in neighborhoods and public housing developments. Nurse led inter-professional care and case management is demonstrating outstanding improvements in blood pressure management and diabetes management at the community level. Since 1989 RSDM, the only dental school in the state, has been committed to enhancing oral health care for the underserved, uninsured and underrepresented individuals in the seven southernmost counties in New Jersey. The dental school maintains clinics in Galloway, Northfield and Somerdale, in addition to its Newark clinics. These state-of-the-art facilities offer high-quality, affordable and comprehensive oral health care to underserved residents and serve as training facilities for students and community oral health providers.

Over the past fifteen years the Research Division in the Department of Family Medicine and Community Health at Rutgers Robert Wood Johnson Medical School has developed expertise in primary care research and practice transformation. The Division's team of faculty and staff comprised of qualitative and quantitative researchers conduct cutting-edge, mixed methods research in the areas of diabetes, cardiovascular disease, prevention and health promotion, cancer prevention and control, and mental health. The Division recognizes that improving primary care means understanding the communities that practices serve and how people in the practice organize and deliver care. Therefore, the Division's researchers often look at the complex factors that shape primary care practice, including relationships among practice members and patients, use of health information technologies, and the interconnection between practices and other sources of care.

Specialty care is the fifth domain of Community Health. RBHS, while certainly not the only provider of specialty care in NJ, is a major player. Whether the specialty services are in cancer treatment, liver transplant, retinal surgery, trauma surgery or a plethora of many other areas of sophisticated medical expertise, RBHS is a major contributor to a major change in health services delivery in New Jersey that no longer require that citizens travel out of state for world class specialty care.

Specialty care in our discussion also connotes hospital based services; the committee fully recognizes that many highly specialized health services are better delivered in a hospital. In contrast, adequate access to hospice services and provision of drug rehabilitation programs are prime examples of specialty care probably better offered outside of hospitals. RU provides specialty care for Newark and New Brunswick residents and those beyond. It is not evident that all subspecialists would consider themselves as part of community health, but community health, prevention and therapy in the community, without subspecialty care would be unimaginable.

In summary, discussion among members of our committee has identified strengths in various aspects of community and urban health in Rutgers University. Even though our searches for activities in community health are incomplete, RU community health is associated with sizable funds and volumes of research and training.

1.2 Gaps and Limitations

There are many. We have avoided analysis of particular areas of health and disease such as "urban health" or violence. We have focused on generic issues that impede RU's contribution to community health.

1. Regionalism and other silos: While not intentional, the history of UMDNJ has not been one of statewide unity. In fact, a great deal of possible collaborative opportunity has been and continues to be lost. While we maintain that RU *in toto* has great strengths in community health, those strengths are not uniformly

shared among campuses. Inevitably this has led to lack of intellectual collaboration between campuses and faculty with similar interests may not be aware of each other's work. Members of the committee see that this is already changing for the better.

2. **Dissipation of strength:** Lack of centralized coordination impedes RBHS' ability to assist communities that face health epidemics and trends such as diabetes and metabolic disease, cardiovascular disease, and violence. When Rutgers has concentrated resources and focus in the past, Institutes such as CINJ and EOHSI have flourished. Resources focused on community and urban health could rapidly propel RBHS towards best-in-class status in community and urban health. This is also an urgent need given the racial/ethnic diversity of New Jersey's population and the disparities these groups are increasingly facing in terms of prevention and access to care.
3. **Limited Expertise:** In every area of importance, it is essential to develop sufficient expertise. It is not evident that expertise exists in all the five domains in RU even when considering expertise from all campuses broadly across RU. Economies of scale would dictate that it may be more efficient to develop expertise in some areas that provides services, training, or research across RU. For example, Legacy UMDNJ came to the appropriate conclusion that focus on health disparities was essential. It created an Institute for the Elimination of Health Disparities. The Institute has not flourished. It was never invested with resources adequate to become a major player.
4. **Missed opportunities:** We live in a state at a time when government has increasing public health mandates and decreasing resources to fulfill those mandates. There are many examples where some state governmental health functions are contracted to RU and other instances where services are provided by the private sector. Collaboration with state and local health departments is an incredible opportunity for service, research, and training. New Jersey, especially our large cities are the epicenters for various epidemics and community health trends of national importance. RBHS across all its communities has not consistently partnered with state and local government to improve community health in response to these epidemics and trends.
5. **Inconsistent Evaluation of Programs and Outcomes:** An important outcome of community health is that we have impacted the lives of our learners, participants in our interventions, and the health outcomes of the communities with which we work. While many evaluations are tied to research projects, medical care, and community health interventions, it is unclear if we collect data in a manner that informs future decision-making and programming. RBHS needs to develop a consistent, robust assessment of community health programming and outcomes. A data initiative cannot be the sole responsibility of RBHS as "public health surveillance" is a primary function of governmental public health, but there is substantial opportunity for RBHS to be first-in-class in the area of health data by joining forces with the New Jersey Department of Health in the creation of a data center that facilitates the collection, analysis and use of data for health improvement.
6. **Integration of specialty and sub-specialty care into community health:** Specialty care is a part of a comprehensive health system for a community. Examples of the importance of this integration are easily found. For example, New Jersey has a very high rate of consultation (presumably specialty consultation) in the last weeks of life, yet has amongst the states one of the lowest rates of capacity for hospice care. Another example is liver transplantation for which Newark has an outstanding program, but it is unclear that RU either has a primary care program for the prevention and treatment of a growing epidemic of hepatitis C, or for the ongoing incidence of accidental and suicide-related acetaminophen ingestion. Similarly RU has outstanding programs for the treatment of HIV disease, but the ability to intervene effectively in the prevention of HIV transmission in the community is less well-established. Future efforts will be needed to clarify those bridges that now exist, or should exist, linking specialty care to community health.
7. **Spotty community involvement:** While the Committee could draw upon examples of well-established and appropriate community involvement by RBHS schools, community engagement has not been enunciated as a central core value of RBHS. There are substantial opportunities for RBHS to improve in the area of community engagement.